Technical Appendix to

The Economic Impact of the Affordable Care Act on California

A Bay Area Council Economic Institute Report
May 2012

This document provides a technical summary of the methods used to develop the results presented in the Bay Area Council Economic Institute's report, *The Economic Impact of the Affordable Care Act on California*, published in May 2012. It also provides a summary of the effects of the Act on state and local taxes.

There were seven major elements in the analytical model used to generate the projected impacts of the Affordable Care Act (ACA) that were presented in the report:

1) Employer Mandate;
2) Small Business Tax Credit;
3) Individual Mandate;
4) Private Coverage Expansion;
5) Medicaid Expansion;
6) Labor Force Participation; and,
7) Reduction of Job Lock.

This appendix describes in more detail the methods and data sources used for each of these analyzed parts. A final section presents results on changes in state and local taxes.

1. Employer Mandate

The employer mandate contained within the ACA assesses fees (or fines) imposed on employers in the following amounts:

- Employers who do not offer insurance and have 50 or more full time employees and at least one employee that receives a premium tax credit are required to pay
  - $2,000 per full time employee (excluding the first 30 employees).
- Employers who offer insurance and have 50 or more full time employees, but have at least one full time employee receiving a premium tax credit are required to pay
  - the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full time employee (excluding the first 30 employees).

The modeling strategy we employed for the report uses establishment level data from the National Establishment Time-Series (NETS) Database for California.[1] The data we used provides employment levels for every business establishment located in the state in 2008. This year was chosen because 2008 is the last year for which reliable data is available. This data was combined with information from other sources to identify the proportion of business establishments falling into each of the two assessment categories listed above.

As a starting point, data from the Medical Expenditure Panel Survey (MEPS) was used to establish the likelihood that individual business establishments provide their employees with health insurance coverage.[2] The Survey provides the percentages of firms of given sizes in California that provide health insurance.

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[1] For more information on the NETS Database, see Walls, Donald W., National Establishment Time-Series Database©: Data Overview (November 2, 2007). 2007 Kauffman Symposium on Entrepreneurship and Innovation Data. Available at SSRN: http://ssrn.com/abstract=1022962 or http://dx.doi.org/10.2139/ssrn.1022962

[2] Agency for Healthcare Research and Quality (AHRQ), Medical Expenditure Panel Survey (MEPS), "Table II.A.2(2010) Percent of private-sector establishments that offer health insurance by firm size and state: United States, 2010," http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2010/tiia2.htm

California Private-Sector Establishments that Offer Health insurance, 2010

Firm Size by Number of Employees	Percent Offering Insurance
1–2	0*
3–9	34.6
10–24	60.9
25–99	77.4
100–200	96.7
200–999	98.0*
1000+	99.5

Source: MEPS
*Zero value is an Economic Institute assumption; 98.0 value is from the Kaiser Family Foundation.

Establishments are identified by the county in which they are located and the 2-digit North American Industrial Classification System (NAICS) code of primary operations. The MEPS percentages were assigned to establishments in California according to reported number of employees. Each business establishment is assumed to insure in the same proportion as establishments of comparable size. The result is therefore a synthetic, but comprehensive, database of business establishments in California, where the rate of insurance is representative of establishments of a given size, but does not reflect the actual rate of insurance of any given establishment. (Actual data on establishment level insurance offerings is not generally available.)

In order to refine the insurance rates for each establishment, we scaled them up or down, as appropriate, so that the overall rate of insurance matches that of the county as reported in the 2010 (3-year) American Community Survey (ACS).

The county level rates of employer-provided insurance obtained from the ACS are based on responses to a survey question asking whether or not insurance is provided to an individual by an employer. The ACS does not distinguish the source of insurance as the individual's own employer or that of their spouse. Accordingly, the likelihood that any married full time employee has insurance from his or her own employer must be scaled down to control for the possibility that the insurance is provided through a spouse's employer-subsidized insurance (ESI) coverage.

This scaling was performed by running a probit regression where the dependent variable is having employer-provided coverage according to the ACS survey. The independent variables include industry fixed effects and

industry-specific controls for marital status. The regression results are then used to reduce the likelihood of any married individual having his or her own employer-provided health insurance to be the same as that of a non-married individual in the same industry.

For any particular 2-digit NAICS industry category, this procedure reduces the likelihood of having ESI for any married individual to be the same likelihood as that of a single person. In general, the likelihood of married individuals having employer-provided health insurance is reduced by between 10 and 12 percentage points.

