

# **EMPLOYER MANDATES AND THE HEALTH CARE CRISIS:**

**Economic Impacts in California and the Bay Area**

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## **Bay Area Economic Forum**

**A Partnership of the Bay Area Council  
and the Association of Bay Area Governments**

**January 2006**

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## **The Bay Area Economic Forum**

The Bay Area Economic Forum is a public-private partnership of business, government, university, labor and community leaders that develops and implements projects that support the vitality and competitiveness of the regional economy, and enhance the quality of life of its residents. Sponsored by the Bay Area Council, a business organization of more than 250 CEOs and major employers, and the Association of Bay Area Governments, representing the region's nine counties and 101 cities, the Bay Area Economic Forum produces economic policy analyses and provides a shared platform for leaders to act on key issues affecting the future of the Bay Area economy.

## Executive Summary

Rising employee health care costs are an increasing burden on all businesses. Since 1998, premiums for employer-sponsored family coverage have risen 95%, four times faster than inflation. At the same time, one in five Californians has no health insurance. This lack of health care coverage is straining emergency rooms and health care providers, and threatens many with economic disaster in the event of a catastrophic illness. Proposed legislation in some states and cities, including San Francisco, would attempt to alleviate the problem by a government directive or mandate that employers provide health insurance coverage to all employees.

However, employer mandates do not address a core problem of the health care crisis - cost containment. Health care spending in the state totals \$194 billion. If the state imposed an employer mandate, premium payments would increase by \$16 billion, of which employers would pay \$12 billion and employees \$4 billion. A mandate in the City of San Francisco would increase employer payments by \$307 million, and employee payments by \$102 million. If no employee contribution was required, employers would bear the full \$410 million cost.

Workers will ultimately pay for employer mandates, since health insurance is considered part of an employee's total compensation package, and additional spending on health will leave fewer dollars for increased wages or other benefits. Companies that cannot pass on these costs to employees or consumers may be vulnerable to bankruptcy or closure. The burden of mandates will fall most heavily on small businesses, who often are the least able to afford coverage for their workers. On the other hand, targeting large companies will not move the state much closer to universal coverage, since almost all of them already offer health coverage to their employees.

Most mandates would not include the large numbers of Californians who are self-employed, undocumented immigrants, or are temporary, part-time, or seasonal workers. If a government mandate did include part-time workers, it would particularly affect businesses, like restaurants and retail, with large numbers of these workers. While some employees would benefit, mandates may have the unintended consequence of reducing employment, as businesses seek to contain growing costs. The risk would be highest to low-wage workers. In addition, costs to consumers using these establishments would rise.

Enacting a mandate within a single jurisdiction, such as a city or county, may cause some companies to relocate, particularly if neighboring jurisdictions don't impose similar costs. The consequences could be material in cities such as San Francisco, where the relative cost of doing business is already high. Local mandates may also hinder the efforts of economic development leaders who are attempting to attract businesses to the city.

The traditional employer-based health care system in the U.S. is under growing pressure. Mandates will compound it. Because of a government mandate's potentially negative impacts on a city's business climate, alternative approaches for expanding health coverage are needed. These approaches will be explored in the second phase of this report, which will be released later in 2006.

## Introduction

California and the Bay Area face a crisis in health care, one with major implications for our economy and quality of life. Both here and nationally, rising employee health care costs seriously burden businesses, reducing their competitiveness, productivity and potential for future growth.

Premiums for employer-sponsored family coverage have nearly doubled since 1998, rising 95% or four times the 24% rate of inflation over the same period.<sup>1</sup> Even as the costs to business rise, lack of coverage threatens many California individuals and families with economic disaster in the event of catastrophic illness. The burdens placed by uninsured patients on hospitals, clinics and physicians, as well as government programs such as Medicaid, are growing at a rapid pace. Finally, the problem arrives not in isolation, but on top of a series of challenges to the state and region – the technology sector downturn, the budget crisis, and the jump in energy prices – whose effects will linger for years.

The economics of health care have become a major issue at all levels of business and government. The escalating costs to businesses of health care raise concerns over their competitiveness and even their economic viability; and access to health care has become a major focus for labor unions. For these reasons the Bay Area Economic Forum has begun a study of several issues related to the provision of health care for the uninsured and underinsured.

