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Why Not Just Eliminate the Employer Mandate?

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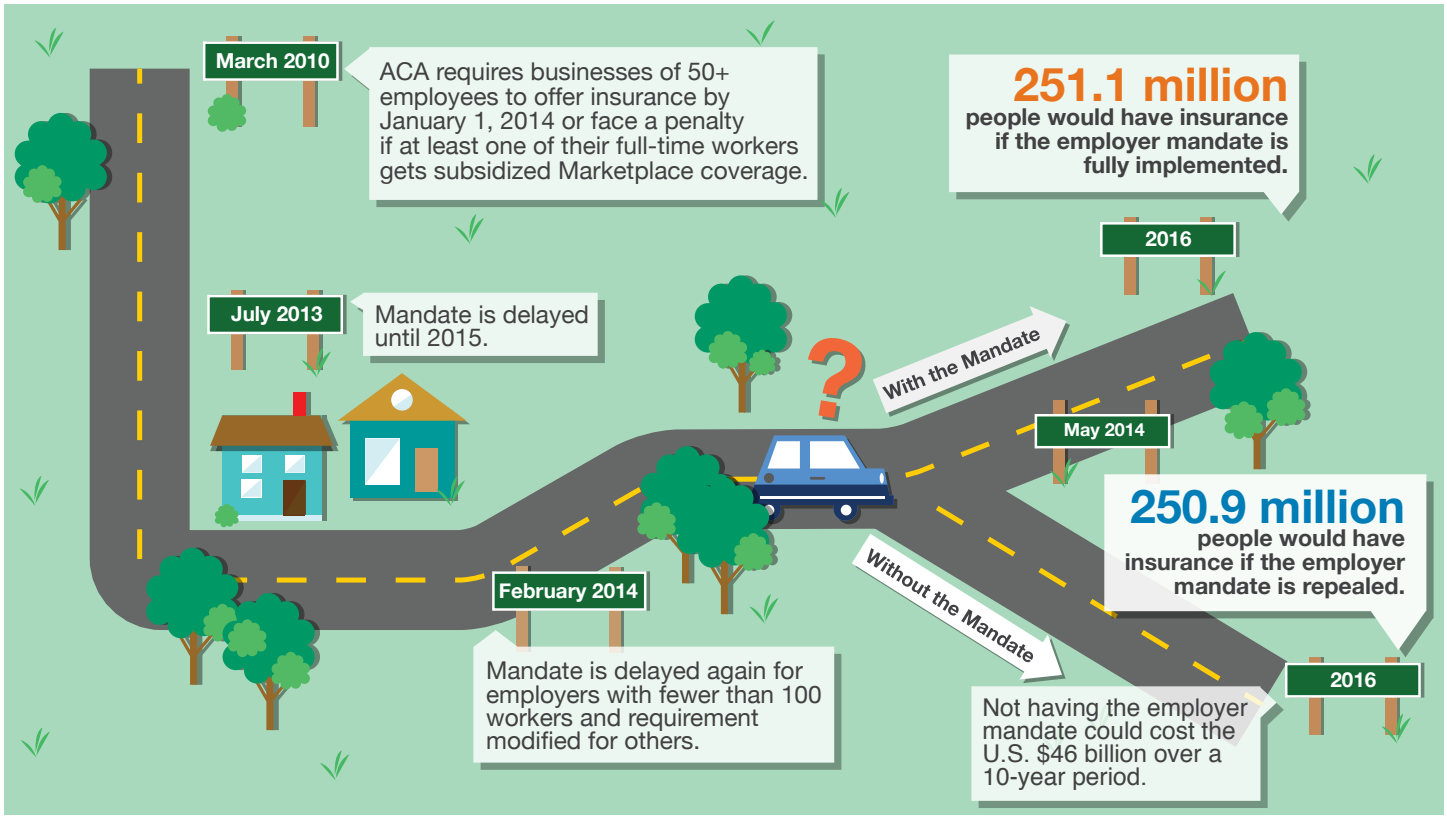
In-Brief

Controversy over the Affordable Care Act's employer mandate continues. The requirement's implications for coverage are small, and yet the negative labor market effects of keeping it in place could harm some low-wage workers.