This process results in ACS-indicated rates of ESI coverage by industry that closely mirror those obtained by applying the MEPS survey results to the establishments in the NETS database. The county level rescaling indicated above controls for differences in ESI rates across counties.

We included the following key assumptions:

1) If an establishment does **not** provide insurance coverage, there is at least one person receiving the premium tax credit.
2) Of the number of employees at an establishment, the proportion who are full time is estimated according to the proportion of individuals reporting full time versus part time status in each NAICS-county pair in California, according to the ACS.
3) 50% of the assessed fee is passed along to employees.

Assumption 3 is worthy of some discussion. It is frequently assumed that increases in benefits or other labor costs are fully passed on to employees. The Congressional Budget Office has justified this position by appealing to research related to payroll taxes (e.g., Social Security), where it has often been found that the tax is largely passed on to employees. However, to the extent that employee costs are increased by establishments paying the penalty rather than offering insurance (which was assumed here), the employee does not benefit directly from the payment. Accordingly, it is more difficult to pass on this expense to the employee than it is to pass on a payroll tax or other increase in employee benefit. It seems unlikely that the penalty will be fully absorbed by either the employee or employer, so we have taken the middle ground and have assumed that the burden of the fee is evenly split.

Another key aspect of the ACA provisions is that coverage requirements and penalties are based on numbers of full time employees. The NETS data provides numbers on employment at business establishments, regardless of whether the employment is full time or part time. For our purposes, full time employment in each establishment was estimated by dividing the Survey's employment number between full and part time according to estimates at the county 2-digit NAICS level derived from the ACS.

An additional control we inserted is the influence of the look-back provision. Whether or not individuals are classified as full time or part time employees is based on their status in the first 60 days of their employment. In industries with high rates of turnover, there is the potential for an establishment with roughly 50 full time employees to hire part time employees for 60 days and then change their status to full time thereafter as a way of avoiding the penalty.

This effect was modeled by using estimated rates of turnover by 2-digit NAICS industry. The number of full time employees in each establishment was scaled down by the rate of turnover divided by 10.[3] This procedure reduces the amount of job loss by a reasonably small amount, roughly 3,500 workers, or less than 7% of all estimated job loss attributable to the employer mandate.

Once establishments were classified as subject to a fine, the influence of the fine on employment was estimated. Labor costs are not provided in the NETS data, but were estimated using data from the ACS and other data on the proportion of labor costs that are due to benefits other than health insurance.[4] Labor costs due to wages and non-health-related benefits were used as a baseline, and the impact of the penalty on labor costs for establishments not providing insurance was the basis for estimating employment changes.

An estimate of the employment responsiveness to changes in labor costs of -0.1 was used.[5] For each one percent increase in labor costs, there would be a 0.1% decline in employment at an establishment. The influence of the penalty would vary across industries according to average wages and the cost of non-healthcare benefits. Higher wages and/or higher non-healthcare benefits would lead to smaller employment losses because of the penalty.

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[3] Annual U.S. Department of Labor employee turnover rates for total separations by industry and region, as reported by the Nobscot Corporation. http://www.nobscot.com/survey/us_total_separations_0806.cfm.

[4] Bureau of Labor Statistics, 2010 National Compensation Survey.

[5] Phillip Cryan, "Will a Pay-or-Play Policy for Healthcare Cause Job Losses?", *Economic Policy Institute*, June 2009.

2. Small Business Tax Credit

Under the ACA, businesses with fewer than 25 full time equivalent employees and average annual wages less than $50,000 will be eligible for a healthcare subsidy. The subsidy is only available to such firms if they offer healthcare coverage and can be as much as 50% of the establishment's healthcare costs once the ACA is fully implemented. The subsidy is maximized for establishments with 10 or fewer full time employees (FTEs) and average annual wages less than $25,000.

Our evaluation of the cost savings and hence employment increases that may result from these subsidies is based on the NETS data for California in 2008. This is the same data that was used to evaluate the impact of the employer mandate. The NETS data on business establishments was supplemented with data from the 3-year 2010 American Community Survey on average annual wages and numbers of full time versus part time employees; the wage and full time and part time data are specific to counties at the 2-digit NAICS level.

