September 24, 2004

Re: SB2 (Burton and Speier) & Proposition 72

Dear Friends and Colleagues,

These are some thoughts on SB 2 (Burton and Speier) and Proposition 72, the ballot referendum seeking to repeal it scheduled for the November 2004 General Election. SB 2 (Burton and Speier) is a mandate for large and medium sized employers to offer coverage for their full time employees.[1] The referendum is an infrequently used ballot measure to repeal legislation opposed by the referendum's proponents. Proposition 72 will be on the ballot; a "no" vote means SB 2 is repealed, and a "yes" vote means that SB 2 is retained. As many of you will no doubt receive many questions about the referendum between now and November, we wanted to summarize our research and perspective about the bill.

- SB 2, when and if fully implemented, will cover 800,000 uninsured workers and their family members.[2] All are employees of medium sized and large employers.
  - According to the 2001 CHIS (California Health Interview Survey) data, about 4.5 million Californians are uninsured at a given point; most (over 80%) work or are dependents of workers.[3] SB 2 would thus reduce California's high rate of uninsured (as compared to other states) by about 18%.

- SB 2 will have little direct impact on small employers, where the bulk of California's "offering" problem resides. "Offering" is an employer's voluntary decision to offer health coverage to employees. California has a lower rate of employment-based coverage as compared to other states, primarily because our offer rates are lower.[4] Offer rates decline with employer size: according to recent studies, about 98% of large employers in California offer coverage while about half of very small employers offer coverage. [5] There may be some indirect

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[1] To be clear with our readers, ITUP supports SB 2. This analysis seeks to provide common and readily available information to supporters, opponents and fence sitters about SB 2.

[2] Brown et al., SB 2 Will Extend Coverage to 1 Million Uninsured Workers (UCLA Center for Health Policy Research, Sept. 2003). We prefer the CHIS data to the federal Current Population Survey (CPS) data of 6.2 million uninsured Californians because CHIS is much closer to the actual counts of MediCal and Healthy Families enrollments. We use the figure of 800,000 rather than a million because the mandates for small employers are conditioned on the legislature's passing a 20% tax credit for all small employers. We project that the costs of the 20% tax credit for small employers (20-50 employees) exceeds the actual costs of coverage for uninsured employees working for employers of 20-50 employees. To put the reduction in the uninsured under SB 2 in context, it is roughly equal to the number of uninsured children enrolled in the state's Healthy Families program. SB 2 would insure about 600,000 adults and 200,000 children. Ibid.

[3] 2001 California Health Interview Survey (UCLA Center for Health Policy Research, 2002)

[4] Kaiser Family Foundation and Health Research Educational Trust, California Health Benefits Survey (March 2001).

[5] Ibid. See also, Kaiser Family Foundation and Health Research Educational Trust, California Health Benefits Survey (March 2003). Nationally offer rates for large employers are holding constant at 99%

beneficial impacts for small employers offering employee and family coverage as large and medium sized employers marginally increase their offer rates.[6]

- ➢ The legislation exempts very small employers (1-20 employees) and also exempts small employers (21-50 employees) unless the legislature enacts a 20% tax credit for the costs of their coverage.

- o The bill will have little impact on increasing coverage for the flex workforce – part time, seasonal, temporary, provisional, and contract workers and the self-employed. Our past studies indicate that about half of uninsured workers belong to the flex workforce; most employers do not offer coverage to flex workers, and many flex workers have incomes too low to be able to afford individual private insurance without financial assistance and too high to qualify for MediCal. As a result the rates of uninsurance for flex workers are quite high. [7]
  - ➢ SB 2 applies to employees who have been employed for at least three months for an individual employer and work at least 100 hours per month for that employer.

- o SB 2 will primarily impact those large employers (over 200 employees) who do not offer coverage for their employees or for employees' dependents and those medium sized employers who offer no coverage to their employees.[8]
  - ➢ There are very few employers who actually fit this description.[9] The studies we have reviewed found that 98% of large employers offer coverage to their workers and dependents. Similarly, 97% of medium sized employers offer coverage nationwide and 94% in California.
  - ➢ Employment sectors with low offer rates include: agriculture, construction, retail trade and the low wage service sector. Manufacturing and government have very high rates of employer offered coverage.[10]

- o The legislation will be at little or no cost to state government. It may reduce costs for state taxpayers and the state's budget deficit.
  - ➢ Newly insured (employers and employees) must pay the full cost of coverage. Previously, public programs (such as MediCal, Healthy Families and county health) paid these costs for some employees and

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while offer rates for mid sized employers (50-200) have fallen from a high of 97% in 2000 to 92% in 2004. Kaiser Family Foundation and Health Research Educational Trust, Employer Health Benefits Survey (2004).

