

HEALTH COVERAGE PROPOSALS IN CALIFORNIA: IMPACT ON BUSINESSES

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This brief was funded by a grant from The California Endowment.



1. INTRODUCTION AND MAIN FINDINGS

California policymakers are considering legislation aimed at expanding health care coverage in the state. Two of the proposals, the Governor's Health Care Proposal and Assembly Bill 8, would require employers to spend a minimum percentage of their payroll on employees' health care or pay an *en lieu* fee to the state as part of the reform measure.

Job-based health coverage for Californians under the age of 65 fell by 5 percent between 2001 and 2006. Over this same period the cost of health premiums doubled, while workers' nominal earnings increased cumulatively by 12 percent. There are 4.8 million uninsured people at any given time in California—6.6 million are uninsured at some point during the year—representing around 20 percent of children and non-elderly adults.

The Governor's Health Care Proposal (GHCP) would require firms to spend a minimum of 4 percent of Social Security wages on health care; AB 8 would require 7.5 percent. California firms currently contribute an average of 7.9 percent of total payroll to employee health care and 11.2 percent of payroll of workers with health coverage through their employer (Graham-Squire 2007).

Both the Governor's Health Care Proposal and AB 8 would significantly expand health care coverage in the state: 3.4 million individuals are projected to gain coverage under AB 8 and 4.1 million under

Foreword

By Michael Reich, Director

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Rising premium costs and declining job-based coverage have put health care reform in the spotlight in California and nationally. Many of the health reform proposals that are being discussed include provisions that would effectively set minimum health spending standards for employers, much as minimum wage laws do for wages. This important new report analyzes the impact of two of the leading proposals on the California economy.

The report builds upon other recent analyses conducted at UC Berkeley's Institute for Research on Labor and Employment. These include analyses of: the state's minimum wage, local living wage laws in California, the impact of employer health care policies on public costs, and on previous proposals concerning health care reform. An important question addressed in all these studies concerns their impact on the California economy—especially upon employers, workers and the efficient operation of labor markets.

The authors' very detailed analyses use the best available data and methods, and the report itself has been reviewed carefully by academic experts. The authors find that the leading health reform proposals for California have been crafted in a manner that is likely not to generate adverse employment impacts. According to their findings, most firms will experience little or no net change in business operating costs after a short adjustment period. Consistent with the best recent research on the minimum wage, payroll and cost increases of these magnitudes are unlikely to reduce employment in California, while improving the health status of many Californians. Moreover, both health reform packages analyzed would boost productivity as workers take fewer sick days due to poor health and as workers are more able to work where they are most valuable, with their job mobility less hindered by health insurance concerns.

The report will be of great interest to all Californians and it will inform similar policy discussions underway in other states and in the nation as a whole.

the Governor's plan (Gruber 2007). This report looks at the impact of the two proposals on business costs, employment and productivity.¹

We use three data sources to arrive at our findings, as no single source contains all the relevant pieces of information. Our key dataset is the 2005 HRET California Employer Health Benefit Survey, which contains employer level information on health spending and insurance coverage. We supplement this with more detailed information on earnings and hours of work using the 2006 March Current Population Survey. Finally, we statistically match information on operating costs as a function of business characteristics using the California Establishment Survey (CES). The CES data is collected by the Institute for Research on Labor and Employment at UC Berkeley as part of its research on California labor markets, and provides a detailed picture of company practices on work and pay.

Using the combined data, this report assesses the potential economic impact of the two California health care proposals, with special attention to the impact on firms' operating costs.

MAIN FINDINGS:

Impacts on Employment and Productivity

- *The Governor's Health Care Proposal and AB 8 are both likely to have no measurable negative effect on job creation in California.* The impact of the health care spending requirements would be similar to a modest raise in the minimum wage. Detailed studies of California's minimum wage legislation have typically found no negative effect on employment. At the same time the proposals would bring between \$1.2 billion (AB 8) and \$3.7 billion (GHCP) a year in new federal matching funds into the state, while Californians' federal income tax payments would be reduced by another \$1.4 to \$3.4 billion. The increased spending will stimulate labor demand, hence offsetting any potential reduction in employment caused by the increased labor costs.
- *Expansion of access to coverage under the proposals should have positive effects on business productivity.* Expanding health coverage would reduce job lock and improve skills matches between employees and employers. It would also reduce the amount of work lost due to poor health.