Using this data, we evaluated companies on a case by case basis to determine their eligibility for the healthcare subsidy and the size of the subsidy. The subsidies are discounted by 10% for each FTE above 10 employed at the business, and by one twenty-fifth for each $1,000 in average wage income above $15,000. These subsidy offsets are implemented independently, so a business with 20 FTEs and average wages above $37,500 would be ineligible for any subsidy.

The impact of subsidies on employment was calculated using a method analogous to the one used for the employer mandate impact analyses. The difference is that here labor costs are falling, while they were rising for the employer mandate. The elasticity calculation was adjusted by 50% for the fact that some of the lower labor costs will be passed on to employees. Another adjustment was made to the proportion of employers that are affected. Of those eligible for the subsidy, we assumed a 50% take-up rate for small businesses with low annual wages, and a 25% take-up for businesses receiving less than the full amount of the subsidy.

3. Individual Mandate

The ACA includes a mandate that individuals must be covered by insurance or pay a penalty at the time that they pay their taxes. Our treatment of the individual mandate estimated the reduced purchasing power among those who are not currently insured and have household incomes in excess of 133% of the appropriate poverty line. Those with lower incomes become eligible for Medicaid through the ACA.

The fine included in the ACA for not obtaining insurance is small enough so that not all individuals without insurance will choose to obtain insurance. We used a calculated size for the newly insured group that is derived from the analysis performed by a team of researchers from the University of California, Berkeley and UCLA. Their model indicates that under the ACA, of those who are uninsured in 2019 (of which there are estimated to be 5.8 million),

1) 814,000 (14.5% of the total) will be buying subsidized insurance through the exchange;
2) 563,000 (9.7% of the total) will be buying unsubsidized insurance through the exchange or outside market; and,
3) 220,000 (3.8% of the total) will be paying some portion of the premium for employer-subsidized insurance.

Although these figures are from a 2019 scenario, our analysis is an assessment of the difference between a fully-implemented ACA world in 2010 and the non-fully-implemented ACA world that was actually experienced. Accordingly, the populations in the first and second groups above were identified using the 3-year 2010 ACS. The primary distinction between the two groups is where they fall vis-à-vis the poverty line. The first group is all below 400% of the relevant poverty line, while the second group is above that mark.

The 3-year 2010 ACS identifies an average of 5.832 million individuals as uninsured in California in each year between 2008 and 2010.[6] Using the percentages above, we estimated the numbers below for two out of three groups of individuals who would have received insurance but who did not at the time.

1) 845,640 (14.5% of the total) would be buying subsidized insurance through the exchange.
2) 565,704 (9.7% of the total) would be buying unsubsidized insurance through the exchange or outside market.
3) For this third group of individuals, we did not estimate numbers, as there is no methodology for estimating the increased premium payments that they might make.

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[6] These are individuals over age 18, or under age 18, but with family income greater than 250% of the relevant poverty line.

Our analysis considered the reduced disposable income available to these individuals because they would be spending money on premium payments that they did not previously have to make.

The ACS provides information on the distribution of income for these individuals. Using this data, it is possible to estimate the change in disposable income available to the families in which these individuals live. The IMPLAN system provides consumption patterns for families with different levels of income.

The change in disposable income was calculated as the premiums that these individuals must pay plus additional out of pocket expenses in excess of what the average uninsured individual pays out of pocket.

Premiums were calculated as follows, with limits applying on an individual basis.

1) For those receiving subsidized insurance,
   a. 0 for those with incomes below 133% of the poverty line,
   b. 3.5% of income for those with incomes between the 133 and 150 marks,
   c. 5.15% of income for those with incomes between 150 and 200,
   d. 7.15% of income for those with incomes between 200 and 250,
   e. 8.7% of income for those with incomes between 250 and 300, and
   f. 9.5% of income for those with incomes between 300 and 400.

2) For those not receiving a subsidy,
   a. $4,800 per year.[7]

Out of pocket expenses were calculated as follows.

1) For those with incomes below 250% of the poverty line,
   a. coverage pays 94% of all costs for those between the 133 and 150 marks,
   b. coverage pays 87% of all costs for those between 150 and 200, and
   c. coverage pays 73% of all costs for those between 200 and 250.