The first phase of this report analyzes the economic implications of one major option for extending health insurance to the 6.6 million Californians who lack it: a government mandate that employers offer and pay for health insurance for their workers. It explores the key design and economic issues associated with employer mandates, and briefly examines their impact on: a) total health care spending in the state, and b) changes in the distribution of spending among employers, households and government. A second phase of this report, to appear later in 2006, will explore alternative approaches to expanding health care coverage. This report limits its assessment to economic costs and impacts, and does not address the related and important questions of health care quality or service.

As a strategy for expanding health care coverage, employer mandates are not unique to California or the Bay Area. Cities and states around the country are grappling with the challenge of health insurance and the need to broaden coverage for their residents.

In an orchestrated move targeted principally at Wal-Mart, lawmakers in 30 states (including Connecticut, Kansas and Florida) are planning to introduce legislation to require large companies to increase health care benefit spending. Most bills stipulate that the largest private employers devote between 8-11% of their payrolls to health care benefits, or contribute a fee to a state fund. Maryland's legislature has passed a Wal-Mart-targeted bill requiring companies with more than 10,000 employees to spend at

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<sup>1</sup> California Health Foundation, Employer Health Benefits 2005 Survey (<http://www.chcf.org/documents/insurance/Employer>)

least 8% of their payroll on health care benefits, or pay into the state's Medicare fund. At the city and county level, in October 2005, New York City enacted legislation to require large grocery stores to pay non-unionized workers a health care benefit worth an estimated \$2.50 to \$3.00 an hour, a measure that targets Wal-Mart but would affect the grocery industry more broadly. Suffolk County, on Long Island, passed a similar measure.

In California, while some proposals for covering the uninsured through employer mandates – such as Proposition 72 in 2004 – have aimed at all residents, others target specific jurisdictions or cities, such as San Francisco.<sup>2</sup> Therefore, this report will also examine the fiscal impacts of a health insurance mandate on employers within a single jurisdiction.

There is an important set of questions around whether the proliferation of single-jurisdiction employer mandates would: a) achieve universal coverage effectively, and b) address a major state or national-level challenge appropriately. This analysis finds that, particularly at a city or county level, employer mandates may narrow the health insurance gap but will not achieve universal coverage. As a strategy, mandates are also likely to incur costs to employers, employees and the local economy at such a level that alternative approaches should be considered.

## **Background: Who Are the Uninsured?**

Most Californians with good jobs have health insurance through their employers. However, the California Health Interview Survey estimates that approximately 6.6 million non-elderly Californians (citizens and legal US non-citizens), or approximately 21% of Californians under 65, were uninsured during 2003. The March 2005 *Current Population Survey* cites 6.7 million, a similar figure. In San Francisco, about 148,000 residents, or 19% of the non-elderly, were uninsured in 2003.

Most of California's uninsured population is from low-income households. Nearly half of them live in families with annual incomes below 150% of the equivalent of \$29,000 for a household of four (150% of the federal poverty line.) In 2004, 42% of California's uninsured had family incomes below \$25,000, 31% had incomes between \$25,000 and \$49,999, 12% between \$50,000 and \$74,999, and 15% above \$75,000.<sup>3</sup> Hence, a significant proportion of the uninsured are in income brackets considerably above the federal poverty line.

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<sup>2</sup> On November 22, 2005, Supervisor Tom Ammiano introduced legislation requiring all employers with 20 or more employees including part-time and seasonal workers (working 80 hours per month) to pay a fee to provide health coverage to their workers. In addition to the health care fee, the City would impose an additional fee to help pay for its enforcement of the new ordinance.

<sup>3</sup> California HealthCare Foundation/EBRI estimates of the Current Population Survey, March 2005 Supplement

**Table 1. Distribution of health insurance coverage in California and San Francisco by income as a percent of Federal Poverty Line (FPL), NonElderly Population, 2003**