Impacts on Business Costs

Short-Term Impacts:

- Under AB 8 the short-term increase in business operating costs in the state would be 0.61 percent. Under the Governor's Health Care Proposal, the short-term increase in overall business operating costs would be 0.11 percent.

¹ The study focuses on two proposals that require employers to meet health spending minimums or pay an equivalent amount into a state fund for the uninsured. We do not consider SB 840, the California Universal Healthcare Act, sponsored by Senator Sheila Kuehl. The Lewin Group analysis (Shields and Haught 2005) found that SB 840 would increase overall employer spending on health care by \$1.5 billion, while reducing costs for employers who provide coverage by 16 percent. They further found that the bill would reduce overall health spending in the state by \$8 billion annually. For firms not currently providing coverage, the impact of SB 840 would be substantially similar to AB 8.

- *Firms would experience the increases differently based on their current health spending.* Under AB 8, 44 percent of firms would have cost increases of less than 1 percent in the short term. Four out of five firms would see increases in operating costs of less than 3 percent. Under the Governor’s plan, 91 percent of firms would have immediate cost increases below 1 percent.

Medium-Term Impacts:

- *In the medium term, we anticipate that the increase in business operating costs would fall to 0.1 percent under AB 8 and 0.02 percent under the Governor’s Health Care Proposal.* The reason for the decrease in business operating costs over time is that we anticipate businesses paying above the minimum wage would pass through the increased health care costs to employees in foregone wage increases over a period of as few as two to three years. This is consistent with both economic theory and empirical evidence on employer mandates.
- Over the medium term, 83 percent of firms would face cost increases of less than 1 percent under the Assembly Bill, while 98 percent of firms would have medium-term cost increases below 1 percent under the Governor’s proposal.
- Both of the measures include elements that may serve to slow the growth of premium rates in the state. Reduction in the rate of premium increases may offset, in part, the net additional costs to firms from the new requirements on business. Under AB 8 employers will have access to the purchasing power of a statewide pool that can leverage its size to obtain significant discounts.

In conclusion, both AB 8 and the Governor’s Health Care Proposal can be expected to have a positive net impact on the California economy. After a short period of adjustment, most firms will experience no or little net change in operating costs. Firms with high current rates of health spending will experience some net gain through a lower rate of increase in health expenses. Firms with a high preponderance of minimum wage workers that do not currently offer health care will face some long-term increases in operating costs. Increases in operating costs are likely to be absorbed through a combination of increased productivity and modest price increases for consumers. In net, we expect little impact of the health policies on long-term employment growth.

2. HEALTH COVERAGE PROPOSALS

This brief looks at two proposals for *en lieu* fees on firms that do not meet minimum health spending standards: The Governor’s Health Care Proposal and Assembly Bill 8. The two proposals share some basic features such as establishing basic standards for employer spending on health care (“pay or play”), expanding access to public coverage, creating a statewide purchasing pool and common measures to contain health care costs. Both plans require employers to establish Section 125 plans, which allow employees to allocate pre-tax dollars for a share of their health premiums.

The plans have important differences as well. The Governor’s Health Care Proposal includes an individual coverage mandate; AB 8 requires employees to take up coverage if their employer pays into the state health care pool and the cost of coverage meets an affordability test. AB 8 requires employers to spend a minimum of 7.5 percent on health care, while the Governor’s Health Care Proposal requires a minimum of 4 percent. The Assembly Bill would require employers to meet the payroll test separately for full- and part-time workers. The majority of the working uninsured—who are not

self-employed—are in firms that provide health coverage to part of their workforce, but are not themselves eligible, often due to the number of hours they work. The separate test for full- and part-time workers distributes the costs of the new program across firms in closer correspondence to the actual distribution of the working uninsured.

The health pools also differ between the two plans. Under AB 8, if employers pay into the state health pool, their employees will be eligible for coverage in that pool; employees would pay for coverage on a sliding scale based on income. Under the Governor's plan, there is no relationship between the employer payment and individuals' eligibility for the pool; the pool is open to all individuals with incomes under 250 percent of the Federal Poverty Level. Therefore, firms gain no direct benefit from paying into the pool.

Both plans rely on a mix of financing from state and federal governments, individuals and employers; the GHCP puts a greater share of the costs on individuals and less on employers than AB 8. Under AB 8, future cost increases would be borne by the state, employees, and employers (at least in the short run); under the Governor's Health Care Proposal, future health cost increases for families above 250 percent of the Federal Poverty Level would be borne entirely by individuals. Finally, the Governor's plan includes a 4-percent fee on hospitals and a 2-percent fee on doctors to pay for an increase in Medi-Cal reimbursement rates.

