



Implications of Health Care Reform for Employers

An Analysis of the Patient Protection and Affordable Care Act

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Introduction and summary

The recent enactment of comprehensive health care reform has many implications for American employers and their workers.¹ But how they are affected by the Patient Protection and Affordable Care Act and the companion Health Care and Education Reconciliation Act, or, together, the Affordable Care Act, will depend on factors such as the size of the employer, family incomes, and health conditions of the workers.

More than 160 million (61 percent) of nonelderly Americans have an employment-related health insurance policy in 2008.² In general, employers are expected to continue providing health insurance for a large fraction of the nonelderly following health care reform. Some small employers will qualify for temporary subsidies, and large employers face fines designed to encourage employers to stay in the game. If individuals are not insured, then they face fines that add to the incentives aimed at employers. Other provisions, notably expanded Medicaid eligibility and the availability of low-income premium and cost-sharing subsidies for those not offered employer coverage, may lead some employers with low-skilled workers to drop health insurance provision, but for the large majority of employers, the reforms are likely to maintain their key role.

More specifically, key features of the enacted final health care reform legislation include:

- The creation of state health insurance exchanges with family income-based premium subsidies (not available if offered employer insurance)
- A requirement that large employers who do not provide health insurance (or those providing health insurance whose workers receive subsidies in the exchange coverage) pay a penalty on behalf of their workers; small employers who offer coverage receive a temporary subsidy
- A requirement that individuals hold insurance coverage—either through a public program, through an employer, or purchased through the exchange—or pay a penalty
- Insurance market reforms, including near-community rating, guaranteed issue, and minimum standards for health insurance plans
- Expanded eligibility of public coverage for all Americans with incomes under 133 percent of the poverty level, or somewhat less than \$30,000 a year for adults in a family of four

- Cost-containment strategies that include Medicare payment reforms that aim to improve delivery system efficiency and quality, a new tax on high-cost health insurance plans, and new investments in delivery system infrastructure, such as comparative effectiveness research
- Financing provisions that include (in addition to the high-cost-plan tax) reduced growth of Medicare provider payments, reductions in Medicare's payments to private health plans, taxes on medical manufacturers, new payroll taxes for high-income workers, and new taxes on unearned income

Employers' coverage decisions will be determined by these changes to the health care system, as well as the aspects of today's system that remain unchanged. For instance, employer-provided health insurance continues to receive a large tax subsidy, being exempt from payroll and income taxes unlike cash compensation and unlike the purchase of health insurance on one's own. Large employer policies are also likely to continue having lower administrative costs relative to individual policies sold through exchanges; small employers have the option of buying into the exchange.³

Among other provisions, the new health reform law also includes demonstration programs, innovation initiatives, independent commissions, and other mechanisms to improve health care management, and redesigned financial incentives for health care providers to reduce the growth rate of health care and health insurance costs.⁴ Cost containment is unambiguously beneficial for businesses; the growth of health insurance premiums has outpaced inflation and productivity growth for many years.⁵ To the extent that the legislation is able to lower health care cost growth it will benefit business because workers would have to give up less of their wages for health insurance. How businesses are affected by insurance expansion provisions will vary according to their characteristics.

The smaller the employer, the lower the incomes and worse the pre-existing health status of the workers, then the larger the assistance provided by the new law relative to the current situation. Employers with fewer than 25 full-time equivalent employees and annual average wages below \$50,000 will receive temporary subsidies for providing health insurance, starting in 2010. Employers with 50 or fewer full-time equivalent employees face no fines for not providing health insurance.

All individuals, regardless of whether they have an offer of coverage or not, face fines if they are not insured. For the very few (less than 3.5 percent) employers with more than 50 full time equivalent, or FTE employees who do not currently offer health insurance, the law requires them to provide coverage to all FTEs or pay a fine.⁶ A more binding restriction for large employers, however, is that even if they offer coverage, they are liable for a fine on FTEs who do not take up coverage, or who were excluded from the offer of coverage, and receive subsidized coverage from the exchange.⁷ Among employers with 50 or more workers that offer health insurance, on average only 54.6 percent of FTEs are currently enrolled in coverage at predominantly low-wage establishments.⁸

The fine-based mandate for large employers, and the temporary subsidies for small employers combined with the existing tax subsidy and other existing advantages of bulk-purchasing policies, act as incentives for employers to provide health insurance. These forces act against the income-based health insurance subsidies available for low-income workers which are available (with some exceptions) only if they are not provided health insurance by their employer.

How the different forces balance out will depend on the employer's size and workforce characteristics. Smaller employers with a relatively homogeneous low-wage workforce may rationally decide to drop coverage and offer higher wages instead, benefiting from the subsidies in the exchange. Larger firms with a substantial fraction of low-wage workers who do not currently offer health insurance may find ways to creatively restructure to the extent allowed by the law if the subsidies available to their workers in the exchange exceed the advantages of employer-provided coverage.