Primary Type of Health Insurance	CALIFORNIA % FPL						Total	
	<=150		151-300		301+		#	%
	#	%	#	%	#	%	#	%
ESI	1,658,007	17.8%	3,932,598	52.5%	12,488,883	81.7%	18,079,488	56.3%
MEDICARE	284,922	3.1%	126,152	1.7%	90,167	0.6%	501,241	1.6%
SCHIP	311,266	3.3%	250,780	3.3%	46,358	0.3%	608,403	1.9%
MEDICAID	2,892,786	31.1%	604,363	8.1%	171,977	1.1%	3,669,126	11.4%
CHAMPUS	82,782	0.9%	128,404	1.7%	108,540	0.7%	319,726	1.0%
PRIVATE	618,207	6.6%	498,307	6.6%	1,159,359	7.6%	2,275,873	7.1%
<b>UNINSURED</b>	<b>3,459,913</b>	<b>37.2%</b>	<b>1,954,192</b>	<b>26.1%</b>	<b>1,218,688</b>	<b>8.0%</b>	<b>6,632,793</b>	<b>20.7%</b>
Total	9,307,882	100.0%	7,494,797	100.0%	15,283,972	100.0%	32,086,651	100.0%

Primary Type of Health Insurance	SAN FRANCISCO % FPL						Total	
	<=150		151-300		301+		#	%
	#	%	#	%	#	%	#	%
ESI	52,617	26.3%	98,045	62.2%	302,244	74.0%	452,906	59.1%
MEDICARE	8,493	4.2%		0.0%	7,802	1.9%	16,295	2.1%
SCHIP	3,535	1.8%	2,200	1.4%		0.0%	5,735	0.7%
MEDICAID	45,689	22.9%	12,399	7.9%	3,405	0.8%	61,493	8.0%
CHAMPUS	2,922	1.5%	2,217	1.4%	5,846	1.4%	10,985	1.4%
PRIVATE	20,088	10.1%	7,942	5.0%	42,459	10.4%	70,489	9.2%
<b>UNINSURED</b>	<b>66,503</b>	<b>33.3%</b>	<b>34,783</b>	<b>22.1%</b>	<b>46,664</b>	<b>11.4%</b>	<b>147,950</b>	<b>19.3%</b>
Total	199,846	100.0%	157,586	100.0%	408,420	100.0%	765,852	100.0%

Source: California Health Interview Survey. ESI is employer sponsored insurance. SCHIP is the State-Children's Health Insurance program. CHAMPUS (now called TRICARE) is the Civilian Health and Medical program of the Uniformed Service. Private is individually purchased insurance. See Glossary for further definition of terms.

Most (55%) of the uninsured are employed. The majority (55%) live in families with at least one full-time worker, with 12% having one or more part-time workers, and 14% having two or more full-time workers. A minority (less than 20%) have no workers in the family.<sup>4</sup> Some of the working uninsured are younger individuals who, though eligible for coverage, turn it down.<sup>5</sup> According to the California Health Insurance Survey, 214,000 of the uninsured are 18-30 year olds who declined offers of insurance. They constitute 6% of the working uninsured.

## Health Care Spending and Uncompensated Care in California

Health care spending in California comes from several sources, including private insurance, and government sources such as Medicare and Medi-Cal. There is no comprehensive source of data on health care spending in California, and the estimates below of 2005 spending were derived using figures from the state budget, the Centers for Medicare and Medicaid Services' national health accounts, and survey data from the Medical Expenditure Panel Survey (see Table 2).

<sup>4</sup> Rand Corporation – Health Care in California: A Policy Assessment, 2005

<sup>5</sup> Employee Benefit Research Institute estimates of the Current Population Survey, March 2004 Supplement

**Table 2. Estimated Health Care Spending in California, 2005**

<b>California Health Care Spending</b>	<b>\$Billions</b>
<b>Medicare</b>	\$36
<b>Medi-Cal</b>	\$34
<b>Private Health Insurance</b>	\$98
<b>Other Private and Public*</b>	\$11
<b>Private Insurance Administration</b>	\$15
<b>TOTAL</b>	<b>\$194</b>

\* Includes military, state and local spending, and health care spending for workers compensation.

During 2005, total health care spending in the state approached \$200 billion. Private health insurance financed half of it, or nearly \$100 billion. Medi-Cal spending (federal and state shares) totaled \$34 billion and Medicare spending \$36 billion.

The uninsured are approximately 20% of the non-Medicare population. An established body of research shows that they get fewer health care services than insured patients. While not denied access to health care, the primary care they receive is often in expensive (primarily emergency room) settings, and they are treated at later and more expensive stages of their illnesses. This pattern places a large economic burden on the health system.<sup>6</sup> In 2003, the 6.6 million uninsured in California generated an estimated \$5.8 billion in costs, of which \$4.1 billion was uncompensated.<sup>7</sup>

This \$5.8 billion is about 3% of total state health spending, and while the figure may not seem large, its distribution is important, since poorer families with the potential for medical bankruptcy bear most of the costs. The uninsured can also cause substantial financial losses for health service providers, who must increase their charges to cover these uncompensated costs. Since the number of uninsured in California is expected to rise to 7.8 million by 2014, and associated uncompensated care projected to increase to \$8.2 billion (see table 3), the need for reform will only continue to grow.