[6] Premiums might slightly drop due to reductions in uncompensated care and there will be some inter-employer shifts in coverage for two worker families.

[7] See Wulsin et al, Developing Models of Coverage for the Flex Workforce (Insure The Uninsured Project, 2001) at www.itup.org

[8] It is possible that these employers may initially offer lower premium, high deductible, high co-pay plans. These may or may not be joined to health savings accounts.

[9] Kaiser Family Foundation and Health Research Educational Trust, California Health Benefits Survey (2001 - 2003). The offer rate for mid sized employers nationally fell from 97% to 92% over the past four years. Kaiser, Employer Health Benefits Survey (2004).

[10] Brown et al, The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey (UCLA Center for Health Policy Research, 2002)

dependents, which would now shift to private employment based coverage.[11] This will produce a savings to the state and federal budgets by shifting costs from the state and federal government to employers and employees.

- Shifting costs from the public sector to the private employer sector could reduce the competitiveness of California's employers and cost the state federal contributions for health care. The extent of the shift will be determined by the program's success in designing and securing federal approval of premium assistance programs, using MediCal and Healthy Families funds.

- SB 2 has inadequate cost containment. Cost containment is crucial because the double digit premium increases of the past five years are adversely impacting job creation, employee take home pay, and employer bottom lines.[12]
  - A separate but linked bill (AB 1528 Cohn) would create a California Cost Containment Commission to study and make recommendations to the legislature and the Governor; Commission members have not yet been appointed.
  - There is no operating consensus on how to control out of control health care costs and employer premiums. Some favor shifting costs to employees and individual consumers and giving them the tools and incentives to be more cost conscious and prudent shoppers.[13] Others favor stronger government regulation of hospital, drug and insurance prices.[14] Others propose a mix of economic incentives for providers and plans with enhanced purchasing power for individuals and small employers purchasing coverage.[15]

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[11] Lewin Group, Cost and Coverage Analysis of 9 Proposals to Expand Coverage in the State of California (March 2002). The shift of low wage workers' coverage from publicly funded to privately insured is quite large; Lewin estimated that MediCal and Healthy Families enrollment would fall by nearly 1.5 million in the context of a mandate covering all sizes of employers. Ibid.

[12] Health insurance premiums have been increasing faster than overall inflation by a factor of 6:1 and worker's wages by more than 4:1. Kaiser Family Foundation and Health Research Educational Trust, Health Benefits Survey (2003). See Porter, As Health Benefits Spike, Firms Stop Hiring, *New York Times* 8/19/04. The most recent Kaiser national survey finds that premium increases (11.2%) exceeded overall inflation and worker's wages by 5:1. Kaiser Family Foundation and Health Educational Trust, Health Benefits Survey (2004)

[13] This is the current hot trend in the market and favored by the Bush Administration and groups such as the National Center for Health Policy Analysis. The fly in the ointment of this approach is the willingness of employees to absorb these rising costs without consumer backlash.

[14] This is the working model in most other industrialized countries; cost control through price control can be done via a large government role as purchaser or a price regulator. In other countries, this model often controls prices without comparable controls on utilization.

[15] This is the managed competition model, favored by many health policy analysts and economists and endorsed as a part of the Clinton plan. As practiced by large health plans in the 90s, it generated a large consumer backlash, leading to our current state of uncontrolled health spending.

- The strong purchasing pool component in SB 2 would allow MRMIB[16] (Managed Risk MediCal Insurance Board) to implement a version of managed competition, envisioned by Professor Alain Enthoven and others as a way to restrain plan and provider health cost increases. MRMIB might also focus on the lower premium, high deductible, high co-payment plans beginning to proliferate in some markets. These plans keep health plan costs to the employer and employee low, but those workers with chronic conditions or unexpected large medical expenses would face heavy out of pocket costs. Health savings accounts may increase in popularity for higher wage employees.