Under the law, employers of 50 or more workers are subject to a penalty if at least one of their full-time workers obtains a Marketplace subsidy. Employees offered coverage deemed affordable and adequate are prohibited from obtaining subsidies, as are their family members, and employers can avoid penalties by offering coverage to at least 95 percent of workers. However, the Administration has delayed the requirements until 2016 for employers of 50-99, for larger employers until 2015, and softened requirements for that first year. Yet there are anecdotal reports of employers changing labor practices even though penalties have yet to be implemented.

Our analyses as well as that of others find that eliminating the employer mandate will not reduce insurance coverage significantly, contrary to its supporters' expectations. Eliminating it will remove labor market distortions that have troubled employer groups and which would harm some workers. However, new revenue sources will be required to replace that anticipated to be raised by the employer mandate.

Employer Mandate: Is It Needed?



The Employer Mandate and Business Opposition to the ACA

The ACA's employer penalties will increase costs for some employers because they must newly provide coverage or pay penalties. This has contributed to vocal opposition to the ACA from business groups. These responses may also influence decisions by employers related to the number of workers they employ and the hours each works. The most frequent claim is that employers will move to more of a part-time workforce. For example, several large firms recently announced that they would be reducing hours for part-time workers to less than 30 (Land's End, Regal Entertainment, Wendy's, and SeaWorld).[1] In a different response, Trader Joe's and Target stopped providing coverage to part-time workers (those typically working fewer than 30 hours per week), believing most would be better off with subsidized coverage in Marketplaces. These claims have taken a toll on the perception of the law, but the actual size of changes in the workforce and whether they are sustainable in strong labor markets is unclear.

Those working 30 to 39 hours per week who do not already have access to employer based insurance and who fall within the income range making them eligible for Marketplace-based subsidies compose 1.8 percent the workforce (2.3 million people).[2] Some firms could also shift a segment of their full-time workforce to part-time status—under 30 hours per week. However, there are problems with a reliance upon a part-time workforce. Moving to more of a part-time workforce means employing larger numbers of workers to do the same jobs, which will lead to increased costs from administrative expenses and nonhealth benefits and lost efficiency from employing more workers to do a job than is necessary. There are also turnover costs and hiring difficulties when workers do not obtain their desired number of hours. Although a small share of the workforce may be affected by these types of changes in hours, the lost income for those who do experience such changes will likely be problematic.

Another claim is that small firms will avoid increasing the number of workers they hire beyond 49. The decision to hire more than 49 workers will be based on many factors, of which health insurance costs are only one. Firms look at the longer-term gains of expanding their workforce and thus their productive capacity; they do not simply look at the marginal cost of adding the 50th employee. All of these concerns provide disincentives to change employer approaches to workforce decisions, somewhat counterbalancing the incentives in the ACA's provisions.

However, even if the ACA's labor market effects are modest, there will undoubtedly be some distortions created. Creating arbitrary thresholds (e.g., potential penalties for firms of 50 or more workers not providing coverage for employees typically working 30 or more hours per week) for financial requirements will change the employment decisions in some firms, and at least some workers will be adversely affected by them.

And, as is the case when employers begin to make contributions to worker health insurance coverage, penalties imposed on employers for not providing coverage to their workers may initially affect employers' bottom lines. But over time, these costs are likely to be passed back to their workers in the form of reduced wages. This transition can take an indeterminate amount of time, though in the interim these costs can affect employers' profits.[3] In the long run, the costs tend to be absorbed by the workers.

Employers with 50 or more workers not offering coverage pre-ACA are the same employers that are highly likely to not offer in the future, therefore incurring the ACA's penalties. Because the nonoffering firms are much more likely to be firms dominated by low-wage workers (Table 1 shows the substantial differences in offer rates by employer size and worker wages), low-wage employees will bear the greatest brunt of the penalties imposed.

Table 1. 2012 Distribution of Employers of 50 or More Workers, by Size, Share of Low Wage Workers, and Offer Status

	Employer Size			
	Total 50+ Workers	50-99 Workers	100-999 Workers	1,000+ Workers
Number of Employers				
Total	1,668,613	218,619	450,402	999,592
Low-wage	656,874	72,760	166,748	417,366
Higher-wage	1,011,739	145,859	283,654	582,226
Number Not Offering ESI				
Total	68,843	37,207	26,551	5,086
Low-wage	48,609	26,094	19,176	3,339
Higher-wage	20,235	11,113	7,375	1,747
Share Not Offering ESI				
Total	4.1%	17.0%	5.9%	0.5%
Low wage	7.4%	35.9%	11.5%	0.8%
Higher-wage	2.0%	7.6%	2.6%	0.3%

Source: Authors' calculations based on Medical Expenditure Panel Survey–Insurance Component data, 2012.

