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How to Structure a "Play-or-Pay" Requirement on Employers:

Lessons from California for National Health Reform

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INTRODUCTION

President Obama has made health care reform a top priority, and Congress expects to pass a bill this year. All of the proposals under serious consideration are "hybrid" approaches, designed to build on the current system of job-based coverage while providing health insurance to all Americans, including those who are not offered it through their place of work. These proposals are often termed "shared responsibility" approaches, because they envision joint contributions by the public sector, individuals and employers. Individuals pay for coverage on a sliding scale based on income with public subsidies for low- and middle-income families. But employers also continue to be responsible for crucial aspects of financing and managing coverage.

In the hybrid health reform proposals under consideration in Congress—as in California in recent years—employer responsibility generally takes the form of "play-or-pay." Firms that do not directly provide health care to their employees (or "play") are required to "pay" into a public pool. Play-or-pay is distinct from what we call "play-or-penalty," in which firms that do not directly provide health care are fined for their noncompliance but those fines do not directly fund their workers' coverage. In play-or-pay proposals, employer contributions are not penalties for failure to provide insurance, but a financing source for the insurance coverage of their workers, whose enrollment in the public pool flows directly from the employers' decision to contribute.

Even within the broad play-or-pay approach, however, many key design choices remain. How Congress resolves these choices will not only shape the constraints and opportunities that employers face; it also has important implications for other strategic aspects of health care reform: how people will be enrolled, how subsidies will be administered, how many people will continue to have employer-sponsored coverage, and so on. And, of course, employer requirements raise important political issues as well. Yet how employer requirements should be structured has received relatively little attention in the current debate, and the experience of states like California that have considered such requirements have been only superficially discussed.

This policy brief examines the policy design, economic effects, and political ramifications of employer requirements. We focus in particular on what Congress can learn from the California experience, as well as from an independent cost and coverage analysis of the "Health Care for America" proposal—a national play-or-pay plan closely resembling current legislative initiatives that was developed by one of us (Hacker) with the support of the Economic Policy Institute. We begin in Part I by reviewing the key reasons for having a play-or-pay requirement. In Part II, we provide a set of recommendations, drawn from the California experience and the "Health Care for America" plan, for navigating the design and political issues raised by national play-or-pay bills. Finally, Part III examines the economic effects of an employer requirement. We conclude that the potential negative effects are modest, are outweighed by potential benefits, and could be easily addressed in the design of the requirement itself.

I. WHY AN EMPLOYER REQUIREMENT?

Employer requirements have been a prominent feature of national reform proposals for decades. President Nixon proposed mandating that employers provide health benefits in the 1970s. The current crop of proposals that include such requirements grow out of the debate of the early 1990s, which saw the introduction of the basic idea of "play-or-pay" with the 1990 report of the Pepper Commission (the Bipartisan Commission on Comprehensive Health Care). The Pepper Commission proposed that employers be required to either provide health insurance or pay a contribution to a new public program to cover those without workplace coverage. The idea was to maintain workplace insurance among employers willing to continue providing it but also to create a relatively low-cost alternative for firms not providing insurance (in the form of the "pay" option).

The Pepper Commission's recommendations helped inspire a number of congressional proposals (most notably, the HealthAmerica legislation introduced by Senator George Mitchell with bipartisan support), as well as proposals from leading business groups. Yet the "play-or-pay" idea was eventually supplanted by President Clinton's proposal for "managed competition." The Clinton plan envisioned virtually all employers paying into regional purchasing cooperatives to help finance coverage for their workers. Although very large employers were ostensibly allowed to set up their own purchasing groups, this option was structured so as to be unattractive to most. Therefore, the Clinton health plan included employer contributions but not a true play-or-pay requirement that would have allowed a substantial number of employers to continue providing coverage on their own.

A Key Element of Current Proposals

Employer requirements are a notable feature of all current leading proposals for reform: Senator Max Baucus's 2008 White Paper; the Senate Finance Committee Options Papers; the Senate Health, Education, Labor, and Pensions Committee's Briefing Paper; and, of course, President Barack Obama's campaign proposal, the key elements of which the

President has continued to promote since taking office. Each of these proposals envision a reform framework in which at least larger employers are required to either provide insurance or pay into a new national insurance pool. Within this pool, workers would have a choice of competing private health plans as well as a public health insurance plan modeled roughly after Medicare.[1]

Health insurance can be expanded without an employer requirement, of course—by, for example, extending the reach of direct public programs (such as Medicaid and CHIP expansions or, at the extreme, creating a new national health insurance program, or "single payer") or by making substantial new vouchers available for private coverage. But all current leading proposals include a major employer role for at least four reasons: (1) the desire to build on the existing system of job-based group health coverage, (2) the goal of leveling the playing field between employers that provide insurance and those competing with them that do not, (3) the aim of reducing crowd out of private coverage by new public programs, and (4) the need to finance expanded insurance.

1. Building on Job-Based Coverage

Job-based coverage is still the major means by which non-elderly Americans receive health benefits. Nationally, about 62 percent of Americans under age 65 get their health coverage through their employer or the employer of a family member.[2] Although most economists believe that employers do not "pay" for coverage, but rather reduce cash wages to offset health insurance costs, much of the financing for health care still flows through employers' coffers—an arrangement encouraged by the federal tax code's exemption of health benefits from taxation as earnings.

In addition to the favorable tax treatment of workplace insurance, employment-based coverage has several other notable advantages over coverage purchased in the individual market. Group coverage serves to share risk and minimize adverse selection. Because administrative, marketing, and enrollment costs are spread across a larger population, group coverage is more efficient and less costly than coverage in the individual market. Employers also have greater bargaining power than individuals in negotiations with

insurers. Moreover, evidence from behavioral economics suggests that individuals are ill-equipped to assess future risk and make sensible decisions among large numbers of plan choices. Employers have greater incentives and means to narrow and tailor plan choices to their specific workforce. Finally, workplace coverage makes plan enrollment simple and virtually automatic.[3]

From a political standpoint, building on employment-based coverage has other important virtues. Americans who have insurance through their employer are by and large happy with their coverage, if not its costs. Public concerns about losing existing coverage were a key reason for the failure of the Clinton health plan.[4] Even without these public worries, replacing the extensive financing that now flows through employers' coffers would require substituting highly visible taxes or mandates on individuals for the relatively hidden contributions now made (nominally at least) by employers. Thus, health reforms that allow families to keep their current sources of coverage are likely to gain greater public support than those that do not.

