



Health Policy Brief

August 12, 2009

“Shared Responsibility”: Should employers be required either to pay a substantial share of their employees’ health insurance or to subsidize coverage of the uninsured?

What’s the issue?

Employers provide health insurance coverage to almost three in five Americans under age 65, or more than 160 million workers and their families. As such, employment-based coverage is considered the bedrock of America’s health insurance system. But not everyone with a job has health insurance: Roughly 30 percent of all workers, and 25 percent of full-time workers, do not have health coverage. Working people and their dependents make up about three-fourths of the approximately 50 million people in the United States who will be without health insurance in 2009.

To shore up the system of employment-based health coverage, and to extend coverage for those not now insured, many health policy experts have long argued for requiring employers to contribute to coverage for their workers. Such measures are known as “employer mandates” or, more recently, “shared responsibility” requirements on employers to help provide coverage. President Barack Obama and many members of Congress are backing legislation that would require most large employers either to pay a large share of the cost of their employees’ coverage or to pay a fee to help subsidize coverage for the uninsured. An em-

ployer mandate has been endorsed by the world’s largest retailer, Wal-Mart; the nation’s largest union federation, the AFL-CIO; and other groups.

Opposition to an employer mandate comes from at least three different directions. Some opponents of an employer mandate believe that employment-based insurance is an anachronism and should be replaced with a health insurance system that is more individual-oriented, portable, and in tune with the flexible and dynamic modern economy.

Others, such as the U.S. Chamber of Commerce, the National Federation of Independent Business, and a number of other business groups, oppose employer mandates for philosophical and practical reasons. They argue in particular that the burden of mandates falls on employers and would raise costs for many companies already harmed by the current economic downturn.

Others who don’t want a mandate would prefer extending employment-based coverage with carrots as opposed to sticks. They favor such provisions as new tax incentives for smaller businesses to offer coverage.

Provisions of the various congressional proposals under consideration, and the arguments pro and con, are detailed below.

What's the background?

Employers began offering health coverage and other fringe benefits as a way to attract workers during World War II, when the federal government froze wages and prices to control wartime inflation. Employers couldn't compete for workers by raising wages and salaries, so they added health insurance benefits instead. A major spur to employment-based coverage came in 1954, when U.S. tax authorities determined that health insurance and other fringe benefits weren't taxable as income. As a result, workers don't have to pay federal income or payroll taxes on the contributions to health insurance that they receive from employers. This "tax exclusion" for employment-based health insurance and proposals for limiting it were explored in an earlier Health Policy Brief (see "[Tax Debate](#)," Health Policy Brief, July 9, 2009).

Today, employers offer health benefits both to recruit and retain workers and to improve workers' health status and productivity. As Paul Fronstin of the Employee Benefit Research Institute notes, employers also play a "watchdog" role, often advocating for workers during coverage disputes with insurers. Many employers also take an active role in improving the quality of health care and in helping employees select top-quality providers.

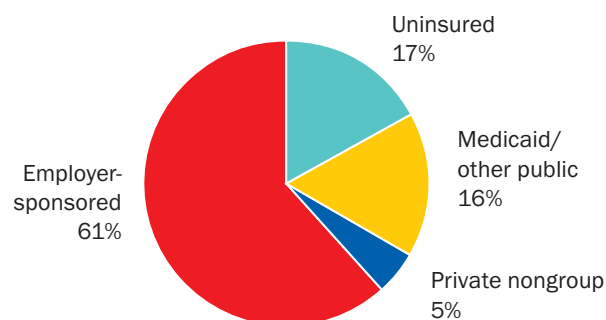
Employers can provide health coverage several ways. Smaller firms typically purchase actual insurance policies for their employees. Most large corporations "self-insure," which means that they pay employees' medical bills directly (although they typically contract with insurance companies for administrative services and "stop-loss" insurance coverage). Insurance policies purchased by employers on behalf of their employees are regulated by the state in which the insurance was issued. Firms that self-insure are regulated under a federal law called the Employee Retirement Income Security Act (ERISA) of 1974. ERISA requires that policies meet certain fiduciary, reporting, and disclosure standards and include consumer protections like an appeals procedure if a claim is denied. ERISA provides exemption from state insurance regulations.