- SB 2 shifts health costs from some employees to some employers. Large and medium sized employers must pay at least 80% of the cost of premiums for employees and where required their dependents. On average, California's "insuring" employers already pay 87% of the premium for employee coverage and 75% of the premium for dependent coverage.[17]
  - For many employers, there will be little change. For employers paying less than 80% of premium, there will be a cost increase.[18] Their employees will experience a cost decrease.
  - Economists report that there is a fixed pot for employee compensation, and it makes little or no difference whether the employer or employee pays for health coverage.[19] They contend that an increase in an employer's share of health premiums will be passed back to employees in the form of reduced wages and salaries.
  - Most employers and employees do not agree with the economists, and many recent strikes have focused on employer proposals to increase employee share of premiums.
  - This is a highly charged issue for both employers and employees. Some employers have been shifting the double-digit increases in health premiums to their employees as a way of giving employees financial incentives to reduce health spending, and some employees say that with frozen wages they are unable to pay for their increased share of health premiums. Some employees are declining health coverage.[20]

[16] MRMIB (Managed Risk Medical Insurance Board) is an independent state agency with its own governing board that has operated pools purchasing private coverage from competing private health plans for small employers (Health Insurance Plan of California, now PacAdvantage, operated by the non-profit Pacific Business Group on Health), children (Healthy Families), pregnant women (AIM), the medically uninsurable (MRMIP). See its web site at www.mrmib.ca.gov.

[17] Kaiser Family Foundation and Health Research Educational Trust, California Health Benefits Survey 2002. The most recent Kaiser Health Benefits survey confirms nationally that employer and employee shares of premiums are holding constant. Kaiser Health Benefits Survey (2003)

[18] Twenty percent of large and medium sized firms pay less than 80% of employee only coverage and 50% of large firms pay less than 80% of family coverage. Ibid.

[19] See e.g. presentations of UCLA Professors Tom Rice and Jack Needleman at "Expanding Health Insurance in California SB 2" (Los Angeles, May 7, 2004).

[20] Employee take up rates are quite high – 90% on average in California – but those reportedly declining due to cost doubled between 2001 and 2002. Kaiser/HRET, California Health Benefits Survey 2002

- The Kaiser Family Foundation/HRET report finds that on average, employers and employees are absorbing roughly equivalent shares of the double digit increases in health premiums.[21]

- SB 2 has affordability protections -- employers must pay more of the premium -- for low wage employees. SB 2 caps low wage employee premium contributions at 5% of wages. Low wage employees are those with wages less than 200% of the federal poverty level for a family of three ($31,340) in 2004. SB 2 also includes provisions permitting low income workers enrolled in the MRMIB purchasing pool to apply for MediCal and Healthy Families if they so choose.
  - ITUP's earlier studies found that employees' share of premium would rarely exceed a 5% cap for individual coverage; however, many working families in California would exceed the 5% cap for family coverage.[22]
  - Employee shares of premiums are typically set at a percentage of premium – e.g. 20% of premium; low wage employees and high wage employees pay the same amount.[23] This approach has a regressive impact, disproportionately impacting low wage workers. Some employers calculate employee contributions based on a percentage of wages – e.g. 3% of wages; low wage and high wage employees pay the same percent, but pay very different amounts.[24] The latter approach makes family coverage in particular far more affordable for low wage working families and shifts costs to higher-wage workers.

- SB 2 is likely to have some adverse impacts on low wage manufacturing jobs both in terms of both job creation and job loss. For example, let's assume that coverage for an individual employee costs $3000 annually and family coverage costs $9000 annually.[25] For a worker making $15,000 annually ($7.50 an hour), health benefits for employee only coverage would be 20% of employee salary, while family coverage would be 67% of the worker's annual salary. Tax advantages[26] for health coverage that help offset the cost of premiums are very regressive -- only 6-7% of the cost of premiums for low wage workers as compared to 50% of

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[21] Kaiser/ HRET, Health Benefits Survey 2003 and Health Benefits Survey 2004

[22] Ibid. Average employee contributions for family coverage were $200 a month in the 2003 nationwide survey and $1500 annually in the California 2002 survey. Ibid. As long as the growth in health benefits exceeds the growth in employee wages, the 5% cap will shift an increasing share of the premium costs for low wage workers from low wage employees to their employers.

[23] See ITUP, SB 480 Options Paper at www.itup.org. Kaiser/HRET reports the average family contribution is $200 a month or $2400 annually. California Health Benefits Survey 2003 Based on this average, families making less than $48,000 annually would exceed the 5% cap.

[24] ITUP, SB 480 Options Paper p.34 at www.itup.org

[25] Average annual employer premiums for individual coverage were $3,100 for all plans, $2,665 for HMOs; premiums for family coverage were $8,505 for all plans and $7,480 for HMOs in California. California Health Benefits Survey 2003 The recently released 2004 national figures are $3,695 per employee and $9,950 per family. Kaiser, Employer Health Benefits Survey 2004.