Nationally, the proportion of uninsured residents of a state is inversely correlated with the proportion that has job-based coverage: the more job-based coverage, the lower the proportion of uninsured. And states vary substantially with regard to the reach of job-based insurance: For example, in Massachusetts—the most prominent state to move toward universal coverage in recent years—an above-average percentage of nonelderly (69.6 percent) have job-based coverage. By contrast, California, where reform efforts faltered, is well below average (55.6 percent compared to 62.3 percent nationally).[5] Not surprisingly, all major reform proposals in California during the recent round of debate, including the 2007 proposal by Republican Governor Arnold Schwarzenegger, included employer requirements.

While a play-or-pay requirement would build on employment-based coverage, it would substantially rectify one of the most serious problems with the employment-based system: the tight link between work for a particular employer and coverage. This is because workers would be assured that all firms subject to the play-or-pay requirement would either provide coverage directly or help fund their workers' coverage through the public pool. Workers would still face the prospect of having to change health plans if they changed employers, as they do today. But they would no longer be at risk of losing coverage

altogether and thus feel compelled to stay with a particular employer to remain insured (so-called job-lock).[6] And workers losing their jobs who covered their spouse or children through their employer-based covered would have access to insurance not tied to their former employer as well.

2. Leveling the Playing Field

Employer responsibility requirements serve to level the playing field between firms that do and do not provide coverage. The vast majority of mid-size and large firms offer health care on the job, at least to their full-time workers.[7] Many small firms, particularly higher-wage firms, also provide coverage. Yet a substantial share of firms does not, with rates of non-provision highest among small employers. Moreover, eligibility, coverage, and benefit levels all vary across firms. Employers contribute significantly different amounts for health benefits based on the risk profile of workers, workforce demographics, and whether they are in the small- or large-group market.[8]

When firms do not provide coverage, or only provide coverage to a limited fraction of their workforce, it raises the costs of coverage for the rest of the population and puts pressure on firms that do offer benefits to cut back their offerings. One way this occurs is by shifting the costs of caring for the uninsured: As uninsured workers and their dependents are forced to rely on emergency rooms for care, hospitals shift costs onto the public and insurers, resulting in increases to the health premiums of firms that do offer coverage. It is estimated that the cost of uncompensated care raises health premiums by between 5 and 10 percent.[9][10] Another path is spousal and dependent coverage: A firm that offers family benefits picks up the cost of spouses who work in firms without health care and of dependents who might have been insured by another firm.

There is also the potential for adverse selection between employers. In the absence of an employer mandate, employees expecting higher health costs may be more likely to apply for jobs with better benefits. This would serve to drive up health costs for employers with low eligibility requirements or better than average benefit plans.[11]

If the cost of employer-sponsored health premiums were to be fully borne by workers, the main competitive impact on firms from these differences in costs would be in firms' ability to attract employees. In any given labor market, firms with less generous benefits would be expected to pay more in cash wages, so the total labor costs for competing firms would be roughly the same. Wage rigidities, however, may significantly limit how much firms can pass on rising health costs to workers, resulting in increased costs to employers in at least the short run. This is likely to be the case when health premium costs are rising two- to three-times the rate of wages since employers are reluctant to reduce nominal wages, or in the presence of a union contract.[12] In these contexts, employers may well face a competitive disadvantage vis-à-vis competitors with less generous (or no) health benefits. A play-or-pay requirement would create a more level playing field for competition.

3. Reducing Crowd Out

If states or the federal government offer subsidized coverage to low- and middle-income families, firms with large numbers of low-wage workers who would qualify for these subsidies have less incentive to provide their workers with health insurance. How extensive such crowd out would be is a matter of debate.[13] [14] Employee health benefits tend to be "sticky," at least in the short run. Health benefits are highly valued by employees, and risk-averse employers may be reluctant to take advantage of the option of dropping coverage. Over time, however, we would expect employers to move toward benefit strategies that minimize their costs, and one such strategy is to allow their workers to be covered by public programs rather than provide benefits directly.

Several studies have found little evidence of crowd out in the first year of implementation of the Massachusetts plan, even with its relatively minor employer requirement. Employer coverage rose as the individual mandate prompted increased take-up while offer rates remained stable. Massachusetts' distinct characteristics, however, make it an imperfect model for national reform: A smaller fraction of the workforce was potentially eligible for subsidies in Massachusetts than at the national level (17.6 percent versus 27.3 percent).[15] Further, Massachusetts waived the individual mandate for middle-income

individuals who were ineligible for subsidies but could not afford coverage. Massachusetts could do this without concern that adverse selection would raise premium costs because it was one of only a handful of states that had guaranteed issue and community rating prior to reform. A national reform that strives for universality will require subsidies for higher income levels than what Massachusetts provides.

At the national level, the extent of crowd out will depend on a number of factors, including comparability between the subsidized plans and the employer plan, the relative bargaining power of the employees, the share of the workforce that qualifies for public subsidies, and a firm's competitive position in its industry. However—and this is the crucial point—crowd out is much more likely when employers are *not* required to contribute a meaningful amount to the cost of covering their uninsured workers, because the cost of allowing their workers to be covered through subsidized options is so much lower. Thus, employer requirements reduce the chance that employers will simply drop coverage to allow their workers to take advantage of coverage outside the workplace.

4. Financing Expanded Coverage

Finally, employer responsibility requirements reduce the degree to which current sources of health financing require radical change that would generate political opposition. In theory, financing is wholly fungible: Taxes could be increased to substitute for employer contributions (which, again, mostly or entirely come out of workers' take-home pay), and indeed would almost certainly be more equitable and progressive. Yet substituting (largely hidden) employer spending for (highly visible) taxes would add a huge additional layer of political difficulty in achieving meaningful reform.

Today, around a quarter of national health spending comes from private employers, which represents a bit less than half of all private health spending—a share that has remained relatively stable since the 1980s.[16] Yet this relatively stable *financing* masks a substantial erosion in the *prevalence* of job-based health insurance. The share of non-elderly Americans with health coverage through an employer—either their own, or a parent or spouse—fell 5 percent points in the United States between the economic peaks in 2000 and

2007.[17] An employer requirement could help reverse that slide and stabilize job-based coverage, allowing new spending on health care to focus on expanding coverage to the uninsured and financing delivery system reforms that improve care and hold down costs for everyone in the long run. Without an employer requirement sustaining current employer funding in the system, crowd out combined with the long-term decline in job-based coverage would mean that substantially greater funds would need to be raised from other sources.