The Governor's Health Care Proposal would expand health coverage to an estimated 4.1 million Californians, close to one million of whom are expected to purchase high deductible health plans on the non-group market under the individual mandate. AB 8 would cover fewer individuals—3.4 million—but with more comprehensive coverage.

KEY PROVISIONS

GOVERNOR'S HEALTH CARE PROPOSAL

- Requires employers with 10 or more full-time equivalent employees to spend at least 4 percent of Social Security wages (currently capped at \$97,500) for employee health care, or pay a fee to a state health care fund.
- Expands Healthy Families coverage to children in families with incomes under 300 percent of the Federal Poverty Level regardless of immigration status.
- Creates a health care pool for individuals with incomes below 250 percent of the Federal Poverty Level.
- Mandates individuals to purchase health coverage.
- Creates a 4-percent fee on hospitals and 2-percent fee on doctors to finance an increase in Medi-Cal reimbursement rates.

ASSEMBLY BILL 8

- Requires all employers to spend at least 7.5 percent of Social Security wages for employee health care or to pay a fee into a state health care pool. Firms would be required to meet the threshold separately for full-time workers, defined as 30 hours a week or more, and part-time workers.
- Employees whose employers pay into the state health care pool would have access to coverage through the pool on a sliding scale based on income.
- Expands Healthy Families coverage to children in families with incomes under 300 percent of the Federal Poverty Level regardless of immigration status.
- Provides premium assistance to low-wage workers not in the purchasing pool.
- Mandates individuals to take-up health coverage if their employer pays into the pool and the cost of coverage meets certain affordability requirements.

3. POTENTIAL IMPACT ON FIRMS' COSTS

Short Run

The proposals establish basic standards for employer spending on health care, so it is important to quantify the likely impact on firms' operating costs. The effect is not going to be homogenous across firms, because while the majority of employers already provide coverage, a minority do not; among those firms that do provide coverage, there is variation in spending as a share of the payroll. Furthermore, labor costs represent a small share of total operating costs in capital-intensive industries and a high share in labor-intensive industries. Therefore, it is important to estimate both the total change in firms' operating costs and the distribution of costs across firms.

California firms currently contribute an average of 7.9 percent of total payroll to employee health care. Estimates of health spending as a share of payroll with coverage through their own employer range from 11.2 percent (Graham-Squire 2007) to 13.8 percent (Gruber 2007).

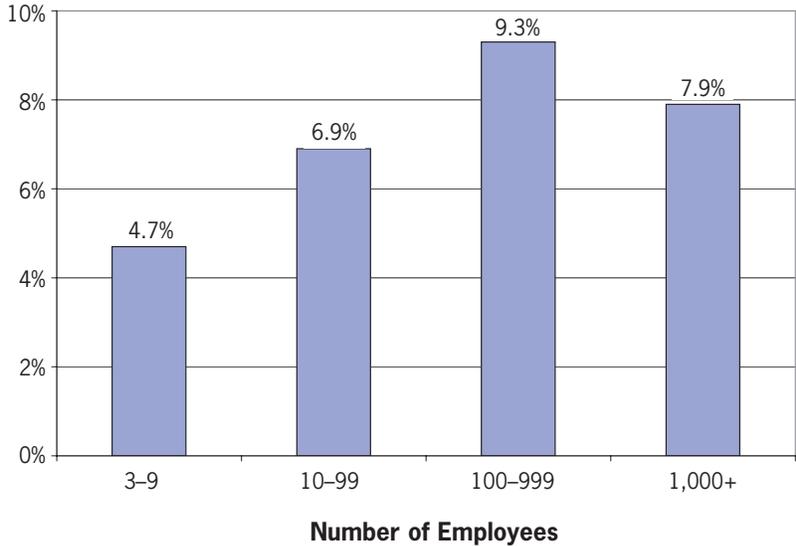
There is substantial variation in actual coverage across industries (Table 1), and particularly by firm size. As shown in Figure 1, employer spending, as a share of the payroll, is much higher for large firms than for small firms.

Table 1—Percentage of California private industry workers with job-based health insurance coverage, firms with 3 or more employees

| Industry | Percentage Covered |
|---|---------------------------|
| Mining | 57.6% |
| Construction | 59.4% |
| Manufacturing | 75.5% |
| Transportation/Utilities/Communications | 83.3% |
| Wholesale | 68.2% |
| Retail | 31.9% |
| Financial | 65.8% |
| Service | 54.0% |
| Health care | 53.4% |
| Total | 58.3% |

Source: 2006 California Employer Health Benefits Survey.