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<sup>6</sup> Under Section 17000 of the California State Health Code, counties receive funds for providing services to the indigent or uninsured population. While some counties provide direct health services with this money, others competitively bid these services out to for-profit and not-for-profit provider organizations.

<sup>7</sup> Some uncompensated care for the uninsured is funded through Medicare and Medicaid.



**Table 3. Estimated and Projected Number of Uninsured in California and Uncompensated Care, 2005 and 2014.**

	2005	2014
<b>Uninsured in California (Millions)</b>	7.1	7.8
<b>Uncompensated Care (\$Billions)</b>	\$5.8	\$8.2

SOURCE: Families USA, Paying a Premium, The Added Cost of Care for the Uninsured, 2005.

### **Assessing Employer Mandates**

Employer mandates would require all employers to provide or pay a portion of the cost of health insurance for their workers. The mandate may apply to all workers (full and part time) or only full-time workers; however, few mandate proposals apply to workers employed less than 20-25 hours per week. Employers would typically pay a pro-rated share of the premium based on hours worked.

Mandate proposals can also provide for government assistance in the form of financial subsidies to small employers and low-wage workers in these firms. Without such aid, mandated employer coverage would impose significant cost burdens on many smaller firms. Given current budget pressures at all levels of government, however, subsidies of this nature are highly unlikely. The analysis below assumes no government subsidies.

In the illustrative mandate, employers have to pay 75% of the cost of an insurance premium, their typical share nationally for family coverage, and employees pay the remainder. Employers and workers with less generous benefits would have to upgrade their benefits package to meet the actuarial value (the ratio of benefits paid through a health plan divided by health plan expenditures and out-of-pocket spending) of the Blue Cross-Blue Shield Standard Offer benefits,<sup>8</sup> or about \$6,340 -- not including skilled nursing, home health care and prescription drug benefits.<sup>9</sup> Of course, employers could provide more generous benefits to their workers if they choose.

### **Incremental Cost**

Table 4 shows the estimated change in health care spending in California associated with an employer mandate plan. For illustrative purposes, it assumes that non-working adults and children are enrolled in a state program (Medi-Cal, or the Healthy Families Program) and are therefore not included in mandated employer coverage.

<sup>8</sup> For a description of the Blue Cross Blue Shield Standard Option Benefits (BCBCSOB) see [www.fepblue.org/benefits/benefits06/benftaagso-06.html](http://www.fepblue.org/benefits/benefits06/benftaagso-06.html)

<sup>9</sup> Chris L. Peterson, Comparison of Actuarial Values: Current Medicare Benefits to a “Typical” Health Plan Available to Federal Employees, Congressional Research Service, March 31, 2003.

**Table 4. Total Health Care Spending in California Under Current Policy and With an Employer Mandate (\$Billions)<sup>10</sup>**

<b>Health Spending in California with Mandate</b>	
<b>Current Spending</b>	<b>\$194 Billion</b>
<b>Increased Health Care Spending Attributed to Covering the Uninsured</b>	\$ 8.25
<b>Increased Health Care Spending Attributed to Upgrading Benefits for the Underinsured*</b>	\$ 4.50
<b>Health Care Spending In California with Mandate</b>	<b>\$206.8</b>

\*Assumes that employers with less generous benefits provide the actuarial equivalent of the statewide benchmark plan.

Under this scenario, total health care spending in the state would rise by approximately \$13 billion (a 6-7% increase) with \$8 billion attributable to the uninsured and \$4.5 billion to the underinsured (those with less comprehensive benefit packages that require upgrading). This increase could be smaller if cost containment initiatives accompanied a reform agenda. However, cost containment is rarely part of employer mandate proposals.

Table 5 presents an estimate of the incremental cost to employers and their workers for providing health insurance at the statewide level, and in San Francisco as an example of a localized mandate. This estimate only includes the incremental costs associated with covering and upgrading benefits for full-time workers.