These four imperatives—building on job-based coverage, leveling the playing field, reducing crowd out of private employment-based insurance, and financing expanded coverage—were all on display in recent debates over employer requirements in California. These debates and the options developed amid them provide important lessons about how to approach the political and policy issues raised by a play-or-pay requirement.

II. LESSONS FROM CALIFORNIA FOR NATIONAL REFORM

In the last five years, California made three notable attempts at hybrid reform, two that ultimately failed on the state level and one in San Francisco that succeeded. Each included an employer mandate and sheds important light on how to approach this key design element of hybrid health reform.

The California Proposals

The first of the three proposals was *Senate Bill 2* (SB 2), a state-wide play-or-pay health reform supported by the California Labor Federation, the California Medical Association, Kaiser Permanente, Blue Shield of California, and Health Access California. SB 2 was signed into law by Governor Gray Davis shortly before his recall in November 2003. SB 2 required employers to pay 80% of the premium for health insurance for full-time workers. The California Chamber of Commerce and the California Restaurant Association led a campaign to force the bill onto a referendum in November 2004, where it was defeated by less than a percentage point.

The San Francisco Health Care Accountability Ordinance (HCAO) (detailed in Appendix 1) was passed in 2007 and the employer responsibility component went into effect in April 2008. The HCAO establishes a new local public health access program, Healthy San Francisco, to provide comprehensive health services to uninsured San Francisco residents through a network anchored by the county hospital and clinics, with private hospitals providing specialty services. It is an access program, not an insurance product and is not portable outside of the city. It set a minimum health care spending requirement for firms with twenty or more workers, calculated as a minimum hourly amount on health services for each covered worker. One way employers may meet the requirement is to contribute to Healthy San Francisco. To date, more than 700 employers have chosen to do so. Of the 73,000 uninsured San Francisco residents, 33,000 had enrolled in Healthy San Francisco by January 2009.[18]

Finally, in 2007 leaders in the California State Assembly and Senate and Governor Schwarzenegger each came forward with variations of shared responsibility plans. Between December 2006 and January 2008, four different proposals emerged, embodying variations on the same approach to an employer requirement.[19] Each of these proposals required employers to spend a specified percent of payroll on health benefits, although the proposals varied with respect to the percentage, the scaling by employer size and other provisions. The Legislature first passed AB 8, which the Governor vetoed, forcing a special legislative session. The final compromise bill, ABx1 1, enjoyed support from important sectors of the business community, consumer organizations, labor, and most of the major California-based insurance companies. However, it ultimately failed in the State Senate in January 2008 as a result of the state budget crisis.

It is worth emphasizing that all of the California proposals were developed within the constraints of the federal Employer Retirement Income Security Act of 1974 (ERISA), which places limitations on states' ability to regulate employer-sponsored health benefits. Furthermore, in California raising state taxes requires a two-thirds vote in the legislature or a ballot initiative. Since fees may be increased by a majority vote, policy makers sought to craft proposals in ways that would qualify as fees rather than taxes, creating further constraints that influenced design choices. These special budgetary and ERISA constraints would not apply to federal health reform proposals. Even with these distinctive hurdles, the California experience provides important lessons for national policymakers about how to structure an employer responsibility requirement, as well as about the political forces that will shape its prospects.

To extend the policy design lessons from California to the national stage, we draw on a recent national proposal that employs a play-or-pay approach similar to the major California initiatives and current national proposals: the 2007 "Health Care for America" plan.[20] Under that proposal, employers would be required to provide coverage or contribute 6 percent of payroll to have their workers covered under a newly-created national health insurance pool called Health Care for America, through which enrollees could choose either a Medicare-like public plan or competing private plans. In 2008, the Lewin Group, an independent health care consulting firm, completed its analysis of Health Care for America using 2007 cost and coverage statistics as a baseline.[21]

LESSON 1: Employer requirements can obtain broad-based political support, though that support is fragile and depends on proper framing and design.

The design of the employer requirement has important political implications for passage. Opposition from the National Federation of Independent Businesses was central to the defeat of the Clinton health care plan in 1993. Even large employers, after initially supporting play-or-pay, eventually came out against the employer requirements in Clinton's Health Security Act. However, business reactions to the California health reform proposals varied and suggest that proposals that provide affordable health coverage alternatives to firms and include meaningful measures to hold down health costs are more likely to gain business support today.

ABx1 1, a bill that shares many features with the national proposals, had supporters and opponents in the business community. The California Restaurant Association and the Chamber of Commerce opposed the measure. Safeway and many of the regional Chambers of Commerce supported it. Firm support and opposition did not break down mainly by business size. A survey by Small Business Majority found support from more than half of small business owners.[22] They were willing to trade off the requirement to contribute to health care for the ability to access an affordable plan for their workers. A survey of small businesses in California's San Mateo County found similar results.[23] The insurance companies, too, were split on the measure, with Blue Cross (Wellpoint) in opposition for reasons not related to the employer requirement, and Kaiser, Blue Shield of California and Health Net supporting reform.

Just as the business community and insurance companies split on ABx1 1, so did organized labor. The Service Employees International Union, the American Federation of State County and Municipal Employees, and many of the building trades unions supported the measure. The California Nurses Association opposed on the grounds that it left insurance companies intact. While it had sponsored SB 2 and been supportive of one of the 2007 bills (AB 8), the California Labor Federation (which represents unions on both sides of the debate) did not support the final version of ABx1 1. Many retail unions affiliated with the Labor Federation were especially concerned that large low-wage low-benefit retailers

who already met the threshold for health spending by providing some coverage to a share of their employees would gain a greater competitive advantage as more of their workers qualified for subsidized coverage, without being required to make any further contribution. In the end, the failure of ABx1 1 had more to do with the California budget crisis than with opposition from any group or groups of stakeholders.