Figure 1—Average employer health care contributions as a percent of payroll (Social Security wages) for all California workers, by firm size



Source: 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

Using information from the March 2006 Current Population Survey (CPS), the California Employer Health Benefit Survey (CEHBS) and the UCB California Establishment Survey (CES), we calculate the additional spending each firm needs to make to meet the minimum requirement under each policy, and express it as a share of total operating costs. The methodology is described in the Appendix.

We find that firms’ total operating costs in California would increase 0.11 percent if the Governor’s proposal were implemented and 0.61 percent if the Assembly Bill were implemented. As shown in Table 2, smaller firms would bear a higher increase in costs than large firms under both proposals—except firms with fewer than 10 employees, which are exempt under the Governor’s proposal. These are pre-tax estimates. To the degree that the increased cost is absorbed by the firm, rather than being passed along in prices, the increase in operating costs will be offset by as much as 20 percent in business tax reductions.

Table 2—Short run increase in firms’ operating costs, by firm size

| Firm Size | Governor's proposal | Legislature's proposal |
|-------------------|---------------------|------------------------|
| 3-9 employees | 0% | 1.43% |
| 10-99 employees | 0.34% | 0.97% |
| 100-999 employees | 0.11% | 0.62% |
| 1,000+ employees | 0.07% | 0.36% |
| Total | 0.11% | 0.61% |

Source: Computed by the authors from the 2003 California Employer Survey, 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

Table 3 presents the distribution of firms by the magnitude of the increase in operating costs in the short run. Under the Governor’s proposal, more than 80 percent of firms would experience no change in operating costs, and none would experience an increase above 3 percent. Under the legislature’s proposal, 44 percent of firms would experience short term cost increases of less than 1 percent, while 79 percent of firms would experience an increase in operating costs of less than 3 percent.

Table 3—Distribution of firms by magnitude of increase in operating costs, short run

| Increase in operating cost | Governor’s proposal | Legislature’s proposal |
|-----------------------------------|----------------------------|-------------------------------|
| No change | 83.4% | 18.0% |
| Increase less than 1% | 7.5% | 26.1% |
| Increase between 1–2% | 6.9% | 14.6% |
| Increase between 2–3% | 2.3% | 20.2% |
| Increase between 3–4% | 0% | 20.2% |
| Increase greater than 4% | 0% | 0.8% |
| Total | 100% | 100% |

Source: Computed by the authors from the 2003 California Employer Survey, 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

Medium and Long Run

The previous estimates assume that, except for firms’ costs, everything else remains constant. This is a useful assumption to analyze the immediate impact of the proposals, but it is inappropriate for assessing the medium- and long-run effects, because firms can adjust wages, employment, prices or output.

Summers (1989) presents a compelling analysis of mandated benefits, and shows that employees are willing to accept lower wages to the extent they value employer-provided health insurance. If workers value health insurance at the full cost of providing it, then firms will pass on the full cost in the form of lower wages. If workers do not value insurance, the degree to which firms can pass the cost to workers depends on the elasticity of the labor supply.

There is a large empirical literature on the incidence of health insurance costs that finds clear evidence that costs are passed on to workers in the form of lower wages. The magnitude of this trade-off, however, is still open to question (Madrian 2006).² We estimate the medium-run effects of the

² Gruber and Krueger (1991) and Gruber (1994) find that the full amount of the cost increase is shifted to workers’ wages, and Baicker and Chandra (2005) find that the insurance costs are only partially passed into wages. While none of the studies directly address the adjustment period, Gruber (1994) used data from two years after mandated maternity benefit legislation went into effect which raised payroll cost for certain workers by 5 percent. He found that the full amount of the cost increase was shifted to wages of workers in the target group over that two-year period.

health spending mandates (i.e., between two and three years after the policy is implemented) assuming that the additional employer spending on health care fully translates into lower wages, except for workers earning the minimum wage.³ In other words, we conceptually treat the medium-run effects of the health mandates as an increase in the minimum wage.

Tables 4 and 5 show that, in the medium run, the increment in firms’ operating costs is negligible, even for small firms, and that the majority of firms do not experience any increase in costs. Almost 98 percent of firms experience less than a 1 percent increase under the Governor’s proposal, and 83 percent under the Assembly Bill.