**Table 5. Illustrative Impact on Premiums of Employer Mandate in California and San Francisco, 2005 (\$Millions)<sup>11</sup>**

<b>Jurisdiction</b>	<b>Total Premiums</b>	<b>Employer Payments</b>	<b>Employee Payments</b>
<b>San Francisco</b>	\$410.1	\$307.5	\$102.5
<b>California</b>	\$16,012.9	\$12,009.7	\$4,003.2

SOURCE: Simulation results using California HIS and Medical Expenditure Panel Survey

<sup>10</sup> Table 4 estimates increased spending that would be paid through private health insurance.

<sup>11</sup> Table 5 estimates the change in health insurance premiums, including benefit payments and administrative costs.

Under this scenario, new premium payments statewide would exceed \$16 billion, with employers financing \$12 billion and workers \$4 billion. This amounts to \$2,426 in added annual costs per employee, or \$202 per month. In San Francisco, a local mandate would increase total premium contributions by \$410 million, with employers paying over \$300 million and workers over \$100 million. If no employee contribution was required, employers would bear the full burden.

An important issue in expanding health coverage is who ultimately pays for the new premium contributions. In the short-term, employers would pay most of the new cost of a mandate proposal. However, a convincing body of economic analysis suggests that California's workforce would ultimately have to absorb all or most of the \$16 billion price tag of the illustrative mandate. These costs can be significant and are likely to keep climbing. In recent years, the cost of health insurance premiums in California increased 8.2% in 2000, to 10.9% in 2001, 12.9% in 2002, 13.9% in 2003, 11.2% in 2004 and 9.2% in 2005. In the same period, inflation grew 2.7% per year, and annual increases in workers' earnings averaged 3.1%. With average jumps of 11% per year, growth in health insurance premiums has dramatically outpaced growth in both wages and inflation.<sup>12</sup>

Workers will ultimately pay for employer mandates, since health insurance costs are considered part of an employee's total compensation package, and additional spending on insurance will leave fewer dollars for other forms of compensation, either as wages or benefits. Higher health premiums paid by employers can therefore lead to slower growth in employee wages over time, the scaling back of other benefits, or both. Where employees do not absorb additional health care costs, consumers will most likely pay more in the form of higher product and service prices. Companies cannot always fully pass on these increases, however, particularly when competing against companies in other jurisdictions that are free of mandates.

Beyond direct costs, employer mandates raise four issues. All relate to the potential impacts on both employers and the intended beneficiaries.

### **1. Burdens Will Fall Most Heavily on Small Businesses**

Statewide, more than 90% of employers are small businesses, with 3-49 employees; however, these small businesses employ only 29% of all workers, and 23% of covered workers.<sup>13</sup> Virtually all large employers in California (those with 200 or more employees) provide health insurance for their workers (98%), while most employers with 50-199 employees (93%) and a substantial majority of employers with 20-49 employees (87%) also do so. Lack of health coverage is most prevalent among small employers with 10-24 workers (where 72% provide health benefits) and firms with 3-9 workers (where 47% do so).

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<sup>12</sup> Employer Health Benefits 2005 Annual Survey, Kaiser Family Foundation and Health Research and Education Trust

<sup>13</sup> California Health Care Foundation, Employer Health Benefits 2005 Survey

The leading reasons firms in California give for not offering health benefits are high premiums and small firm size; many also indicate that their employees are covered elsewhere, or that offering health coverage is not necessary to obtain good employees.<sup>14</sup> Employer mandates will therefore disproportionately affect small businesses, which in many cases are the least able to pay. The impact will be significant, as the approximately 580,000 California businesses with 0-19 workers employ 2.4 million people and have a combined annual payroll greater than \$80 billion. If the additional 66,000 businesses with 20-99 employees are included, those figures jump to nearly 5 million paid employees and \$170 billion in annual payroll. However, principally targeting large firms with employer mandates will not address the problem either.

## **2. Employer Mandates Will Not Produce Universal Coverage**

Seventy-five percent of California workers in firms offering coverage in 2005 were eligible to enroll, and 86% of the eligible did. Overall, 65% of workers in companies offering health insurance received coverage from their firm.<sup>15</sup> Those who chose not to enroll did so for a variety of reasons, including premium costs (particularly for lower wage workers), or a preference for cash over insurance (particularly for younger workers aged 18-34, who may not feel the need for insurance or may not want the typical high benefits package).