SB 2, with its more robust employer spending requirement, had the full support of labor and the California Medical Association, but faced more severe employer opposition. The California Chamber of Commerce led the opposition and the main contributors to the referendum (named "Proposition 72") to overturn the legislation were large retailers such as Macy's and Wal-Mart as well as restaurant chains. Campaign contributions to the ballot measure provide a useful measure of intensity of opposition in various sectors of the business community: Similar to a minimum wage or living wage fight, about three quarters of the campaign contributions opposing SB 2/Proposition 72 were from restaurants—primarily fast food, another fifth from retailers, and the remaining 5 percent or so from general businesses.[24]

By contrast, the major San Francisco employer organizations supported Healthy San Francisco but remained neutral on the employer spending requirement. The Golden Gate Restaurant Association opposed the requirement and filed suit to invalidate that section of the local ordinance on grounds of ERISA preemption. Ultimately, a three-judge panel of the Ninth Circuit Court of Appeals stayed a District Court injunction and then ruled in favor of San Francisco in September 2008.[25] The Ninth Circuit denied *en banc* review in March 2009; the Golden Gate Restaurant Association has appealed to the U.S. Supreme Court.

In California, small businesses were more supportive of employer requirements than commonly assumed. As noted above surveys of small business owners found that a majority supported such reforms,[26] signaling that an employer contribution would be an acceptable trade off for the benefit of affordable care for their workers.

The California experience strongly suggests that employer requirements are a more politically salable way to achieve key reform goals than other leading proposals, including a single payer approach or a straight individual mandate. But they also indicate that minimizing

the direct costs for employers, reaching out to those sectors of the business community that support reform, providing affordable options for uninsured workers in exchange for the employers' contribution, and framing reform proposals in terms of a level playing field and shared responsibility are all important preconditions of alliance-building among employers.

LESSON 2: The employer requirement should apply to all workers, but coverage of part-time workers should be pro-rated.

Because most Americans either work or live in a family with a worker, a broad play-or-pay requirement has the potential to reach virtually all Americans. By way of illustration, the Health Care for America proposal—which applies to all employers (and all classes of workers)—would reduce the number of uninsured by 46.5 million people (that is, 97.3 percent of the uninsured in 2007), leaving only about 1.3 million people uninsured.

For these broad coverage gains to be realized, however, the play-or-pay requirement must apply to all of a firm's employees as well as their employees' spouses and non-working children. While 97 percent of large firms offer health coverage, they only cover an average of 70 percent of their employees. In fact, three out of four workers who do not have coverage through their employer work at firms where fellow workers have coverage. The plurality of these uncovered workers are not eligible for coverage (45 percent); the next largest share have not taken-up coverage (30 percent), often because the costs are viewed as prohibitive.[27]

However, many reform proposals envision excluding part-time workers or small businesses (variously defined) from the play-or-pay requirement. If part-time workers are excluded from a play-or-pay requirement, it creates a strong incentive for employers to offer part-time employment as a way of reducing costs. There is evidence of significant labor market sorting along these lines in Hawaii as a result of its health care mandate.[28,29,30] Instead of excluding part-time workers altogether, a play-or-pay requirement should be designed to make the cost for firms that hire part-time workers proportional to the hours worked. By the same token, as we discuss in *Lesson 3*, concerns about economic impacts on small businesses would be best addressed through a sliding scale requirement on firms, rather than by excluding small firms from the requirement altogether.

The California experience suggests that a requirement on part-time workers can be structured so that it is not economically burdensome on employers. San Francisco's play-or-pay requirement applies to all employees working more than 8 hours a week and is pro-rated by hours worked, based on a forty-hour work week. San Francisco requires businesses to spend a minimum of $1.23 or $1.85 for each worker on health services depending on firm size. For a full time worker, this is the equivalent of 50 or 75 percent of the average cost of an individual health plan in the state, prorated by hours worked.[31] Firms may spend the funds directly on healthcare services or pay into the city fund for the uninsured. By pro-rating the spending amount per hour, the San Francisco ordinance has the advantage of avoiding labor market distortions.

The pay requirement for employees who are not provided coverage should likewise apply to part-time workers and be adjusted to take into account hours worked. A monthly assessment of $100, $250, or $500 for workers who are not offered coverage on the job could be applied to all workers regardless of hours worked and pro-rated by hour. If the assessment is done as a percent of payroll, it should apply to the payroll of all workers who are not offered coverage on the job. The share of premium that the employer is required to finance can be pro-rated for part-time workers.

LESSON 3: The coverage requirement should be reasonable, but meaningful.

Coverage requirements concern both the amount that employers contribute on behalf of workers when they provide coverage directly and the quality of that coverage. The average employer currently contributes 85 percent of the cost of individual health premiums and 74 percent of the cost of family premiums.[32] While a higher contribution creates greater direct costs for employers, a low employer requirement generates affordability concerns for lower-income workers and encourages a greater shift of cost onto the federal government.

The Health Care for America proposal, for example, would require employers that offer coverage to contribute at least 75 percent towards the cost of individual coverage (66 percent for family coverage) for full-time workers (i.e., those working at least 20 hours per

week). Although employers would be required to cover part-time workers, the share of the premium that they would be required to finance would be reduced by one percentage point for each hour under 20 hours.[33] The law currently in effect in San Francisco requires small- and medium-sized employers to cover the equivalent of 50 percent of the average cost of an individual premium and large employers to cover 75 percent of the same cost, pro-rated by hour.

To qualify as coverage, an employer-sponsored insurance plan should be required to meet a minimum benefit standard that takes into account services provided, deductibles and maximum out-of-pocket costs. Health Care for America contemplates that the minimum standard would be based on the minimum benefit plan in a new national insurance pool. This minimum standard would not need to be onerous for employers. Most employer-sponsored health plans are likely to be more generous than a new national minimum benefits standard. Moreover, employer-sponsored plans could be required simply to have benefits that were at least actuarially equivalent to the minimum benefit standard and covered all the same basic service areas.

LESSON 4: The required payments for firms not providing coverage should be modest, but not so low as to encourage crowd out.

The California experience shows that the play-or-pay requirements may be structured in a variety of ways. The requirements may be calculated as an hourly amount per worker as in San Francisco, a percent of premium costs as in SB 2, or a percent of payroll, as with the 2007 California state proposals.

Whatever the method, however, the lower the "pay" requirement the greater the potential that employers will opt to pay rather than continue (or begin) providing coverage. The higher the requirement, on the other hand, the greater the potential for adverse economic impacts. The average firm currently spends 10 percent of payroll on health care.[34] Most play-or-pay proposals, including the Health Care for America plan, have called for a contribution rate approximating 6 to 7 percent of firm payroll, at least for the largest firms.