Table 4—Medium-run increase in firms’ operating costs, by firm

| Firm Size | Governor’s proposal | Legislature’s proposal |
|-------------------|----------------------------|-------------------------------|
| 3–9 employees | 0% | 0.211% |
| 10-99 employees | 0.056% | 0.144% |
| 100-999 employees | 0.019% | 0.117% |
| 1,000+ employees | 0.011% | 0.057% |
| Total | 0.019% | 0.099% |

Source: Computed by the authors from the 2003 California Employer Survey, 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

Table 5—Distribution of firms by magnitude of increase in operating cost, medium run

| Increase in operating cost | Governor’s proposal | Legislature’s proposal |
|-----------------------------------|----------------------------|-------------------------------|
| No change | 91.0% | 62.1% |
| Increase less than 1% | 6.8% | 20.6% |
| Increase between 1–2% | 2.2% | 8.5% |
| Increase between 2–3% | 0% | 7.7% |
| Increase between 3–4% | 0% | 1.1% |
| Increase greater than 4% | 0% | 0% |
| Total | 100% | 100% |

Source: Computed by the authors from the 2003 California Employer Survey, 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

³ Given that employers maintain a wage-hierarchy, we assume that health care expenses would not translate into lower wages for any worker earning less than \$9 per hour.

Finally, we compute the medium-run impact on firms' operating costs restricting the sample to firms that are not currently providing coverage. As shown in Table 6, the share of firms not offering coverage that would experience an increase in costs lower than 1 percent is 56 percent under Assembly Bill 8 and 94 percent under the Governor's proposal.

Table 6—Distribution of firms not offering coverage by magnitude of increase in operating cost, medium run

| Increase in operating cost | Governor's proposal | Legislature's proposal |
|-----------------------------------|----------------------------|-------------------------------|
| No change | 84.2% | 46.3% |
| Increase less than 1% | 9.4% | 9.3% |
| Increase between 1–2% | 6.4% | 22.6% |
| Increase between 2–3% | 0% | 21.8% |
| Total | 100% | 100% |

Source: Computed by the authors from the 2003 California Employer Survey, 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

Figure 2—Governor's Proposal: Distribution of firms by magnitude of increase in operating cost, medium run

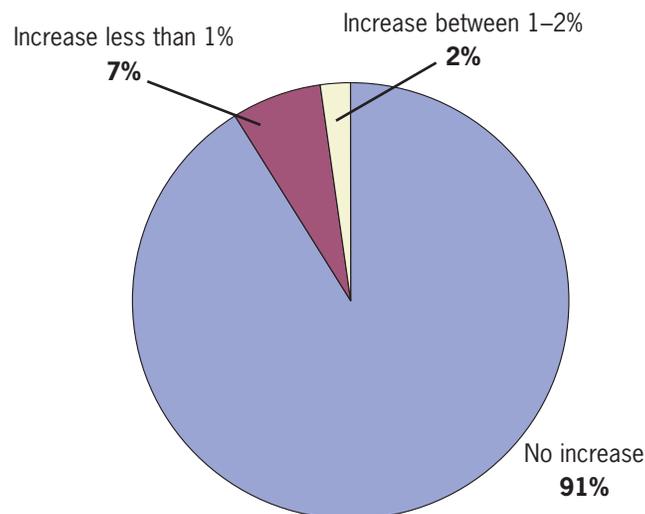
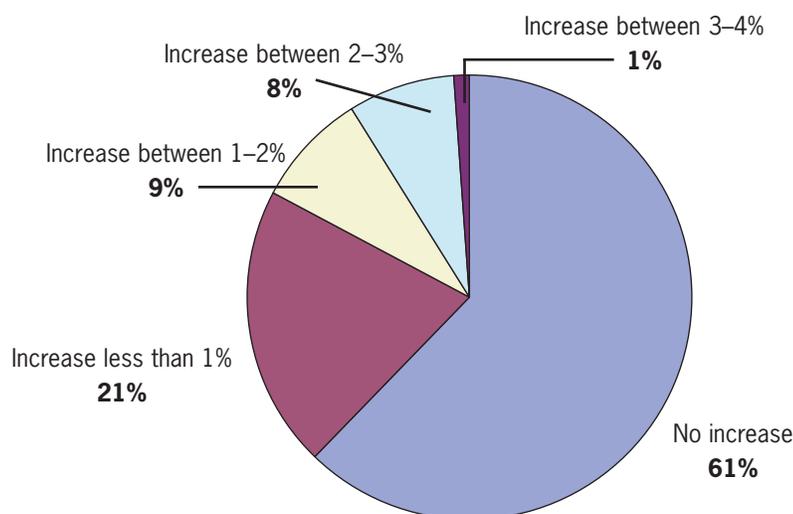