Additional provisions of federal law also apply to employer-based health benefits. A 1985 law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) and a 1996 law, the Health Insurance Portability and Accountability Act (HIPAA), added such requirements as allowing workers to continue their coverage if they leave or change jobs; limiting exclusions for pre-existing conditions; and setting privacy protections for electronic medical information.

Coverage by firm size: By and large, most large firms in the United States contribute to

EXHIBIT 1

Health Insurance Coverage of the U.S. Nonelderly Population, 2007



Total = 261.4 million people

Source: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of data from the 2008 Annual Social and Economic Supplement, Current Population Survey.

Note: Medicaid/other public includes Medicaid, CHIP, other state programs, Medicare (for the nonelderly), and military-related coverage. Data might not add to 100% because of rounding.

Employer-based health insurance varies by company size (2008)

3–9 employees:	49%
10–24 employees:	78%
25–49 employees:	90%
50 or more employees:	95%

Source: Kaiser Family Foundation and Health Research and Educational Trust, 2008

coverage for their workers. In 2008, 95 percent of firms with 50 or more employees offered benefits, according to a survey by the Kaiser Family Foundation and the Health Research and Educational Trust (HRET). These employers contributed an average of 73 percent of the \$12,680 cost of a family policy and 84 percent of the \$4,704 cost of individual coverage. (*Health Affairs* will be publishing the equivalent 2009 data in September 2009.)

Employment-based coverage is less common among smaller firms and, in fact, has been shrinking — although there is debate over how quickly. The 2008 Kaiser-HRET survey found that since 1999, the number of firms with 3–199 workers offering coverage to workers fell by three percentage points — from 65 percent to 62 percent. For employers with fewer than 10 workers, those offering coverage fell by seven percentage points — from 56 percent to 49 percent. Yet during the same time period, employer-sponsored coverage remained relatively stable for employers with 200 or more employees. Economist Elise Gould has described the overall loss this way: After accounting for population growth, as many as fourteen million more people under age 65 would have had employment-sponsored health insurance in 2007 if the coverage rate had remained at the 2000 level.

A major reason for the decline is cost. From 1999 to 2008, the Kaiser-HRET survey indicates, the average cost for family coverage more than doubled, from \$1,543 to \$3,354 for the worker's share, and from \$4,247 to \$9,325 for the employer's contribution. That growth rate is three and a half times faster than the rise in workers' earnings and more than four times faster than inflation. Even in instances where employers have continued to offer coverage, 18 percent of eligible workers have declined to take it, either for themselves, their dependents, or both.

History of mandate proposals: With employment-based coverage having been so dominant in the United States for so long, there have been periodic proposals to extend coverage even further through mandates on employers to contribute to health insurance. The State of Hawaii enacted an employer mandate in 1974. That same year, President Richard Nixon proposed a mandate at the national level, as did President Bill Clinton in 1993. In neither case, though, was a mandate proposal passed by Congress. In 2007 and 2008, employer mandates were features of

health reform plans put forward by several U.S. presidential candidates, including Sens. Hillary Clinton and Barack Obama.

Central to the debate over employer mandates over the years has been discussion of who — the employer or the employee — actually bears the cost of mandates. Even though employers contribute the money toward health coverage for their workers, economic theory and some real-world evidence suggest that active employees actually bear the cost. This is because firms make decisions to hire and pay workers based on the total compensation package — wages and salaries plus the value of all benefits, including sick and vacation leave as well as health and disability insurance. If they offer more in benefits, either voluntarily or because it's mandated that they do so, they will offer less in wages and salaries.