Setting the assessment based on a percent of payroll would automatically scale by high and low-wage industries. To the degree that costs are passed on to workers, it is a more progressive form of taxation than a flat head count. There is a general recognition, moreover, that some firms have a greater capacity to contribute towards worker health care costs than others. This led California policy makers to develop sliding scales on coverage requirements. SB 2 and San Francisco used sliding scales based on the number of workers. Scales based on the number of employees are relatively simple to administer, but are not the most optimal approach for national reform. First, the number of employees is an imperfect proxy for firms' ability to pay. A small law firm or a doctor's office may have much more capacity to pay than a larger retail store or restaurant. Second, the large differences between steps create a significant marginal cost of hiring additional employees for an employer near the threshold.

By contrast, ABx1 1 would have created a sliding scale based on payroll size as seen in Table 1. Payroll size is likely a better measure of a firm's capacity than number of employees, since it is a function of both number of employees and wage and salary levels. The sliding scale in ABx1 1 would still have created cliffs as firms moved from one category to another. These cliffs could be avoided altogether by setting the requirement on the increment, as with the marginal income tax brackets. Under that scenario, employers would pay 1 percent on the first $250,000 of payroll, 4 percent on the next increment, and so on. Although a sliding scale could significantly reduce the amount of funding available to the public pool relative to a flat rate, it is preferable to exempting large numbers of employers altogether, as argued in *Lesson 3*.

Table 1: Employer Requirements

	Employer Requirement	Applies to:
SB 2	80% of cost of coverage	20-49 employees (if subsidies available) 50-199 employees (employee only) 200+ workers (employee and dependents).
San Francisco Health Care Security Ordinance	$1.85 an hour $1.23 an hour	100 or more employees 20-99 employees
AB 8	7.5% of payroll	All firms
Governor's Proposal	4% of payroll	Firms with 10 or more workers
ABx1 1	1% of payroll 4% of payroll 6% of payroll 6.5% of payroll	Payroll of $250,000 or less. $250,000 to $1 million $1 million to $15 million $15 million and above.

A national health proposal would work best if it combined key elements of the employer requirements in California proposals: As in SB 2, employers should be required to provide coverage or pay into a public pool. For firms electing to play, however, coverage should be required to meet minimum standards for employer contributions and benefits on a scale similar to ABx1 1. As noted, if a monthly or per hour assessment is adopted it should be pro-rated by hour for part-time workers, as in San Francisco.

Finally, indexing the assessment amount is necessary. Indexing based on the actuarial value of the minimum benefit would more closely track the costs of health premiums than indexing on the urban or medical Consumer Price Indexes. By placing the requirement on a specific standard of coverage SB 2 was automatically indexed to health care inflation. The San Francisco Health Care Security Ordinance achieves the same result by setting as a base the average spending on individual health care coverage by the state's ten largest counties. In the national Health Care for America proposal, employer contributions would be scaled to total spending by the pool, producing a similar result. By contrast, employer fees under ABx1 1 were tied to a percent of payroll. If health care costs continued to rise faster than workers' earnings, the health care buying power of the employer contributions would decline

over time. This is a crucial issue, as health care costs have risen well over the rate of inflation and workers' earnings for all but three of the last twenty years.[35]

The issue of who would bear the future risk of rising health costs was of central concern to all stakeholders in the California debates. Businesses were looking for stability and predictability in health premium costs. Consumer advocates feared an individual mandate without guarantees of affordability. And policy makers raised concerns over the long-term costs to the public treasury. Therefore, any proposal must also credibly promise to hold down costs.

LESSON 5: Play-or-pay is preferable to play-or-penalty.

Some reform plans, including the Massachusetts approach, which assesses employers that do not provide coverage a modest fine, treat the employer payment as a "penalty." A better option would be to treat it as a social insurance contribution. Workers whose employers choose to pay the assessment would be automatically enrolled in the pool, with their share of the premium cost deducted from their paycheck pre-tax. To facilitate this, employers would be required to set up cafeteria plans. Workers could choose to opt out, but the default would be to provide coverage. Employees of firms that opt to pay the assessment would receive a discounted rate on the premium in the pool. The discount would not be dollar for dollar based on their employer's payments but would be averaged across employers and take into account the need to finance greater subsidies for low-income workers.

Most firms would make the decision to play-or-pay based on the average wage of their workers and the subsidies available for those workers in the pool. As a result, the pool would almost certainly enroll employees whose average incomes are lower than the average incomes of workers covered by employment-based insurance. It is important, however, that the pool not be limited to low-income workers or the employees of low-wage firms in order to ensure broad public support for the pool over time. Social insurance programs are capable of developing extensive support coalitions that include the middle class as well as the poor,

allowing them to weather fiscal and political challenges and providing a stronger political incentive for their improvement over time.

The health care proposals in California included both social insurance and penalty proposals. SB 2 was set up as a social insurance program. The pool was funded by employer contributions and available only to those whose employers chose to pay in. Under AB 8, all workers of employers who chose to contribute to the pool would have been automatically enrolled, and the employer contribution would have covered part of the individual premium.

In San Francisco, all residents are eligible for *Healthy San Francisco* if they have not been insured in the last 90 days and are not eligible for other public programs. Workers whose employers pay into the pool receive a 75 percent discount on the programs' participation fee, which is paid quarterly on a sliding scale based on income. Quarterly participant fees for individuals without an employer contribution run from $0 for lower income families to $675.

In Governor Schwarzenegger's original proposal in California, by contrast, the contribution was a penalty and the pool functioned as a social welfare program. The pool was only available to families under 250 percent of the federal poverty level, with sliding scale contributions based on income. The rates were the same for all eligible families, regardless of whether or not their employer made a contribution.

ABx1 1 fell somewhere between the two approaches. It allowed all workers whose employers chose to pay rather than play to access the pool. Employees who qualified for subsidies would have received the same subsidy rate as individuals without an employer contribution, but would have further benefited from the tax treatment of a Section 125 plan. The question of rates for employees who did not qualify for subsidies was left to the regulatory phase.

Part of the reason for the hybrid approach in ABx1 1 was financial—after covering the cost of subsidies for low- and middle-income families, there would be little left to apply towards the cost of coverage for higher-income workers. The other major consideration was adverse selection into the pool. Employers who pay higher premium rates in the private market are more likely to choose the pay option than employers who pay relatively low rates.

Because employer rates correlate with the risk profile of their employees, the self-selection of firms with higher costs into the public pool would raise the average risk of enrollees in the pool.