[26] Health insurance for employees is bought with a pre-tax dollar; the average tax subsidy is 30% of premium, however the distribution of the tax subsidy is skewed to high salaried workers who pay at higher marginal tax rates.

high salaried employees. Some employers may choose not to fill or not to create low wage jobs due to the added cost of purchasing health coverage; some may move jobs out of state or out of country, while others may reduce employee hours.

- Many jobs, such as store clerk, hair dresser, construction, and restaurant and hotel workers, are not easily shifted from California to another state since most Californians are not likely to drive to Arizona, Nevada or Oregon to purchase groceries, eat a meal or get a hair cut.
- Other low wage jobs such as light manufacturing could be shifted from California to neighboring states or countries.
- SB 2 defers the issue of affordability of coverage for low wage workforces to MRMIB, which is tasked to set the fee(s) employers and employees must pay. If MRMIB sets the fee in a manner to promote affordable coverage for low wage workforces within the pool, low wage employers will have incentives to choose the pool.

- Under SB 2, MRMIB will set the fee level for the required benefits. The employer may choose whether to cover their employees by purchasing coverage or by paying a fee into a purchasing pool for their coverage. The pool then buys private coverage for the participants. Medium sized employers may find paying the fee into the pool allows them to access the economies of scale of large scale purchasing.[27]
  - MRMIB has many options as to where and how to set the fee and these have wide-ranging consequences both as to affordability of coverage through the pool and the viability of the pool.
  - The cost of coverage for a defined set of benefits among employers is highly variable: varying by age, family composition, geographic region claims experience, type of industry and the insurer's assessment of the "risks" of coverage.
    - The fee could be set at a flat amount (pure community rating) equal to the average cost of coverage: such as $3000 for employee coverage, $6000 for employee and spouse and $9000 for an employee, spouse and children. The fee could be adjusted by the average age and gender composition of the employees and/or by the region of the state in which the employees reside.
    - The fee could be set at the mid range, high end or low end of market prices. The fee could be tied to the most efficient purchasers and most cost efficient (least costly) plans, thus giving providers and plans cost efficiency incentives.
    - The fee could be set by the average percent of wages for coverage. This could be adjusted by geographic region as well.
  - Approaches that might improve affordability for low wage workforces include: setting the fee at the lowest market prices, age rating and setting

[27] Purchasing pools were touted initially for their ability to restrain premium increases through more efficient purchasing and the bargaining power of large units; their performance has not lived up to expectations.

fees by a percentage of wages.[28] Approaches that would reduce affordability for low wage workforces include flat fees and gender rating.[29]

  - In California, premiums are highly variable by geographic region;[30] the highest priced coverage is in rural areas and regions with shortages of medical personnel; the lowest priced coverage is in urban areas where price competition among plans and providers is strongest. Some rural areas have very high concentrations of low wage workers; in setting its fees, MRMIB will need to reconcile the conflicts between promoting affordability and enhancing competition.

- The purchasing pool component is an extremely important feature of SB 2 as it has the potential to solve affordability issues for low wage workers and the potential to lead towards more effective cost containment for all employers and employees, as discussed above. The pool also has the potential to implode due to adverse selection if not properly designed. For example, if MRMIB sets the fee at the average cost to employers, higher than average cost (older or higher risk employees) employers may select the pool, and the pool may have inadequate revenues to purchase coverage.[31] If MRMIB sets the fee at the average percent of compensation spent by employers, lower wage employers will have incentives to join the pool and again the pool may become inadequately financed.[32]
  - Both of these problems can be fixed by future legislation. The peril of adverse selection of the pool by high-risk employers can be avoided by expanding the underwriting reforms now in place in California's small employer market to large employers (SB 2 includes underwriting reforms for medium sized employers). Incorporating Healthy Families and MediCal funding into the SB 2 purchasing pool can mitigate the peril of adverse selection by low wage workforces and solve affordability problems for low wage workforces. In our view, this will require an1115 waiver from the federal government.[33]

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[28] See Wulsin, California at the Crossroads: Choices for Health Care Reform (Center for Governmental Studies, 1994)

[29] Ibid.

[30] See study of small employer managed care premiums for 48 California counties at www.itup.org/reports and plan costs and benefit variations for individual counties at www.itup.org/workgroups.