2) For those with incomes above 250% of the poverty line,
   a. additional out of pocket expenses were estimated to be $702 less what they would have been when those individuals were uninsured: (550+583)/2 * 1.074 = $608 or a net increase of $94.[8]

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[7] http://www.healthexchange.ca.gov/FederalGuidance/Documents/Milliman-Essential_Health_Benefits_Comparison-Cost_of_Services2-21-2012.pdf

[8] Jack Hadley et al., "Covering the Uninsured in 2008: Key Facts about Current Costs, Sources of Payment, and Incremental Costs." *Kaiser Commission on Medicaid and the Uninsured*, August 2008. Page 3 of the fact sheet indicates $654 in 2008. Inflating this by 1.074 yields a 2010 figure of $702.

The following elements were also included in our calculations.

1) Children under age 18 in families with incomes below 250% of the poverty line are excluded.

2) The formulas for premiums are ignored if they result in a premium greater than that available on the exchange; $4,800 is assumed to be the effective cap.

3) Average healthcare costs were taken from the Kaiser fact sheet, "Covering the Uninsured in 2008." Average healthcare expenditures for the insured were $4,463.

4) Inflation between 2008 and 2010 was 7.4%. Adjusting the expenditures results in an estimate average in 2010 of $4,793.

5) As the exchange insurance is assumed to cover 70% of that estimated average, potential out of pocket expenses amount to $1,438.

The individual mandate has the further likely effect of lowering premiums for people purchasing insurance in the private or individual market. These individuals fall into one of three categories:

1) those in families with income in excess of four times the poverty line,

2) those in families with income between 1.33 and 4 times the poverty line, or

3) those in families with income less than 1.33 times the poverty line.

The individuals in the first category would experience a 12.6% reduction in their insurance premiums.[9] The individuals in the second category would receive a subsidy and would purchase insurance on the exchange. Their total healthcare costs would fall to the lesser of their current spending or the levels established above. Individuals in the third category would find themselves eligible for Medicaid and would see their premiums fall dramatically.

We assumed that in the no-reform scenario, individuals were purchasing insurance with an average premium of $5,405 ($4,800 * 1.126), and had out of pocket costs of $702 in 2010. The increased purchasing power that these individuals would experience post-reform offsets the reduced purchasing power of those who are insured in the post-reform scenario but were un-insured in the pre-reform scenario.

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[9] John F. Sheils and Randall Haught, "Without The Individual Mandate, The Affordable Care Act Would Still Cover 23 Million; Premiums Would Rise Less Than Predicted," *Health Affairs* 30:11 (November 2011), 2177-2184.
http://content.healthaffairs.org/content/30/11/2177.short

4. Private Coverage Expansion

Because of the increase in insurance coverage for those above the poverty line as defined above, there would be an increase in spending on healthcare for these same individuals.

Our assumptions also included the following figures.

1) In 2008, $2,335 was spent on healthcare for an uninsured individual.
2) In 2008, $4,462 was spent on healthcare for an insured individual.
3) Healthcare costs increased by 7.4% between 2008 and 2010.

The first two figures are based on reports from the Kaiser Commission on Medicaid and the Uninsured, 2008.[10] The cost increase figure is from the Bureau of Labor Statistics.

Additional spending by county in California was estimated according to the geographic distribution of uninsured additional individuals receiving insurance in 2010, as outlined in the individual mandate section above.

5. Medicaid Expansion

Changes in Medicaid coverage imply increases in healthcare spending in the same way that insuring higher-income individuals does.

Our model included the following key assumptions.

1) 641,520 more individuals covered (11% of the 5.832 million uninsured adults in 2010):
   a. 11% is from the UCB/UCLA base scenario;
   b. 5.832 million is from the ACS;
   c. those individuals are spread around the state according to the distribution of individuals in households with income greater than 1.33 times the poverty line, according to the ACS.
2) In 2008, $2,335 was spent on healthcare for an uninsured individual.
3) In 2008, $4,462 was spent on healthcare for an insured individual.
4) Healthcare costs increased by 7.4% between 2008 and 2010.

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[10] Hadley et al., 2008. $2,335 is an average of what was spent on those who were uninsured for the full year ($1,686) and what was spent on those who were uninsured for part of the year ($2,983).

6. Labor Force Participation

Increasing the proportion of the population that has healthcare coverage also has the potential to increase labor force participation. The link is through improved health outcomes resulting from the receipt of more timely and thorough healthcare.

The ACA is projected to lead to greater numbers of insured workers. Having insurance results in more favorable health outcomes. Staying healthy over time increases labor force participation rates.

Higher rates of labor force participation lead to more people being employed in California, assuming a full employment economy. Increased employment leads to earnings that will be spent in the local economy, creating jobs in a variety of sectors.