Figure 3—Assembly Bill: Distribution of firms by magnitude of increase in operating cost, medium run



Impacts on Productivity

The proposals are likely to increase workers' productivity due to a reduction in job lock and a healthier workforce. "Job lock" refers to workers staying at their current place of work and foregoing better job matches for the fear of losing health insurance coverage. There is a large empirical literature on job lock, and the most convincing evidence suggests that health insurance plays an important role in job mobility decisions. There is very little evidence, however, on the welfare implications of this result (Gruber and Madrian, 2004). Dube (2003) estimates that 2.3 percent of the California workforce with employment-based coverage would have made productivity improving job changes absent job lock, and the presence of job lock annually leads to about \$800 million in foregone productivity gains.

Productivity gains may be greater under AB 8 than under the Governor's Health Care Proposal. Under AB 8 health access will be broadly available to working Californians through job-based coverage and the new health pool, which has no restrictions for participation based on income. This can be expected to have the effect of reducing barriers to switching jobs. It is less clear how the individual mandate will affect job lock. While guaranteed issue on the individual market opens up opportunities for workers to gain health care if they leave an existing job, the individual mandate would create an additional cost to workers for switching to a non-covering job. For older workers, even with community rating, the cost on the individual market may be quite steep and could act as a barrier to change.

The lack of health coverage also has a significant effect on workers' health and labor force participation. Individuals without health coverage are more likely to skip and delay needed care, less likely to receive treatment for chronic conditions like asthma and diabetes, and more likely to experience a debilitating health condition. Expanded health coverage under AB 8 or the Governor's Health Care Proposal can be expected to decrease absenteeism and exits from the labor force due to disability, with resulting increases in productivity and earnings.

Impact on Federal Spending in the State

By expanding eligibility into public programs, both proposals would bring additional federal funding into the state. Such expenditure would increase aggregate demand and employment. The estimated additional amount of federal dollars, according to Governor Schwarzenegger's health care team, is \$4.5 billion, and under the Assembly Bill, \$1.2 billion (Gruber 2007). Moreover, individuals who currently either do not have insurance or buy it with after-tax dollars would save an estimated \$3.4 billion under the Governor's Health Care Proposal in Federal Income Tax and FICA through the expansion of Section 125 plans. The estimate for the Assembly Bill is \$1.4 billion.

Impacts on Health Care Costs

The previous estimates suggest that the employer mandates will result in a modest aggregate increase in firms' operating costs in California. The proposals, however, also include a number of measures to contain health care costs, such as promoting health information technology and evidence-based practices, implementing healthy lifestyle programs, capping health insurers' administrative costs, and using the larger state purchasing power to improve competition in the sector. If health care costs were effectively contained, then health insurance premiums would increase at a lower rate implying savings for firms and workers.⁴

Hillestad et al. (2005) estimate that effective implementation of health information technology (HIT) could save the U.S. \$81 billion per year by improving health care efficiency and safety, and that HIT-enabled prevention and management of chronic disease could double those savings. Davis et al. (2007) estimate national savings between \$32 and \$46 billion a year if the insurance industry cost structure is brought in line with those in other countries with mixed public-private insurance system. Medication errors, hospital infections and medical errors are estimated to account for about \$15 billion per year nationally.⁵ These figures combined represent approximately 15 percent of private medical care expenditures.

Additionally, by increasing coverage, the proposals are likely to generate a further reduction in insurance premiums because cost shifting (often referred to as the "hidden tax") would be reduced. Those individuals who actually have health insurance are paying the cost of health care delivered to the uninsured, because health providers transfer the costs of uncompensated care to insurers who in turn pass the costs on in the form of higher premiums. While there is no dispute about the existence of the hidden tax, there is debate about its magnitude. The available estimates for California range from 5 to 10 percent of private health insurance premiums (Institute for Health Policy Solutions 2006; Harbage and Nichols 2006).

A reduction in the rate of premium increases from the combination of cost containment measures may offset in part or in whole the net additional costs to firms from the new requirements on business. These benefits would be felt unevenly across firms based on the amount firms currently spend on health care coverage.

⁴ Language on cost containment in the two proposals has not been finalized; the impact will depend significantly on the details of the bills.