Employer mandates will not extend coverage to the large number of residents who are outside the traditional employment system. This includes temporary, part time and seasonal workers, individuals employed by temporary placement agencies, and self-employed independent contractors. In California, 8% of the population or 2.7 million residents work part time, including 770,000 temporary workers and 1.8 million with alternative work arrangements (independent contractors, on-call workers and day laborers, temporary help agency workers, and contract company workers).<sup>16</sup>

A 2005 study by the Iowa Policy Project found that one in four such “non-standard” workers had no health insurance, compared to 12% who lacked insurance among traditional, full-time workers. Only 21% of non-standard workers had employer-provided health insurance, compared to 74% of traditional workers. Unless an employer mandate specifically includes non-standard workers, efforts to achieve universal coverage by regulating employer-based insurance will miss these workers.

A further issue impacting the universality of coverage from employer mandates relates to undocumented immigrants. Rates of insurance coverage are closely associated with not only place of employment, but also levels of education and income. This largely explains the fact that foreign-born residents constitute a disproportionate share of adults without health insurance. Of the 6 million non-citizens in California (who account for 18.5% of

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<sup>14</sup> Employer Health Benefits 2005 Annual Survey, Kaiser Family Foundation and Health Research and Educational Trust

<sup>15</sup> California Health Care Foundation, Employer Health Benefits 2005 Survey

<sup>16</sup> Kaiser Family Foundation, Statehealthfacts.org

the population), almost half are undocumented immigrants.<sup>17</sup> Undocumented immigrants have significantly lower rates of coverage than documented immigrants, and account for approximately one-third of the total increase in the number of uninsured adults in the U.S. According to the California Health Insurance Survey, 40% of the uninsured are non-citizens. Another explanation for this lower rate of coverage involves the fact that undocumented immigrants change jobs and residences frequently. As a result, even when insurance is offered, the transient attachment of many undocumented immigrants to their employers will limit their eligibility and the effectiveness of an employer mandate strategy in achieving universal insurance coverage.<sup>18</sup>

### **3. Employment in Low Wage Occupations May be Impacted**

Employer mandates could increase unemployment. According to a June 2005 study by the Employment Policies Institute, nearly 43% of uninsured workers are paid within three dollars of the minimum wage. These workers, who are concentrated in smaller businesses, are normally the intended beneficiaries of employer mandates. They are also likely to be the lowest skilled workers.

Employers are likely to shift a significant portion of the burden of new mandates to their employees over time – in the form of reduced wages and benefits. However, some employee wages are at or near the minimum wage and thus too low to permit that shifting. The result is a net increase in payroll costs that may be substantial in relation to the wage base. As noted already, in San Francisco an additional \$1.79 in mandated health care costs on top of an \$8.62 minimum wage would constitute an effective 21% increase in compensation, a cost that many businesses may be unable to absorb.

Because a mandate in these circumstances would constitute the equivalent of a payroll tax on low-wage workers, employers may respond by reducing their payrolls, particularly in the lowest wage categories. The resulting risk of unemployment would be highest among the most vulnerable populations, including minorities and those with the lowest (high school or less) education levels.

While including part-time workers in a mandate would impose a significant burden on many businesses, if part-time workers were not included in an employer mandate, the related increase in payroll costs would increase the disincentive for employers to move part-time workers to full-time status or to otherwise increase their hours above the part time/full time threshold. Overall, sectors such as retail and restaurants, which employ large numbers of seasonal and part-time workers, would feel the most concentrated effects. Both sectors are significant employers in San Francisco, with 97,000 and 74,000 employees respectively.

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<sup>17</sup> Kaiser Family Foundation, Urban Institute

<sup>18</sup> Goldman, Smith and Sood, Legal Status and Health Insurance Among Immigrants, Data Watch, December 2005

Take restaurants as an example. The typical restaurant in San Francisco employs 54 people, of whom 27 are full time and 27 are part time. The average hourly wage for full-time employees is \$10.46 (\$8.96 not including tips), and the current monthly average health insurance cost for those employees is \$230 per employee (a figure that can vary with the benefit package). The monthly compensation package for full time employees therefore averages \$1785 (not including tips).

Under an employer mandate in San Francisco, based on a benefits standard set by the city of \$345 per month, the additional health care cost for those employees would be \$115 per month. For part-time employees who currently do not receive coverage the additional cost would be \$345 per month. The average incremental cost per employee, including both full and part time workers, would be \$230.