The general methodology we used for providing these estimates is based on previous research.[11] The approach involves calculating the transition probabilities between good health outcomes and bad and how they vary with the presence of health insurance. Similarly, the transition from good health to bad has the potential to alter an individual's labor force participation decision; bad health is associated with lower labor force participation.

Transition probabilities are estimated using matched March Current Population Survey (CPS) data files. These data files have information on the same individuals in 2008 and 2009, 2009 and 2010, and 2010 and 2011. Controlling for individual characteristics, including age, sex, marital status, industry, occupation and other factors, transition probabilities between good health and bad health and the influence of health insurance on these probabilities is estimated using a probit regression. The following table presents the increase in the likelihood of good health status in year 2 that comes from having health insurance in year 1. Somebody with bad health status in year 1 with insurance is 4.6% more likely to have good health in year 2 than is somebody with bad health status in year 1 with no insurance.

Increased Probability of Good Health in Year 2

	Increase in Probability of Good Health Status in Year 2
Bad Health in Year 1	4.6%
Good Health in Year 1	3.5%

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[11] Arijdrajit Dube, "Productivity Impact of Health Care Reform in California," *Institute for Labor and Employment, University of California, Berkeley*, August, 2003.

Similar transition probabilities for labor force participation and the influence of changes in health status from one year to the next are also estimated controlling for individual characteristics using a probit regression.

Increased Probability of Labor Force Participation in Year 2

	Out of the Labor Force in Year 1	In the Labor Force in Year 1
Bad Health in Year 1	13.9%	6.8%
Good Health in Year 1	15.4%	5.0%

This table indicates that a person with bad health in year 1, who is out of the labor force in year 1, would be 13.9% more likely to be in the labor force in year 2 if they had health insurance in year 1.

The change in the size of the labor force due to this effect is then estimated using the March 2009–2010 data. This data provides the proportion of people by health, labor force, and insurance status in California. Focusing only on those without health insurance, it is possible to estimate the extent to which having health insurance would increase their labor force participation. Data from the 3-year ACS is used to apportion these individuals across counties in California.

Estimates of the increased size of the labor force, by 2-digit NAICS industry category, were then introduced into the IMPLAN model. Increases in employment imply a particular increase in sales, which then reverberates throughout the broader economy.

We assumed that
1) 39% of those currently uninsured would be insured under the ACA.

7. Reduction of Job Lock

In the current U.S. healthcare system, many workers receive their health insurance coverage from their employers. With health insurance tied to a job, many individuals will be less likely to look for alternative employment that might improve both their productivity and their take-home pay. This tie to a particular job is often described as "job lock."

Under this system, health insurance can lock an individual into a particular source of employment. The two primary ways in which this can happen are the open enrollment waiting periods and limitations due to pre-existing conditions. The potential for less extensive healthcare coverage on the new job can also be a source of job lock.

Job lock is estimated by examining the propensity of those without employer-provided health insurance to switch jobs relative to that of those with employer-provided health insurance.

As with labor force participation, estimates of mobility are derived from matched March CPS records. "Movers" are identified as individuals reporting no unemployment in either year 1 or year 2; hours worked in excess of 30 in both weeks; and either

1) a different detailed industry in each year,
2) multiple employers in year 1, or
3) multiple employers in year 2.

The change in earnings observed among these individuals (adjusted for inflation) was taken as an estimate of the expected change in earnings among all movers, both realized and potential.

The effect of the availability of insurance coverage other than through an individual's own employer is the variable used to measure the change in likelihood of moving. Based on the results from a probit regression, individuals with insurance coverage that does not come from their own employers are roughly 10% more likely to move.

This observation can then be translated into the number of people who might have moved between 2009 and 2010 and the increased income that they might have realized. These estimates can come directly from the March CPS data files. The ACS is used to apportion these individuals across counties in California.

The increased income from a job move is then translated into disposable income as 0.7 times the increased income. The spending of this increased disposable income would lead to the generation of economic activity across the state, including employment in a variety of sectors.

State and Local Taxes

Full implementation of the ACA would have a variety of influences on the behaviors of individuals and companies. Due to the individual mandate, increased labor force participation and reduced job lock, for example, some individuals will consume more and others will consume less. Due to the employer mandate and small business tax credits, companies will change their hiring patterns and, to some extent, their production patterns.

As a result, employee compensation would change, spending on goods would change, and production levels would change. These changes would have an effect on a variety of different types of taxes. The following taxes were analyzed during the course of our research.