[31] This approach leaves the pool with higher risk enrollees and "average risk" revenues. SB 2 extends the California underwriting protections that have worked well for small employers to medium sized employers with a wider rate band for high and low risk employers. The underwriting rules are guaranteed issue, guaranteed renewal, age and geographic rating and limits on risk rating to plus or minus 15% from the mid range price. The pool has the potential to attract the higher risk large employers under any circumstances and the higher risk medium sized employers, depending on whether it decides to rate and price its coverage using the same rate bands as health plans operating outside the pool.

[32] This approach leaves the pool with lower income, average risk enrollees and sub average revenues.

[33] We believe that an 1115 waiver is necessary because at a minimum, the MediCal and Healthy Families programs are payers of last resort to an individual's employment based coverage. The waiver should allow the state to mix and match MediCal and S-CHIP funds with employer and employee contributions in order to promote affordability for low wage working families. Massachusetts sought and secured federal 1115 waivers in conjunction with its expansion of coverage and the intersections between public and private

- The merits of such reforms need to be debated, but it would solve two important issues: affordability of coverage for low wage workforces and misplaced incentives for carriers to pre-select the healthiest lives as opposed to control spiraling health costs.

- SB 2 will shift costs among employers; primarily this will be a shift of coverage and costs from “insuring” employers to "uninsuring" employers. This will occur in two ways: the uncompensated care cost shift to employers who offer coverage will be somewhat reduced and coverage for two earner families will be more equitably shared.[34] Some will argue that this will make California a more desirable place to do business for “insuring” employers and, concomitantly, less desirable for heretofore “uninsuring” employers.

- SB 2 sets a minimum package of benefits – those already required under the Knox-Keene Act, plus prescription drugs. Ninety-nine percent of employees with coverage from their employers already have these minimum benefits.[35]
  - SB 2 does not set rules governing employee cost sharing, copays and deductibles, but instead leaves this challenging task to MRMIB for those employers participating in the purchasing pool.
  - Employee cost sharing in the form of copays and deductibles for employers not participating in the pool remains under the regulatory authority of the Departments of Managed Health Care and the Department of Insurance for those plans under their respective jurisdiction and the United States Department of Labor for self funded plans under its jurisdiction.

- SB 2 has obvious flaws that need fixing: e.g. linkage to effective cost containment, affordability for low wage employers, relationship with public programs, insurance reforms for large employers and the potential for adverse selection. Effective administration of the program by MRMIB has the potential to solve or mitigate some of these challenges; others will need to be corrected in follow up legislation.

- If SB 2 survives the ballot referendum, it may never be implemented due to lawsuits on two issues. ERISA is a federal law governing employer benefits; it was interpreted by the Supreme Court in a case arising over thirty years ago to

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coverage. Maine may seek waivers for such an approach under its DIRIGO plan, which seeks to merge public and private contributions in expanding coverage for low wage working families employed by small businesses.

[34] The redistribution effect among employers is quite large. A Lewin VHI study in 1993 projected a $2.3 billion cost shift from “insuring” to “uninsuring” employers in the context of an employer mandate covering all employers. See Lewin VHI, Potential Financial and Economic Impact of Health Care Reform in California (November 1993) In a more recent, but comparable study, Lewin projects savings of about $500 per employee for insuring firms and new costs of about $1000 per employee for uninsuring firms under an employer mandate for all employers. Lewin, Cost and Coverage Analysis of 9 Proposals to Expand Coverage in the State of California. (2002).

[35] Employer Health Benefits Survey 2003. There was little change in covered benefits, co-pays or deductibles between the 2003 and 2004 Kaiser surveys of employer health benefits.

prohibit state mandates that employers covered by the act offer a particular package of health benefits.[36] SB 2 seeks to avoid this prohibition by characterizing the employer's obligation as "pay or play" i.e. pay a fee for coverage unless you choose to provide the minimum package of benefits. This is an untested theory and is weakened by SB 2's list of minimum required benefits. In our view, a state payroll tax on either employers or employees to pay for health coverage is not prohibited by ERISA.[37] The second issue is whether the employer's obligation to pay can be characterized as a fee (requiring only a majority vote by the state legislature) or is a tax (requiring two-thirds legislative approval).