⁵ Institute of Medicine and Centers for Disease Control and Prevention.

Under AB 8, employers will have access to the purchasing power of a statewide pool that can leverage its size to obtain significant discounts. Firms will have the option of paying the 7.5-percent fee into the California Cooperative Health Insurance Purchasing Pool (Cal-CHIPP), which will provide coverage to workers at a sliding scale based on income. The pool will make use of federal funds to subsidize coverage for workers in low-income families.

Effects on Employment

There is little economic research on the impact of employer health spending requirements. Hawaii is the only state with a health coverage mandate in effect; the law has been in place since 1974. The City and County of San Francisco passed an ordinance requiring all firms with 20 or more workers to meet a minimum health spending requirement that is scheduled to go into effect in January 2008.

Research on Hawaii found an increase in health coverage due to the mandate. While employment growth in Hawaii exceeded the rest of the United States following enactment of the mandate, part-time work was significantly higher than the national average (Thurston 1997). People working under 20 hours a week are exempt from the Hawaii law. Neither of the proposals studied here makes an exemption for part-time workers.

Health reform in Canada was implemented in different provinces over a nine-year period between 1962 and 1971. Gruber and Hanratty (1995) exploit variation in implementation across provinces and find that employment rose after the introduction of the public insurance programs.

The California health care reform proposals could affect employment through two distinct avenues. First, the employer spending mandates, by increasing labor costs, could lead to a reduction in demand for labor. Second, by bringing federal dollars into the state, the proposals could increase aggregate demand.

The available evidence suggests that firms will largely shift health spending onto workers in the form of lower wages over time. For employers who currently do not offer health insurance and employ minimum wage workers, a 7.5-percent increase in payroll costs amounts to just above \$0.50/hour, substantially less than the most recent minimum wage increase in California. Firms at the minimum wage will pass on increases through a modest adjustment to prices.⁶ Since all employers will be required to meet the same health spending minimums, firms will largely be able to pass along cost increases to consumers without facing a competitive disadvantage. As seen in Table 1, firms with low rates of current health spending are more likely to be in industries such as retail, construction and other services that do not face competition from out of state or internationally. Furthermore, Dube and Reich (2003) find that 90 percent of establishments in California that do not offer health insurance say their competitors do not either, suggesting that the proposed reforms are unlikely to alter the competitive position of affected businesses.

The medium-range projected increase in business operating costs is similar to past minimum wage increases in California and throughout the country. Previous studies on minimum wage policy that sufficiently control for underlying employment trends (Card 1992; Card and Krueger 1995; Dube, Naidu and Reich 2007) find no measurable effects of those increases on employment.

⁶ Several recent studies have founds small increases in restaurant prices rise in response to an increase in the minimum wage (Aaronson 2007; Dube, Naidu, Reich 2007).

The increase in federal funds will raise aggregate demand in the state, particularly in the health care field, which is a labor-intensive industry, and hence is expected to increase employment. In net, the proposals can be expected to have little effect on the medium- or long-term employment outcomes in the California.

CONCLUSION

Both AB 8 and the Governor's Health Care Proposal are likely to have a positive net impact on the California economy. Most firms will experience no or little net change in business costs, but may see some productivity benefits. Firms with high current rates of health spending will experience some net gain through a lower rate of increase in health expenses. Firms with a high preponderance of minimum wage workers that do not currently offer health care will face a small long-term increase in operating costs, which may be passed on to consumers in the form of modest price increases. Any remaining negative employment effect will likely be offset by increased labor demand from new federal dollars to the state.

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APPENDIX

Methodology for determining increased health care spending as a percent of operating cost.

Summary

The 2005 California Employer Health Benefit Survey (CEHBS) was the basis for looking at increased operating costs under the two proposals. The CEHBS contains detailed health care information for the sample of 846 private sector employers but lacks information on payroll practices and operating expense. We used the March 2005 Current Population Survey (CPS) to arrive at payroll amounts for each firm and the California Establishment Survey (CES) to determine operating expenses of the employers. These elements were combined to generate a current level of health care spending as a percent of employee payroll. Each of the steps is described in more detail below.

Employer health care spending

Each firm surveyed in the CEHBS provides information on the number of employees covered by different medical plans and the amount that employers contribute to those plans. From this a total annual health care expenditure was computed for each firm.

Payroll information

Earnings information was obtained from the March 2006 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The sample contains earnings information for the 2005 year for 5,905 Californians employed in the private sector. All earnings have been capped at \$550,000.