This is not an issue for low-wage firms where heavy subsidies in the pool will provide a strong inducement to "pay" regardless of risk profile. It is mainly an issue for high-wage firms where employers with high-risk workforces would have a stronger financial incentive to pay the fixed payroll contribution than similarly-situated employers with low-risk workforces.[36] The extent of the problem will depend on the overall design of the plan. We discuss the impact of risk selection in *Lesson 6*.[37]

LESSON 6: Adverse selection against the pool is likely to be more minimal than feared.

One major criticism of play-or-pay proposals is that the pool will be subject to an influx of unhealthy workers, because firms with the highest health costs will enroll their workers in the pool. It is worth separating this concern from the oft-stated (but incorrect) claim that the uninsured are a highly costly group to insure. Although some of the uninsured are in poor health (in part because they lack insurance), many are young and inexpensive to insure. Past estimates suggest that the overall costs of uninsured Americans should be about equal to the rest of the population once they are covered.[38]

But, of course, a play-or-pay proposal does not simply cover the uninsured within a new pool. It covers all workers whose employers do not provide insurance. And employers with higher premium rates will be more likely to choose the pay option than employers with the lower rates, creating the potential for adverse selection.

In analyzing Health Care for America, the Lewin Group looked at the degree of adverse selection that was likely to occur at different payroll contribution rates. The main measure of adverse selection this analysis focused on was differences in the monthly costs per member. To obtain an "apples-to-apples" comparison of the health care costs of enrollees, the Lewin Group assumed that plans inside and outside the pool used the same

payment rates and excluded administrative costs from consideration. This means that differences in spending figures are based on utilization of health services only.

The Lewin Group found that as the payroll tax rate decreases, the distribution of workers in the Health Care for America pool shifts slightly to older workers. This is because as the payroll tax rate decreases, the employers that would continue to offer coverage would have younger and lower-cost workers. Overall, however, the Lewin Group found only slight differences in the health status of enrollees inside and outside the pool at any of the three tax rates examined (5, 6, and 7 percent).

With regard to comparative spending, the differences were also relatively minimal at all tax rates. As the contribution rate decreased from 7 percent to 5 percent, average per member per month spending within the pool increased and average per member per month spending outside the pool decreased. But again, the differences were small. The Lewin Group concluded that "applying a 5 percent, 6 percent or a 7 percent payroll tax did not appear to result in any significant adverse selection."

LESSON 7: To minimize adverse selection, the pay requirement should either be "all-in or all-out" or employers should be required to pay what they would have paid on workers behalf for workplace coverage when individual workers opt into the pool.

In the Health Care for America proposal, firms would be required to enroll all their workers either in job-based coverage or the new pool. Allowing employers and employees to make decisions on an individual basis of who retains job-based coverage and who opts for the pool would create another potential source of adverse selection: Employers could price coverage to their workers so that higher-risk workers find it advantageous to go into the public pool and lower-risk workers find it advantageous to keep job-based coverage. Conversely, if healthy individuals find it cheaper to access the pool, and less healthy individuals choose to stay in job-based coverage, adverse selection would go against the firm health plan, driving up costs. In order to solve this problem, SB 2 (like the Health Care for

America plan) required firms to make an "all in" or "all out" decision: Either they covered all workers, or they paid for all workers to go into the pool.

In San Francisco, employers may pay into the public program for only those workers who are not eligible for job-based coverage, while retaining employer-sponsored insurance for the rest of their workforce. As noted above, individuals must also have been uninsured for at least 90 days in order to be eligible for *Healthy San Francisco.* Workers' costs for *Healthy San Francisco* are based on family income, so low-wage workers place greater value on the program than those with higher incomes, which would lessen the potential for adverse selection. Notably, *Healthy San Francisco* is not an insurance plan but instead provides access to care through a restricted network structured around the public hospital, so workers are also less likely to place the same value on it as they would on an employer-sponsored health plan, which in turn would discourage employers from dropping existing coverage. It is too early to evaluate the impact of the program on employer and individual coverage decisions.

AB 8 divided full and part-time workers into two separate groups allowing employers to make the selection separately on each of the two groups. This acknowledged the reality that many employers do not currently provide coverage for part-time workers, and that many part time-workers would not be able to afford a pro-rated share of the employer-premium price.

A proposal outlined by the Senate Finance Committee in its "options" paper addressed the issue of low-wage workers by allowing individuals to decline employer coverage and opt into what they term the exchange. The employer would be required to contribute the amount it would have paid towards the worker's premium, but workers would pay as if they enrolled as individuals, with income-based subsidies.[39] This would allow low-wage workers to take advantage of subsidies within the exchange while still maintaining the employer's contribution to the cost of care. The incentive to opt out of coverage would be mainly driven by income level, rather than health risk. Workers eligible for subsidies in the exchange that exceed the share of premium paid by their employer would be likely to decline employer coverage in favor of coverage through the exchange.

III. POTENTIAL ECONOMIC IMPACTS

The main argument against employer requirements is that they place a tax on employment, leading to fewer jobs.[40] Recent economics research as well as the California experience strongly suggests, however, that these concerns are overstated when it comes to the play-or-pay proposals currently under consideration, with their relatively modest requirements.

How Firms Would be Affected by New Costs

In any play-or-pay proposal, employers subject to the new employer requirements that do not sponsor health insurance would have to pay some minimum amount for health benefits, and employers that do sponsor health insurance would have to bear new costs if their coverage fails to meet the minimum standards and they choose to upgrade it. And all firms would face new administrative and compliance requirements.

Firms may absorb the costs of an employer requirement in a variety of ways. Over time, we would expect a large share of the cost to be passed on to workers through forgone wage increases. Pass-throughs to consumers are also well documented. After the passage of the health-care ordinance in San Francisco, many restaurants added small health-care surcharges to their checks to cover the costs of the program.