The median profit margin for a restaurant in San Francisco is 4.5% on revenues of \$1,879,000, yielding a median profit of \$84,500. The incremental cost of insurance for a full-time employee based on the mandate adds \$1,380 to annual payroll costs. For part-time employees it adds \$4,140. When both full-time and part-time employees are included, the incremental insurance cost of \$2760 per average employee (working an average of 30 hours per week) under an employer mandate produces an average hourly increase in payroll cost of \$1.77 per hour. Measured against the minimum wage in San Francisco of \$8.62, that amounts to a 20% increase in payroll cost for an average employee. For the average restaurant, this adds \$149,040 in costs against \$84,500 in profits.

Restaurants may raise prices in order to pass on these costs, but customers won't necessarily continue to spend at the same level. They may eat less (fewer courses) or less often. Even if prices rise, the impact on the bottom line can therefore be substantial. In response, restaurants may reduce their payrolls, particularly among part-time employees. This may have unexpected impacts on San Francisco's workforce, as many students, artists, writers and others work in restaurants part-time.<sup>19</sup>

#### **4. Business Climate Effects May Lead Companies to Relocate**

Employer mandates imposed in a single jurisdiction may impact jobs located within that city's or county's boundaries. In the case of San Francisco, an undetermined number of smaller and medium sized companies may choose to relocate outside the city in order to avoid the costs associated with the mandate. These will most likely be companies whose business activities are not tied to a specific geographic location, but could comfortably be provided from another site. These businesses could relocate to adjacent jurisdictions that are not subject to similar mandates, as well as to other cities in the region or the state, or outside the state.

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<sup>19</sup> Source for industry data: Economics of the San Francisco Restaurant Industry 2005, Golden Gate Restaurant Association, May 2005.

The number of employers that move would depend on their short-term relocation costs compared to the incremental costs associated with the new mandate over time. If all incremental costs are ultimately passed on to the workers, the level of relocation by these businesses outside the jurisdiction could be mitigated. If, on the other hand, the increased incremental costs are not fully passed on – which is likely in the near-to-medium term – or if they come on top of an already high business cost structure relative to other jurisdictions, the rate of business relocation could accelerate. This should be a particular concern for San Francisco, which ranks among the most expensive cities in the nation for business operations, based on a quantitative comparison of business taxes. According to the Kosmont-Rose Institute Cost of Doing Business Survey, the cities of San Francisco, Oakland, Alameda and Berkeley are the highest cost jurisdictions in the Bay Area in which to do business. All other cities rank lower for business costs, many of them significantly so.<sup>20</sup>

A 2003 study of a cross-section of California industries by the Los Angeles Economic Development Corporation found that two-thirds of the small and medium-sized companies surveyed were concerned that state-mandated employer coverage would have adverse effects on their profits, payrolls, benefits and competitiveness. Specific concern was expressed that this could lead to layoffs, or could force operations to close or move to other states.<sup>21</sup> While the survey sample was limited and actual business decisions on a large scale cannot be predicted with certainty, these concerns can impact both internal and external perceptions of a city or county's business climate. If a mandate took effect within a single city or county, those perceptions would likely influence location decisions not only by businesses currently within that jurisdiction, but also by those elsewhere that the city is seeking to attract, or that would otherwise consider moving there. In this case, the mandate could be a significant deterrent to business attraction and retention, impacting the city or county's economic development efforts.

## **Conclusion**

An employer mandate to provide employee health insurance, coupled with a required individual contribution, could extend health coverage to many of California's 6.6 million uninsured residents. Health care spending in the state would increase by nearly \$13 billion. This umbrella would not extend, however, to the substantial number of residents who are self-employed, work in temporary or part-time positions, or are undocumented workers. While insurance coverage would increase, it would remain less than universal.

Employer mandates can have major economic consequences for businesses. Competitive pressures, now global, can make even small increases in business costs a significant factor in a company's success or failure. Nearly all large businesses already offer health

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<sup>20</sup> Kosmont-Rose Institute Cost of Doing Business Survey, 2004. Of 44 rated cities (including San Francisco) are ranked as highest cost, 12 as high cost, 19 as moderate cost, and 9 as relatively low cost. The survey is a benchmark document widely used by economic development organizations.