According to this line of analysis, if employers are mandated to offer health benefits, they will adjust wages and salaries downward to compensate. This adjustment, in the long run, will limit the cost of a mandate to employers. An exception may be companies that pay at or near the minimum wage and offer no fringe benefits. They may have little if any room to adjust wages downward and, in worst-case scenarios, may be forced to cut jobs.

As is often the case in economics, there is some disagreement over whether workers bear the full cost of health benefits and whether or not employers are immune. For an analysis showing that some economists have found that employers may also bear some costs, see the article by Neeraj Sood and colleagues listed in the Resources section below.

What's proposed?

Two major health reform bills in the House and Senate backed by Democrats; a House Republican bill; and a separate bipartisan bill under development in the Senate Finance Committee all take different approaches to extending or mandating employer-sponsored health insurance. The two major House and Senate bills also have requirements on individuals to have health coverage, known as "individual mandates." The individual and employer mandates, plus new federal tax subsidies and the creation of purchasing groups called insurance exchanges, would all operate

Full-time workers
without health insurance
in 2007:

21 million

Part-time workers
without health insurance
in 2007:

5.8 million

Source: U.S. Census Bureau,
Current Population Survey.

together to expand health insurance coverage to millions of uninsured Americans.

House of Representatives: The majority-backed bill passed by three House committees, HR 3200 (America's Affordable Health Choices Act) adopts what is termed a "play-or-pay" approach. Employers choosing to "play" would pay at least 72.5 percent of the value of the lowest-cost health insurance plan offered to individual full-time employees and 65 percent of the lowest-cost plan available to cover a full-time employee's dependents. (The definition of who is a full-time employee is to be left to federal regulators to decide.) Under a version of the bill adopted by the House Ways and Means Committee, employers choosing to "pay" — not to offer coverage — would have to pay a percentage of their payroll, starting at 2 percent for firms with annual payrolls between \$250,000 and \$300,000 and rising to 8 percent for firms with annual payrolls above \$750,000. These sums would be paid into a new Health Insurance Exchange Trust Fund that would in turn make "affordability credits" available to help uninsured people buy health coverage. In addition, firms with fewer than 25 employees and average annual wages of less than \$40,000 would receive partial tax credits to help pay some of the costs of employee coverage.

Under a somewhat different version of the bill adopted by the House Energy and Commerce Committee, all firms with annual payrolls less than \$500,000 would be exempt from the mandate. Firms with annual payrolls between \$500,000 and \$585,000 would pay 2 percent of payroll if they chose not to offer coverage; above that level, the required share of payroll rises to 8 percent for firms with annual payrolls above \$750,000.

A bill introduced by the House Republican Study Committee on July 30, 2009, called the Empowering Patients First Act (HR 3400), does not include an employer mandate. However, under the plan, a business with fewer than 50 employees would be eligible for a one-time \$1,500 tax credit to offset the cost of auto-enrolling workers in the company's health plan. The bill would also require all employers to disclose on an employee's annual W-2 form the annual amount the employer spends on the employee's health insurance premium, so

that employees will become more aware of the value of their employer-provided benefits.

Senate HELP Committee: In the Senate, the bill that passed the Committee on Health, Education, Labor, and Pensions (HELP) with only Democratic votes takes an approach similar to the House bill, albeit with a far less stiff "pay" requirement on employers that don't offer coverage. Under the HELP committee's bill, employers would have to contribute 60 percent or more of employees' monthly health insurance costs. If they did not, they would have to pay a \$750 annual fee for each uninsured full-time employee and \$350 for each uninsured part-time employee. As with the House bill, small businesses would get a break: Employers with 25 or fewer workers would be exempt from the mandate. Beginning in 2010, employers with 50 or fewer workers, whose average annual wage was under \$50,000 and who paid at least 60 percent of their employees' health insurance costs, would be eligible for tax credits to help offset some of the costs of workers' health coverage.

Senate Finance Committee: As of the publication date of this brief, the Senate Finance Committee had not yet produced its bill. But the committee has been considering several different approaches. The one deemed most likely to be included in the bill would not be an employer mandate. Instead, it would be a measure designed to maintain existing employment-based coverage and to require employers that don't offer health insurance to help subsidize the costs of covering their workers and dependents through other means.