- Three other states have preceded California in enacting employer mandates. Hawaii was successfully sued under ERISA and then secured an ERISA exemption. It has the only operational mandate. Hawaii through a combination of its employer mandates and program expansions has achieved a far lower rate of uninsured (10.1%) than California (18.3%).[38] Massachusetts ultimately repealed its pay or play version of an employer mandate; Massachusetts secured an 1115 waiver covering low income working adults and adopted several measures to improve affordability of coverage for small employers and low wage workers. Massachusetts has a far lower rate of uninsured (10.3%) than California (18.3%). Oregon adopted a pay or play version of an employer mandate along with securing an 1115 waiver to cover low wage working adults. Its mandate was also repealed and then its program expansions were scaled back as state tax revenues declined over the past 4 years. Similar reductions in program expansions in light of state revenue shortfalls have plagued Massachusetts and Hawaii as well.

California cannot continue to sustain the impacts of 15-20% of the state's population uninsured, double digit premium increases for insuring employers and employees and the strain of rising health prices and the huge numbers of uninsured Californians on over stressed state and local budgets. To move forward in expanding coverage for the uninsured, Californians face a choice among the following: employer mandates, individual mandates, strategic incrementalism or a tax based single payor. Each has its advantages and disadvantages:

- Employer mandates build on the existing employment based system; however, that has a stacked deck due to federal and state tax policies disfavoring coverage

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[36] Standard Oil of CA v. Agsalud 442 F. Supp 695 (ND CA, 1977), 633 F 2d 769 (9th Cir. 1980) 454 US 801 (1981) See Butler, ERISA Implications of SB 2: Full Report at www.chcf.org/topics/sb2 and presentation of Curtis Leavitt Esq. at "Expanding Health Insurance in California SB 2" (Los Angeles, May 7, 2004).

[37] We do not believe that ERISA was intended to or would be interpreted to prohibit a state from enacting a payroll tax, a sales tax or an income tax to pay for health insurance for a state's residents. We believe that ERISA permits and may even compel a state to give credit against the payroll tax for an employer's expenditures under an ERISA plan for covered health expenses to that state's residents. Over half of insured workers nationwide are in ERISA self funded plans. Employer Health Benefits Survey (2004)

[38] See US Census Bureau, Income, Poverty and Health Insurance in the United States: 2003 (Aug. 2004). Minnesota has the nations smallest rate of uninsured – 8.3% -- due to a high rate of employer-sponsored coverage, combined with broad public program coverage for low wage workers and their families.

for the uninsured low-wage worker. To correct this deficiency, either a well designed pay or play option, merging existing public spending or a major overhaul of state and federal tax policy for employer health coverage[39] is needed.

- Individual mandates[40] to purchase coverage (as we already have for car and home insurance) build from the far smaller base of individuals with individual coverage; it will require a radical restructuring of federal tax policies to subsidize health coverage for low income workers and their families and an overhaul of health plans underwriting, pricing and purchasing policies; depending on design, it might destabilize and even dismantle the system of employment based coverage.
- Strategic incrementalism refers to expansion of MediCal and Healthy Families to cover low income workers and parents and targeted refundable tax credits and vouchers for the higher income uninsured workers such as the flex workforce;[41] this requires roughly $3-4 billion in new revenues from an already hard pressed, deficit ridden state government.
- Single payor[42] would cover all residents for all services and consolidate cost controls with a single state agency; it faces the huge challenges of raising taxes equal to two thirds of the current state budget.
- SB 2 with its acknowledged flaws discussed above provides a not insignificant increase in coverage with minor disruption of the existing system and an important building block for future expansion of coverage to the working uninsured.[43] The financial impacts fall primarily on the small number of uninsuring large and medium sized employers. SB 2's flaws highlight our need to solve affordability for low wage workforces and to curtail double digit increases in health costs and premiums.

ITUP favors any and all approaches that will increase coverage for the uninsured. We are concerned that defeat of SB 2 at the ballot box may set back state efforts to cover the uninsured for up to five years much as the utter defeat of the Clinton plan in Congress did for federal efforts. We hope this analysis is helpful to you. For more information on SB 2 and Prop 72 we urge you to visit the California Health Care Foundation website at www.chcf.org/topics/SB2.

Sincerely,

Lucien Wulsin, Jr.

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[39] See California at the Crossroads: Choices for Health Care Reform.
[40] Ibid.
[41] ITUP, SB 480 Options Paper at www.itup.org/reports
[42] See SB 921 (Kuehl) and Lewin, Cost and Coverage Analysis of 9 Proposals to Expand Coverage in the State of California.
[43] We should all bear in mind that a bill that becomes law reflects a series of compromises necessary to gain passage and that laws change over time to correct both apparent and latent flaws that subsequently surface during a program's implementation.