<sup>21</sup> Analysis of the Economic Impacts of Mandatory Health Coverage in California, Los Angeles Economic Development Corporation, September 2003

insurance, while small businesses, where many of the working uninsured are concentrated, would be disproportionately affected. Businesses with many part-time employees, such as the retail and restaurant sectors, would be heavily impacted. While some employees would benefit, the risk of unemployment would increase for others, particularly employees in lower wage occupations.

Mandates limited to single jurisdictions, such as cities or counties, will create incentives for employers to relocate in order to avoid these new costs. In San Francisco, for example, these costs would total between \$300 and \$410 million, depending on whether employees shared the cost or employers were required to bear the full burden.

The implementation of mandates on one city or county is particularly problematic when neighboring jurisdictions do not impose similar cost burdens. Some companies may choose to relocate to other cities in the region, or outside California altogether. The extent to which firms choose to relocate will depend on whether they are location-dependent (i.e., whether they serve a customer base where physical presence is required), on relocation costs relative to the new taxes they are facing, and on the comparative cost of doing business in alternative jurisdictions. From any of these perspectives, the impact on economic development is likely to be negative.

Since an employer mandate does not address the issue of cost containment and will not by itself simplify the administration of health care, adopting this option will not produce a significant reduction in the growth of health care spending, but will instead lead to an initial rise in expenditures. Employer mandates may in fact exacerbate the innate moral hazard issue in health care by reducing the incentive for individuals to exercise personal responsibility in the use of health care services. While the United States spends about 50% more per capita than any other country in the world, the growth in real per capita spending on health care over the past twenty years has been similar to most European countries. Addressing the growth in spending will therefore require additional changes in the organization and delivery of health care.

While employer-provided health care remains the bedrock of the U.S. health insurance system, traditional employer-based coverage is under growing pressure. Employer mandates will add to that pressure. In light of the uneven and often poorly distributed impacts of employer mandates, and their potentially negative effects on a jurisdiction's business environment and economic development efforts, alternative approaches are needed to achieve both universal health care coverage and contain rising health care costs. Achieving this will require engaging both the public and private sectors in new ways. Because of the political difficulty in achieving this goal at a national level, cities and counties offer a promising test bed for public-private experiments which, if successful, could be expanded regionally, statewide or nationally. These alternative approaches will be the focus of the second phase of this report.



## **Glossary**

**CHAMPUS** (Civilian Health and Medical program of the Uniformed Service): CHAMPUS is a health benefits program that covers medical necessities, providing authorized in-patient and out-patient care from civilian sources for those in the Uniformed Services.

**ESI** (Employer Sponsored Insurance): Healthcare coverage offered by employers to their employees. The types of benefits and plans vary greatly, including programs where employees are required to cover some portion of their costs. ESI is incentivized by providing tax advantages to both employers and employees.

**Healthy Families:** California's State Child Health Insurance Plan (SCHIP). Healthy Families provides health insurance for low-income children in families with incomes too high to qualify for Medi-Cal.

**Medicaid:** National health insurance program for low-income persons. Medicaid standards, regulations and guidelines are set at the Federal level, and operation of the program is at the State level. Medicaid covers in-patient hospital services, nursing home services, physician services, drugs, laboratory services, X rays, and other services

**Medi-Cal:** California's Medicaid program. Medi-Cal is a combined federal and state health insurance program for low income families or individuals, the elderly, the disabled or families enrolled in AFDC (Aid to Families with Dependent Children).

**Medicare:** National health insurance program for persons aged 65 and over and the disabled. It provides a basic program of hospital insurance, which protects enrollees against major costs of hospital and related care. It also provides supplementary medical insurance to aid in paying doctor bills and other health-care bills. It is funded by a tax on the earnings of employees that is matched by the employer and by premiums paid by enrollees.

**SCHIP** (State-Children's Health Insurance program): Jointly financed by the Federal and State governments and administered by the states, SCHIP provides health insurance for children under 19 years of age in low-income families, who do not qualify under Medicaid income requirements. States determine the design of their respective programs, eligibility requirements, benefits, reimbursement levels, etc. within broad Federal guidelines.

**Uncompensated Care:** Broadly refers to unreimbursed services provided to financially and/or medically indigent populations. These include the uninsured, underinsured, and patients whose medical bills exceed certain criteria, even after third party payer payments.

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