Notes: A low-wage worker is defined as a worker earning at or below the 25th percentile for all hourly wages in the US, based on data from the Bureau of Labor Statistics. In 2012, workers earning at or below $11.50 per hour were deemed low-wage workers. A low-wage firm is defined as having 50 percent or more of its workers low-wage. Counts are numbers of establishments by firm size.

Therefore, using employer penalties as a tool for financing reform tends to be a regressive approach.

Eliminating the employer responsibility requirements should substantially diminish employer opposition to the ACA. In fact, without that burden, employers may play more of a role promoting the expansion of coverage under the law.

Why Employers Will Generally Continue Providing Coverage without a Mandate

Most employers would not drop coverage if the penalties were eliminated. About two thirds of American workers now have offers of employer coverage when there is no mandate to do so.[4] Why do employers provide health insurance coverage voluntarily? One major reason lies in the tax benefits. Workers benefit from receiving employer health insurance contributions—nontaxable compensation—in lieu of salary. The alternative would be giving individuals a higher salary, which would be taxable income, and those workers would then have to purchase coverage in the individual market. These tax benefits to individuals increase as incomes increase, thus incentives to offer coverage are greater for employers with a higher-paid workforce than a less well paid one. Individuals also benefit from employers providing coverage because of efficiencies in administration. Human resource offices develop expertise in assisting with the choice of insurance. Businesses also provide natural risk-pooling (i.e., individuals come together because of their skill and work interests, not to obtain health insurance); this reduces risk to insurers and lowers premiums. It is also argued that firms provide coverage to enhance employee loyalty.

The ACA has components that, alone, would lead to both increases and decreases in the number of employers offering health insurance. The penalties on employers will increase the likelihood that some employers will offer coverage, although most firms that do not offer coverage today (e.g., those with fewer than 50 workers) are not subject to penalties. The presence of the Small Business Health Options Program (SHOP) may make insurance easier for employers to purchase, reduce premiums, and provide broader choice of insurance plans for employees, although this program has gotten off to a slow start in most states. There are also small business tax credits which, though limited to the smallest, lowest-wage employers, may induce more employer-based coverage. Finally, the individual mandate is likely to cause employees, particularly those not eligible for income-related subsidies, to seek to have their employers provide health insurance coverage.

On the other hand, firms with large numbers of low-wage workers may become less likely to offer. For such firms, workers may benefit more from premium tax credits than they do from the tax benefits from employer-based coverage. The employer penalty can make the difference in the employer's coverage decision if the value of the premium tax credits to the firm's workers exceeds the value of the employer-based tax benefits by less than the size of the penalty. Firms with extremely low-wage workers (those with family incomes below 138 percent of the federal poverty level) will benefit from having their workers enroll in Medicaid (employers do not incur any penalties from their workers enrolling in Medicaid).[5] These low-wage firms were far less likely to offer coverage before the ACA and some will drop coverage whether there is an employer penalty or not, simply because subsidies for those without an affordable offer of insurance and expanded Medicaid eligibility make dropping coverage more likely.

On balance, the individual mandate and tax benefits will keep most employers offering coverage regardless of the penalty. And those that drop because of the ACA will have done so because of other provisions in the law (e.g., the Medicaid expansion and income-related subsidies). Few employers will decide to no longer offer coverage simply because penalties are eliminated.

Coverage Impacts of Eliminating the Mandate

Our analysis using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), taking all of the law's coverage-related provisions into account, indicates that there will be little change in the number of employers offering coverage and the number of workers obtaining employer-based coverage under the ACA if the employer mandate were eliminated (compared to it being fully implemented). Table 2 shows the key results—overall, coverage is changed very little. The number with employer coverage falls by 500,000, a relative decrease of just 0.3 percent. Other forms of coverage (i.e. nongroup and Medicaid) change more modestly, increasing by 300,000 and 100,000 people respectively. The number of uninsured increases by about 200,000 people, a relative increase of about 0.6 percent.