Dubbed a "free-rider" provision, the proposal had not been fully fleshed out when this brief went to press. But in general terms, it would work as follows. For companies that decline to offer coverage and have 50 or more employees, there would be a requirement that they reimburse the government for some expenses associated with employees' obtaining coverage elsewhere. Specifically, if those employees have family incomes below 300 percent of the federal poverty level and purchase coverage through a new insurance exchange with the aid of new federal subsidies, employers would have to reimburse the government for the average cost of those subsidies. These employers

would not have to reimburse the government for any costs associated with employees who receive Medicaid, the federal and state health insurance program for the poor and low-income.

Finally, in the Senate, a bill introduced by Republican Senators Tom Coburn of Oklahoma and Richard Burr of North Carolina (S 1099 and HR 2520) also has no employer mandate. Employers could still offer coverage to workers, but the federal tax exclusion for employment-based health insurance would be cancelled and replaced with tax credits for individuals and families. People would then use those tax credits to help pay for private insurance purchased through state-based health insurance exchanges.

What's the argument?

In favor of an employer mandate: Supporters argue that expanding employer-based health insurance through mandates would have several advantages. The approach would build on existing private employment-based group health insurance, which provides coverage to the majority of insured Americans. This type of coverage is typically a good deal for most workers because of lower administrative costs than is typically the case with individual insurance coverage.

Employment-based coverage is also an effective way to “pool risk” since these policies are not “medically underwritten” — that is, priced to take into account individual workers’ level of sickness or health. Instead, they are priced similarly for everybody in the group, so that the higher costs of covering sicker workers are spread across healthier ones. This is precisely the reason that it’s sometimes argued that individually underwritten insurance would be more attractive to healthy workers, since in an employer group or other “pooled risk” arrangement, they in effect subsidize their sicker, higher-risk coworkers. The fear that the risk pooling provided by employment-based insurance could unravel is one of the reasons proponents advocate sticking with employment-based insurance and shoring it up. The only other way to provide a similar level of risk pooling would be to require everybody to purchase individual insurance well before they became sick. This could be done going forward, but unfortunately such a system alone would not provide for the tens of millions of people who are currently sick.

In addition to the employer mandate, supporters of expanding employment-based coverage point to other legislative provisions of the main House and Senate bills that would level the playing field for smaller versus larger firms. Currently, smaller firms buying coverage for their workers may have to pay high fees to insurance agents, or high administrative fees to insurers, to obtain coverage for their workers. This means that small businesses may now pay as much as 18 percent more than large companies pay for the same health insurance policy. These costs can erode profits and can be passed on to workers in the form of lower wages or less generous health benefits. But once the exchanges were up and running, employees whose firms did not offer coverage could obtain insurance through them. In effect, those workers would then be eligible for “pooled,” lower-cost health insurance and standardized benefit packages and would receive better coverage than they typically now receive.

Although there are concerns that an employer mandate would reduce employment overall, the Congressional Budget Office as well as most economists generally agree that the effect on overall employment would not be large. Small, lower-wage firms could be among the most affected, because they might have trouble adjusting wages downward to compensate for having to pay more in benefits. These firms might respond by firing or declining to hire workers. Several studies on the effects of play-or-pay requirements have thus projected the loss of anywhere from 224,000 to 750,000 jobs — in the end, a very small proportion of jobs in an economy that currently employs about 140 million people.

An upside of an employer mandate, proponents say, is that it would reduce what’s known as “job lock.” This occurs when workers feel compelled to stay in jobs they’d rather leave because their current employers offer health benefits, while a new employer might not. In 2008, one in four adults responding to a survey by the Employee Benefit Research Institute reported that they had either passed up another job opportunity, stayed at a job they would have quit, or declined to retire early in order to retain employer-provided health insurance. Coupled with the \$53 billion in affordability tax credits that small businesses would be eligible for under the House bill, the end of job lock should lead to growth in the number of jobs, as well as

higher wages and larger profits, according to the Council of Economic Advisers.