The real concern is for workers at or near the minimum wage, where pass-throughs to workers are prevented. As long as all employers face the same rules, however, firms with workers at or near the minimum wage may pass on part of the cost to consumers without impacting their ability to compete. The vast majority of firms that currently do not offer health benefits are in non-tradable industries and in markets where their competitors also do not provide benefits, and thus would see increases similar to those of their competitors.[41]

Moreover, the incremental costs even for these firms would be small. An analysis of the California proposal ABx1 1 found that the average firm would have had an increase in

payroll costs of a little less than 1 percent, for an increase in operating costs of about 0.4 percent.[42] An important new study of the impact of the Hawaii health-care mandate found no evidence of reduced employment as a result of the law.[43] Likewise, recent studies of minimum wage raises of increments similar to those proposed in the Senate options paper have found no measurable impact on employment.[44,45] An analysis of the effect of an employer requirement of 8 percent of payroll on all firms regardless of size, assuming no pass-through of costs onto consumers or profits put the worst case scenario at 166,000 jobs lost.[46] A more reasonable range of assumptions generates between close to 50,000 jobs lost and an equivalent number of jobs gained. *This is prior to taking into account any of the positive economic impacts of health reform.*

Weighing the Benefits Alongside the Costs

These positive impacts of reform could be substantial. Firms that do not now provide coverage will be able to purchase low-cost coverage for their workers through the pool. Many firms that provide coverage for working dependents of their employees would no longer have to. Some firms that provide coverage would also benefit from the option of enrolling their workers in the new pool, which would effectively cap their direct obligations. Moreover, the cost of COBRA continuation coverage would likely be reduced as non-workers receive coverage from the pool. This is because workers who elect COBRA generally have higher health costs but pay a premium equal to what it costs to provide coverage to employed workers. And all firms would benefit from the reduction of cost-shifting from unpaid medical bills incurred by the uninsured.

In addition, increases in payroll costs from the employer requirement would be offset through declines in the cost of health coverage and improvements in productivity. The play-or-pay requirement is one part of a broader health reform. Proposed improvements in information technology, greater focus on preventative care and chronic disease management, use of evidence-based medicine, and administrative simplification will all serve to contain health care costs.[47,48] The Council of Economic Advisors found that lowering the rate of annual health cost growth by 1.5 percentage points would increase real gross

domestic product compared to the non-reform scenario of 2 percent a year by 2020 and 8 percent by 2030. Under this assumption, employment would increase by 500,000 each year over the baseline. Covering the uninsured would increase economic well-being by $100 billion a year.[49]

Expanded access to health care can also be expected to raise productivity through improved workers' health, labor-force participation, and better matches of jobs to workers skills. Workers without health coverage are more likely to miss necessary care, less likely to receive treatment for chronic conditions and more likely to suffer from debilitating conditions that will keep them out of the workforce. Broader coverage is likely to result in decreased absenteeism and disability-based exits from the labor force. Moreover, there is strong evidence that health insurance plays an important role in worker mobility decisions. Universal coverage would decrease "job-lock" and improve matches between workers skills and positions.[50,51] Finally, the high cost of health premiums restricts self-employment and small business creation. Affordable options for coverage would encourage entrepreneurship and small business creation.

Table 2 summarizes these new costs and benefits.

Table 2: Costs and Benefits of Employer's New Role

	Firms That Do Not Sponsor Insurance	Firms That Sponsor Insurance
New Costs	• Some minimum percent of payroll for health benefits • Reporting and compliance expenses	• New requirements governing level and breadth of coverage • Reporting and compliance expenses
New Benefits	• Access to low-cost coverage for workers through pool • Reduced cost of COBRA • Reduction in uncompensated care, making coverage more affordable • New, affordable coverage options • Reduction in the growth in premiums due to delivery system reform • A healthier, more productive and mobile workforce	• New payments to cover working spouses • Opportunity to limit cost of health benefits by paying into pool • Reduced cost of COBRA • Reduction in uncompensated care, making coverage more affordable • Reduction in the growth in premiums due to delivery system reform • A healthier, more productive and mobile workforce

The analysis by the Lewin Group of Health Care for America, which includes many of the features discussed above, found that private employer health contributions would decrease by $10 billion in the first year, although the impact on any given firm would depend on its current level of health spending.[52]

In sum, any accounting of the economic impacts of health reform must take into account both the costs and the benefits of the total reform proposal. The net impact of health reform on the economy is likely to be large and positive. A play-or-pay requirement as part of a broader shared responsibility health reform poses no economic threat to business and the economy.

CONCLUSION

The leading health reform proposals in Congress are all hybrid plans that build on our existing system of job-based coverage. Employer responsibility is an essential element of such plans. Employer requirements help stabilize job-based coverage, reversing the slide in coverage rates. They reduce the incentives of low- and middle-wage firms to drop coverage in the context of public program expansion. They serve to level the playing field between employers, and they provide an important source of financing for the expansion of health coverage to uninsured workers. While in theory financing is fungible, politically, raising taxes to pay for a health coverage expansion and to subsidize coverage for workers whose care is currently financed by their employer would add a significant obstacle to reform.

How Congress designs the employer requirement will have important implications for the health reform strategy as a whole. Key design choices include the relationship between employers and the pool, the structure of the requirement, the contribution level or levels for different firms and which workers and firms are covered under the requirement. California's recent experience with play-or-pay proposals illuminates all of these issues.

Based on the California experience, and drawing on the Lewin Group analysis of the Health Care for America plan, we have presented our conclusions as a series of lessons for national reformers. The basic lessons are straightforward:

1. **A shared responsibility approach to health care reform can attract political support from across a broad range of stakeholders, including important sectors of the business community and labor.** Indeed, the California proposal might have enjoyed even greater support if not for forced design choices due to ERISA preemption and California laws governing taxes. Polls of businesses in California showed a plurality of support for employer requirements in the context of comprehensive health care reform that would create new options and control costs.

2. **Because most Americans either work or live in a family with a worker, a broad play-or-pay requirement has the potential to reach virtually all Americans.** For these gains to be realized, however, the requirement must apply to all of a firm's employees as well as their employees' spouses and non-working children. To minimize the impact on employers that rely heavily on part-time workers, however, a play-or-pay requirement should be designed to make the cost for firms that hire part-time workers roughly proportional to the number of hours worked.

3. **The employer contribution level will need to be high enough to reduce the incentive for firms to drop coverage, while also taking into account firms' abilities to absorb the higher costs.** If a sliding scale is used, payroll cost is a better measure of firms' ability to pay than the number of employees. Sliding scales should be designed in such a way to minimize cliffs by size of firm.

4. **The standard for coverage to meet the "play" requirement should include both a minimum employer contribution towards health premium and a minimum level of benefits.**

5. **The pool should be open to all employees of firms that choose to pay, regardless of worker income, and its premiums should be reasonable for higher-income workers.** To the degree that the pool has participation from across the income spectrum and is understood as a social insurance program, rather than a welfare program, it will have greater public buy-in and political support over the long run.