In comparison, the Congressional Budget Office's (CBO) estimates of the effect of a one-year delay in the employer requirement were that employer coverage would fall by 1.0 million people;[6] this is higher than our estimate but still 0.6 percent of the expected level with the employer mandate. The CBO model is based on a different data set than HIPSM and implicitly assumes more employers will drop insurance coverage under the ACA than is computed by HIPSM. Nevertheless, both of these different models show very small coverage effects from eliminating the employer responsibility requirement. By CBO's estimate, about half of the extra 1 million not obtaining employer coverage would gain Medicaid or nongroup coverage and the number of uninsured would increase by 0.5 million. CBO suggests that the effects would be larger if the mandate was permanently delayed, but they did not provide such an estimate.[7]

These projections of small coverage effects of the employer penalty are consistent with the evidence of reform in Massachusetts. In 2006, Massachusetts passed comprehensive health insurance reform legislation, expanding Medicaid eligibility, providing subsidized private nongroup insurance coverage for the low-income population without affordable access to employer based coverage, and instituting an individual mandate to obtain coverage. The Massachusetts

Table 2. The Impact of Eliminating the Employer Mandate on Insurance Coverage (in Millions)

	ACA With Employer Mandate		ACA Without Employer Mandate	
	N	%	N	%
Insured	***251.1***	***90.6%***	***250.9***	***90.6%***
Employer	160.9	58.1%	160.4	57.9%
Non-Group (Non-Marketplace)	3.5	1.3%	3.5	1.3%
Non-Group (Marketplace)	20.6	7.4%	20.9	7.5%
Medicaid/CHIP	58.3	21.0%	58.4	21.1%
Other (Including Medicare)	7.7	2.8%	7.7	2.8%
Uninsured	***26.0***	***9.4%***	***26.2***	***9.4%***
Total	***277.1***	***100.0%***	***277.1***	***100.0%***

Source: Urban Institute analysis, Health Insurance Policy Simulation Model 2014.
Note: The ACA is simulated as if fully implemented in 2016.

reforms served as a model for many of the coverage components in the ACA. However, the Massachusetts law provided more generous financial subsidies for the purchase of private insurance to those residents below 300 percent of the federal poverty level than does the ACA,[8] and the state's employer penalties were considerably smaller than those in the ACA.[9] In fact, at a maximum of $295 per worker per year, the employer penalties in Massachusetts were sufficiently small to be considered irrelevant by many. While the subsidized nongroup coverage was more attractive for the low-income population and the penalties for employers not offering coverage were smaller than the ACA, there is no evidence that the state's reforms decreased the rate of employer offers or the rate of employer-based coverage. According to the Medical Expenditure Panel Survey-Insurance Component, the share of employers offering insurance coverage to their workers increased from 63.3 percent in 2005 to 64.6 percent in 2011, a period during which the offer rate in the US overall fell from 56.3 percent to 51.0 percent.[10] In addition, the share of the state's adults with employer-sponsored insurance rose to 63.6 percent in 2012 from 61.0 percent in 2006.[11]

Revenues

Ending the employer responsibility requirement would eliminate the federal revenues from penalty payments that employers would pay under current law. Our simulation estimates show that this would amount to just under $4 billion in 2016. Slight increases in Medicaid and Marketplace subsidies when the employer requirement is eliminated mean that net government cost would be about $4.3 billion higher per year absent the requirement, or about $46 billion between 2014 and 2023. The CBO estimates were $130 billion between 2014 and 2023.[12] Even though HIPSM estimates show that the federal revenue effects of the employer requirement are significantly smaller than those estimated by CBO given the different models, data, and behavioral assumptions, eliminating the requirement necessitates replacing revenues in the amount estimated by CBO, the official legislative scorekeeper. CBO's recent report[13] lists many options for raising revenue, including increasing income and payroll tax rates and broadening tax bases. CBO also suggests a number of health care–related options, including increasing the payroll tax for Medicare hospital insurance, raising taxes on alcoholic beverages and cigarettes, and reducing the tax preference for employer-based insurance. However, changing the tax preference, which can yield large sums of revenue, is a complicated option because it can have significant interactive effects with employer decisions to offer insurance (i.e., as the tax preference is reduced, the likelihood that employers will offer coverage to their workers decreases).

Reaching political agreement on new sources of revenue is never an easy task; however, the policy tradeoffs are straightforward. Concerns over labor market distortions and employer financial burdens related to the ACA's employer penalties can be eliminated with little relative impact on overall insurance coverage or the distribution of that coverage; the cost is agreeing upon an alternative source of $130 billion in federal revenue over 10 years.