Each worker in the sample was assigned to one of four firm size categories (fewer than 10 employees, 10 to 99, 100 to 999, and more than 1,000 employees) and to one of nine industry categories (mining, construction, manufacturing, utilities/transportation/communication, wholesale, retail trade, financial, services, health care) for a total of 36 different size-industry categories.

Finally, 2005 average earnings for workers earning less than \$20,000 and average earnings for workers earning \$20,000 or more were computed for each of the 36 size-industry categories. Because many in the sample did not work the full 2005 year, earnings were computed based on a 52-week work year. This allowed workers' earnings from the CPS to represent annual amounts and match the annual health care premium amounts from the CEHBS. The percentage of workers earning above and below \$20,000 a year for each firm in the CEHBS was adjusted to match the CPS average for that industry size category.

Percent of spending on health care

The payroll information and health care spending information yielded the amount each employer spent on health care as a percent of payroll and the required increase in spending under the two California health care proposals.

Employer spending full-time and part-time employees

AB 8 requires that employer contribution amounts be applied separately to part-time and full-time employees where part time is defined as working less than 30 hours per week. For each firm surveyed, the CEHBS gathers the percentage of employees covered, the percentage of part-time employees and whether or not part-time employees receive benefits (and 40 percent of the firms surveyed do offer benefits to part-time employees). What the CEHBS does not track is the percentage of part-time employees who receive benefits and the percentage of full-time employees who receive benefits.

We use the CPS to determine coverage probabilities for part-time employees for the 36 different industry-size categories and apply this to the number of part-time employees to arrive at the number of part-time employees receiving health benefits and then the number of full-time employees receiving health benefits. We assume that health care expenditures are equal for part- and full-time employees to arrive at health care expenditure amounts for part- and full-time employees. Payroll amounts for part time and full time are determined in the same way that overall payroll is determined yielding separate expenditure levels on health care, as a percentage of payroll, for part-time employees and expenditure levels on health care, as a percentage of payroll, for full-time employees.

Because the CEHBS defines part-time employees as working 20 or fewer hours per week we also used this as our definition of part-time for all analysis in this report.

The table below presents the average short-run increases in the payroll, by firm size

| Firm Size | Governor's proposal | Legislature's proposal |
|-------------------|----------------------------|-------------------------------|
| 3–9 employees | 0% | 3.72% |
| 10–99 employees | 0.81% | 2.33% |
| 100–999 employees | 0.23% | 1.34% |
| 1,000+ employees | 0.16% | 0.85% |
| Total | 0.26% | 1.41% |

Source: Computed by the authors from the 2003 California Employer Survey, 2005 California Employer Health Benefit Survey and March 2006 Current Population Survey.

Operating expense

In the California Establishment Survey, participating firms report the fraction of total operating expense due to labor costs. On average, labor costs represent about 40 percent of total operating costs. We constructed a simple regression model predicting this fraction with industry type (in nine categories) and firm size (in four categories) as independent variables. This prediction equation was then applied to each firm in the CEHBS to arrive at total operating expense costs and the fraction of increased health care spending as a percentage of total operating costs.

Medium-term increases in operating expense

We assume that increased spending in health care will be offset equally by decreased employee wages so that in the “medium term” the only additional spending will be due to the portion of the employer increase spent on workers earning near the minimum wage (earning less than \$9/hour). We assume that increased employer spending will apply equally to uninsured workers earning below or above \$9/hour so that:

$$\text{amount of increase in the "medium term"} = (\text{amount of increase in the "short term"}) \times (\text{the percentage of uninsured workers who are low wage})$$

To determine the percentage of uninsured workers who are low wage in each firm, we start with the number of workers in the firm earning less than \$20,000. The CPS is used to determine the fraction of these who are uninsured and low wage. This is done separately for each of the 36 industry-size categories and the appropriate fraction is applied to each firm to determine the percentage of the firm who are uninsured and low wage. For AB 8 this is applied separately for full- and part-time employees.

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Acknowledgments

We appreciate the helpful comments and reviews we received from Michael Reich and Arindrajit Dube. Special thanks to Andrea Buffa for her editing, and to Sarah Lawton and Jenifer MacGillvary for proofreading and layout. We also wish to thank The California Endowment for funding this research.

The views expressed in this policy brief are those of the authors and do not necessarily represent the Regents of the University of California, UC Berkeley Institute for Research on Labor and Employment, The California Endowment, or collaborating organizations or funders.