- **Employee Compensation**: Employee Compensation in the IMPLAN model is the total payroll cost of the employee paid by the employer. This includes wage and salary, all benefits (e.g., healthcare, retirement, etc.) and employer-paid payroll taxes (e.g. the employer side of social security, unemployment taxes, etc.).

- **Indirect Business Taxes (IBT)**: Prior to the 2003 comprehensive National Income and Product Account (NIPA) table revisions, IBT was the name of one of the three components of value added. IBT consists of tax and nontax liabilities that are chargeable to business expenses when calculating profit-type incomes and of certain other business liabilities to government agencies that are treated like taxes. Thus, IBT includes taxes on sales, property, and production, but it excludes employer contributions for social insurance and taxes on income. As part of the NIPA revision, this component was modified and termed "taxes on production and imports less subsidies." The major differences between the two are attributable to the Bureau of Economic Analysis (BEA) treatments of subsidies and non-taxes. In more general terms, IBT can currently be considered the combination of excise, sales and property taxes, as well as fees, fines, licenses and permits.

- **Household Taxes**: This category is the combination of excise, sales and property taxes, as well as fees, fines, licenses and permits levied on final users of nondurable goods and services.

- **Corporate Taxes**: The Corporate Taxes category is the combination of excise, sales and property taxes, as well as, fees, fines, licenses and permits levied on corporations. A corporation is a legal entity, created for the purpose of producing goods or services for the market, that may be a source of profit or other financial gain to its owner(s); it is collectively owned by shareholders who have the authority to appoint directors responsible for its general management.

The findings about the changes in each of these taxes are presented below, first for aspects of the ACA and second for California's regions.

Overall, our analysis projects a net increase in state and local taxes of nearly $830 million. This is not surprising, and correlates well with the findings about increases in employment and output that are presented in the report. However, some elements of the ACA, the individual and employer mandates for instance, do lead to lower tax revenues. This is particularly true of the employer mandate, which reduces taxes of all kinds by a total of nearly $1.5 billion (Table TA.1)

Table TA.1: Changes in State and Local Business Taxes ($ Millions)

ACA Policy Element	Employee Compensation	Indirect Business Taxes	Household Taxes	Corporate Taxes	Total
Private Coverage Expansion	15.3	259.2	129.3	23.9	427.7
Individual Mandate	-0.9	-30.2	-9.2	-2.8	-43.1
Labor Force Participation	22.8	635.1	210.8	67.0	935.7
Reduction of Job Lock	1.5	43.2	13.3	3.9	61.9
Medicaid Expansion	4.7	75.6	40.6	6.9	127.9
Employer Mandate	-34.2	-975.0	-318.0	-113.7	-1,440.9
Small Business Tax Credit	16.8	558.1	148.6	36.6	760.1
Total State and Local Taxes	**26.1**	**566.0**	**215.5**	**21.8**	**829.4**

Source: Bay Area Council Economic Institute calculations using IMPLAN system analysis.
Note: Rows and columns may not sum to exact totals due to rounding.

Significant increases resulting from greater labor force participation and the small business tax credit make up for the reduced taxes. Not only is there an increase in the overall level of tax revenues, but there is an increase in each type of revenue.

Results across regions similarly correlate with the results presented in the report. In particular, the Bay Area—the only region to lose GDP—would experience a decline in corporate taxes. The San Joaquin Valley is the only region that would have a reduction in the Corporate Taxes category while experiencing an increase in value added. This result is merely a consequence of the reorientation of employment and output towards industries with lower levels of tax relative to value added.

Table TA.2: Changes in State and Local Business Taxes ($ Millions)

ACA Policy Element	Employee Compensation	Indirect Business Taxes	Household Taxes	Corporate Taxes	Total
The Bay Area	0.9	23.4	13.5	-7.2	30.6
Sacramento Valley	5.6	90.9	25.4	7.0	128.9
San Joaquin Valley	1.5	18.8	9.4	-1.4	28.3
Greater Southern California	13.5	322.8	133.5	16.9	486.7
San Diego County	1.3	38.7	14.5	1.7	56.2
Remaining Counties	3.2	71.5	19.3	4.8	98.7
California	26.1	566.0	215.5	21.8	829.4

Source: Bay Area Council Economic Institute calculations using IMPLAN system analysis.
Note: Rows and columns may not sum to exact totals due to rounding.

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