6. **While the potential for adverse selection into the pool is an important design consideration, it does not preclude opening the pool to large employers and higher-income employees.** Health Care for America provides one model for how this can be done.

7. **Minimizing adverse selection requires either an all-in or all-out approach, in which workers whose employers "play" rather than "pay" all receive coverage from their employer; or carefully structuring any proposal so that workers (and employers) do not face incentives that encourage only high-risk workers to enroll in the pool.**

Finally, play-or-pay proposals currently under consideration pose no economic threat to business and the economy. The cost to employers would be similar to a modest increase in the minimum wage. At the same time employers would benefit from access to the new pool, a reduction in the cost shift from uncompensated care into premium costs, and other reforms that would bring down the cost of coverage over time.

Employer requirements are an essential part of any reform proposal that attempts to build on employment-based health insurance while filling the growing gaps in workplace coverage. The California experience offers important lessons for how such a requirement should be designed to ensure political support, provide the broadest coverage, and minimize the potential dislocations for employers. Ultimately, however, the most important precondition for a successful play-or-pay requirement is a broad commitment that all Americans have access to secure, affordable, quality care.

APPENDIX:

SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE

The San Francisco Health Care Security Ordinance has two central elements. First, it establishes a new health program, Healthy San Francisco, to provide comprehensive health services to uninsured San Francisco residents with a focus on prevention. Second, it sets a minimum health spending requirement for firms with 20 or more workers.

Healthy San Francisco

Healthy San Francisco is a comprehensive medical care program for uninsured San Francisco adults operated by the San Francisco Department of Public Health. The program is open to uninsured San Francisco residents regardless of health, employment or immigration status on a sliding scale based on income. Applicants must have been uninsured for a minimum of 90 days and be ineligible for public insurance programs.

The program restructured the county indigent health system in order to encourage preventive care and continuity in primary care. Enrollees are assigned a medical home and a primary care physician. Services include preventive care, primary care, specialty care, urgent and emergency care, behavioral health, laboratory, inpatient hospitalization, x-ray and pharmaceuticals. Healthy San Francisco is a health access program, not insurance. Health services are not available outside the city or outside of the local network.

Healthy San Francisco is financed by a combination of individual participant fees, employer contributions, and city, county and state funding. The participant fee is paid quarterly based on a "sliding scale." The fee is both predictable and affordable for individuals. Point of service fees are also on a sliding scale based on income, with little or no cost sharing for individuals in families below 100 percent of the federal poverty level. By

using a centralized eligibility system, the city is able to maximize access to public funding streams.

Quarterly Fees for Healthy San Francisco

Percent of Federal Poverty Level	2-100%	101-200%	201-300%	301-400%	401-500%	500%+
Quarterly Fee	0	$60	$150	$300	$450	$675
Fees as a percent of income	0	2.3%	2.9%	3.9%	4.4%	5.2%

Source: San Francisco Department of Public Health

Of the 73,000 uninsured San Francisco residents, to date 33,000 have enrolled in Healthy San Francisco. The Department of Public Health projects that this will grow to 60,000 by the end of 2009.[53]

Employer Health Spending Requirement

Firms with 20 or more employees are required to spend a minimum hourly amount per worker on health services. This may include contributions toward health benefits, Health Savings Accounts, direct reimbursement of health care costs, or payment into the city program.

Businesses with 20 to 99 workers are required to spend a minimum of $1.23 an hour per employee on health services. For a full-time employee, this is equivalent to 50 percent of the average amount that the 10 largest counties in California (other than San Francisco) spend on individual health coverage for their employees. Businesses with 100 or more workers are required to spend a minimum of $1.85 an hour per employee on health services. For a full-time employee, this is equivalent to 75 percent of the average amount that the 10 largest counties in California (other than San Francisco) spend on individual health coverage for their employees. Workers of firms who pay into the program receive a 75 percent discount on enrollment fees. There is currently no enrollment fee for any worker with a household income of less than 300 percent of the Federal Poverty Level whose employer pays into the program. [54]

Nearly half of those who work in San Francisco do not live in the city and are thus not eligible for Healthy San Francisco, which is only available to San Francisco residents. To ease the administrative burden on employers, the ordinance was amended to allow them to pay into the program for non-residents as well as residents; funds paid for workers who do not live in the city are used to established Medical Reimbursement Accounts in those workers' names.

The employer spending requirement went into effect on April 17, 2008, for employers with 50 or more workers and on April 1, 2009, for employers with 20 to 49 employees.[55] Over 700 employers had chosen to pay into the city plan in 2008, contributing $26 million on behalf of 31,000 workers. This represents three-quarters of large employers and half of medium sized employers. Half the workers were eligible for Healthy San Francisco, the other half received Medical Reimbursement Accounts.

NOTES

[1] For information on how such "public plan choice" works see Jacob S. Hacker, "The Case for Public Plan Choice in National Health Reform" (Berkeley: Center on Health, Economic & Family Security, 2008) and "How to Structure Public Plan Choice" (Berkeley: Center on Health, Economic & Family Security, 2009) available at http://www.law.berkeley.edu/chefs.htm.

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[4] Jacob S. Hacker, "Yes We Can? The New Push for American Health Security," *Politics & Society* 37 (1) (2009): 3-32.

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[7] According to the Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 99 percent of large firms and 62 percent of small firms (3-99 workers) offer health coverage. Kaiser Family Foundation and Health Research & Educational Trust, "Survey of Employer Health Benefits" (2008) accessible at http://ehbs.kff.org/images/abstract/7814.pdf (last accessed June 2009).

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[14] Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?," *Health Affairs* 21 (1) (2002): 225-239.

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[17] Sylvia Allegretto, Arindrajit Dube, Dave Graham-Squire, and Ken Jacobs, "Labor Day 2008: Recession or Not, a Downturn for Working Families: A Briefing on Jobs, Wages, and Healthcare" (Berkeley: Center for Labor Research and Education, 2008) available at http://laborcenter.berkeley.edu/jobquality/laborday08.pdf (last accessed June 2009).

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[32] Kaiser Family Foundation, "Survey of Employer Health Benefits" (2008).

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[35] Kaiser Family Foundation, "Employer Health Benefits: 2007 Annual Survey" (2007) Exhibit 1.1.

[36] Rick Curtis and Ed Nueschler, "Designing Health Insurance Market Constructs for Shared Responsibility: Insights from California," *Health Affairs* 28 (3) (2009): w431-w435 available at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.28.3.w431 (last accessed June 2009).

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