“Free-rider” provision: Supporters of a broad employer mandate object to the proposal that is expected to be part of the Senate Finance Committee bill. It would not mandate coverage but would require firms to reimburse the government for the cost of the average subsidy an employee receives if he or she purchases insurance through an exchange. A recent study from the Center on Budget and Policy Priorities points out that charging fees for only some employees could distort hiring decisions, creating an incentive for employers to avoid hiring workers likely to qualify for these subsidies. Provisions in health reform legislation to prohibit discriminatory hiring practices would be difficult to enforce, the study concludes.

Against an employer mandate: Opponents of an employer mandate, such as the U.S. Chamber of Commerce and the National Federation of Independent Business (NFIB), underscore the concern that it could lead to job losses — especially now, in a recession. They also point to the rising cost of health insurance, noting that from 2001 to 2008, premiums increased as much as 75 percent for individual employees and 80 percent for families. They say that many businesses newly forced to contribute to health coverage for workers simply could not shoulder these rapidly rising costs. And they doubt that the other health reforms Congress and President Obama propose, such as creation of health insurance exchanges and pooling, will actually make health insurance more affordable for small businesses.

A recent report by the NFIB, the nation’s largest small-business organization, suggested that the toll would be higher than has been borne out by other economic research. The report said that an average of roughly 320,000 jobs would be lost for each of the first five years after an employer mandate was implemented, with a corresponding \$200 billion reduction in gross domestic product over the entire period. Contrary to HR 3200, however, the NFIB report assumed that all employers would have to pay one-half the cost of private health insurance for their workers, not just those with payrolls over \$500,000. It also made no allowance for tax credits for the smallest businesses to offer health insurance. In addition, the NFIB analysis is nontransparent on some crucial assumptions and is also based on several uncon-

ventional assumptions — such as that costs of offering health insurance rise dramatically with firm size, when the opposite is true. The effect is to greatly increase the estimated cost of an employer mandate in the NFIB report relative to other studies.

Critics also object to technical specifications of the employer mandates under consideration. Consider an employer mandate that offers an alternative of “playing” or paying fees based on a specific share of the company’s payroll — or a mandate based on a particular firm’s workforce size. As the current bills stand, these formulas wouldn’t take into account geographic differences in medical and health insurance costs, or variations in payroll or size by type of industry. The NFIB complains, for example, that a small business would have to pay taxes based on a share of payroll regardless of whether or not the firm was profitable. The association also says the mandate proposed in the House Democratic bill would in effect “punish” employers that provide health coverage for workers but don’t meet the minimum premium contribution rates in the bill (72.5 percent of premiums for individuals and 65 percent for family plans). Finally, there is also concern about congressional efforts to create “standardized” benefit packages; these could become so generous, mandate opponents say, that even a mandated partial contribution toward the costs would be unaffordable for many firms. (An excessively expensive minimum benefit package worries not just people concerned about an employer mandate, but also people concerned about an individual mandate that would require individuals to buy coverage.)

What’s next?

As this brief goes to press, Congress is on its annual August recess, and the Senate Finance Committee has not yet completed work on its bill. The specifics of whatever it proposes — an employer mandate or other approach — will have to be reconciled with the bill passed by the Senate HELP committee before any bill goes to the Senate floor for debate and voting. Differing provisions of the bill that passed three House committees will also have to be reconciled in a final House bill. It is unclear at this point when the House would vote on the final House Democratic proposal once it returns from the August recess.

Assuming health reform legislation does pass the House and Senate, eventually differences between the pieces of legislation will have to be reconciled in a congressional conference committee. Both chambers must then vote on a so-called

conference report before the final bill can be sent to the president for his signature. It is not clear whether what would emerge from that process would be similar to or different from the proposals discussed in this brief.

Resources

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