CONCLUSION

In summary, eliminating the employer mandate would eliminate labor market distortions in the law, lessen opposition to the law from employers, and have little effect on coverage. Alternative sources of revenue would have to be found to compensate for the federal loss of penalties. Both the elimination of the mandate and creating a new source of revenue to replace it will require legislation. Current legislation before Congress proposes to move the employer requirement from employers of 50 or more workers to employers of 100 or more. While this approach would help those firms between 50 and 99 employees and decrease the exposure to adverse incentives within that group, it shifts the threshold where labor market effects could take place to a different point and does not address the concerns of large, low-wage firms. The individual mandate, together with the Medicaid expansion and income related subsidies, is, as we have shown elsewhere,[14] critical to expanding coverage under the ACA; the employer mandate is not.

Notes

1 Rocco M. "With Eye to ObamaCare, Companies Move to Cut Workers' Hours." *Fox Business*, Wednesday, September 11, 2013. http://www.foxbusiness.com/industries/2013/09/11/with-eye-on-obamacare-companies-move-to-cut-workers-hours/.

2 UC Berkeley Labor Center. "Which Workers Are More At Risk of Reduced Work Hours under the Affordable Care Act?" Berkeley: University of California Berkeley Labor Center, 2013. http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf.

3 Garrett B and Chernew M. "Health Insurance and Labor Markets: Concepts, Open Questions, and Data Needs." *Inquiry*, 45(1): 30–57, 2008.

4 Medical Expenditure Panel Survey, Insurance Component, 2012. Eighty-five percent of workers are in firms that offer coverage (http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tib2.pdf) and 78 percent of workers in offering firms are eligible for coverage (http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2012/tib2a.pdf).

5 26 U.S.C. § 4980H(a)(2) and 26 U.S.C. § 4980H(b)(1)(B) (2010).

6 Congressional Budget Office. "Analysis of the Administration's Announced Delay of Certain Requirements Under the Affordable Care Act." July 30, 2013. http://www.cbo.gov/sites/default/files/cbofiles/attachments/44465-ACA.pdf

7 Rand estimates an even smaller effect on coverage of eliminating the employer mandate, noting that 300,000 fewer people would have access to employer insurance and nearly all of them would get coverage from another source. See Price CC and Saltzman E. "Delaying the Employer Mandate: Small Change in the Short Term, Big Cost in the Long Run." Santa Monica, CA: Rand Corporation, 2013. http://www.rand.org/content/dam/rand/pubs/research_reports/RR400/RR411/RAND_RR411.pdf.

8 Commonwealth of Massachusetts, Executive Office of Health and Human Services and the Commonwealth Health Connector. "Update on ACA Subsidized Coverage Configuration." Boston: Commonwealth of Massachusetts, Executive Office of Health and Human Services, 2013.

9 Blavin F, Blumberg LJ, Buettgens M, and Roth J. "Massachusetts under the Affordable Care Act: Employer-Related Issues and Policy Options." Boston: Blue Cross Blue Shield of Massachusetts Foundation, 2012. http://www.urban.org/UploadedPDF/1001626-Massachusetts-Under-the-Affordable-Care-Act-Employer-Related-Issues-and-Policy-Options.pdf.

10 Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2005 and 2011 Medical Expenditure Panel Survey-Insurance Component (http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2005/tiia2.pdf and http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_2/2011/tiia2.pdf).

11 Long SK and Fogel A. "Health Insurance Coverage and Health Care Access, Use, and Affordability in Massachusetts: An Update as of Fall 2012." Boston: Blue Cross Blue Shield of Massachusetts Foundation, 2014. http://bluecrossmafoundation.org/sites/default/files/download/publication/MHRS_2012%20Full%20Report.pdf.

12 Rand estimated that the revenue from the employer penalty would total $149.2 billion over the 2014 to 2023 time period. See Price and Saltzman "Delaying the Employer Mandate."

13 Congressional Budget Office. *Congressional Budget Office Choices for Deficit Reductions: An Update.*

14 Blumberg LJ and Holahan J. "Delaying the Individual Mandate Would Disrupt Overall Implementation of the Affordable Care Act." Washington, DC: Urban Institute, 2013.

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