Large firms that offer coverage but not to all workers may extend coverage and reduce wages. At the margin, low-skilled employment growth may be spurred in small firms and dampened in large firms because of the relative advantages from the new law to being in a small firm.⁹ Small employers with higher-income workers with high health care costs may find themselves able to provide coverage because of the near-community rating rules in states that did not already have such insurance reforms.

On the flip side, small employers with workers who have low health care costs may see a rise in premiums. Employers in the health care sector itself stand to gain from having greater demand for their services when more Americans are insured. And firms of all sizes and types stand to benefit from reductions in health care cost growth, to the extent they materialize from cost control provisions of the law.

So what will this all mean for employers? In the pages that follow, this paper will unpack each of these provisions contained in the new health care reforms. I do not provide a detailed account of the legislation for the sake of brevity; summaries are available elsewhere.¹⁰ The complexity of the legislation means that this analysis will not capture all aspects of importance to employers. Nor is it meant to be an endorsement or criticism of the law. Rather, I demonstrate in this paper and the detailed appendices that employers are expected to be affected by the reform provisions in different ways depending on their circumstances, but that they are nevertheless expected to continue playing a central role in providing health insurance to workers. It will be important for policymakers to monitor the intended and unintended consequences of reforms, and to understand the full incidence of costs and benefits brought about by the new laws.

New market dynamics and new decisions for employers

New avenues of subsidized access to health insurance for low income families as well as new fines for those larger employers who do not offer coverage will change important dynamics that are characteristic of today's health care insurance system.

One of the key features of the new law is the creation of state-based insurance exchanges, which will create a new, regulated marketplace where private insurers who meet some minimum standards can sell their plans. Individuals and small firms can purchase coverage through these exchanges, and over time they will expand to larger employers as well. Families who meet the income eligibility standard of up to four times the federal poverty level, or \$88,200 for a family of four, may receive sliding-scale premium and cost-sharing subsidies to help them purchase coverage within the exchange (as long as they have not received an offer of employer coverage).¹¹

These subsidy amounts are indexed to the cost of a medium-priced policy in the state exchange. They are only available to those who do not have an offer of employer coverage, or whose employer coverage does not meet minimum standards. Lower-income individuals, particularly those with incomes at or below 133 percent of the poverty level, or slightly less than \$11,000 a year for an individual, would also be eligible for Medicaid coverage.

At the same time, the tax subsidy for employer-based coverage remains in place, and employers will continue to be able to purchase coverage outside of the new insurance exchanges. Employer (including self-employed) provision of health insurance receives a substantial tax benefit not available to individual health insurance. The amounts that employers provide in health insurance compensation (as well as the employee contributions towards coverage) are not subject to income and payroll taxes, as is cash compensation. This continued tax preference is one reason why employers' large role in providing health insurance may not change dramatically even when exchanges with subsidies become operational.¹²

The exchanges are scheduled to be in place in by 2014, and all individuals without access to large-employer coverage as well as small businesses can start purchasing from the exchanges as soon as they are operational. In many cases, this new health insurance market will feature a greater degree of coverage, and more transparent policies than what are currently typical

in the individual and (to a lesser extent) the small-group markets. And for those who qualify for income-based subsidies, the post-subsidy price will be much cheaper than otherwise, according to the Congressional Budget Office's November 2009 analysis.

Small-firm workers are likely to benefit disproportionately from the subsidies in the exchange, both because their employers do not face fines if their employees receive these subsidies and because of the greater concentration of low-income workers in small firms (see Appendix D).

When CBO looked at the November 2009 proposal from Senator Harry Reid (D-NV), they predicted that the reform bill—including insurance exchanges and other provisions but not including subsidies—would result in a net increase in premiums on average for individuals who currently purchase coverage in the nongroup market; the subsidies would reduce the out-of-pocket prices substantially, for those who qualify for it. Further, CBO predicts that premiums will stay relatively unchanged for small and large employers. Dynamics that remain largely unchanged under the enacted legislation.¹³

An employer mandate

The new health care law also aims to achieve greater coverage through a combination of an employer and an individual mandate. Employers with more than 50 FTEs are required to provide health insurance or face a fine.¹⁴ Employers with 50 or fewer FTEs face no penalties for not sponsoring health insurance.¹⁵ The provision for large firms is technically not a “mandate” as the fines only apply when at least one worker receives a subsidy in the exchange. But it is likely this condition would be triggered for almost all large firms that either do not offer coverage or have low take-up of offered coverage.¹⁶

What are the ways in which employers may react to the employer mandate provisions, and how do the mandates interact with the individual fines and subsidies? All benefit provisions will be reflected in wages, to the extent that workers value the benefits, as pointed out by then-Harvard economist Lawrence Summers, thus this discussion views the implications from both a firm and a worker perspective.¹⁷

Only 3.5 percent of employers with 50 or more workers do not offer health insurance.¹⁸ But data from the Department of Health and Human Services’ Medical Expenditure Panel Survey Insurance Component, MEPSIC, shows that among FTEs at large firms (50 or more employees) that offer health insurance, the average take-up rate is 70.7 percent; it is 54.6 percent at employers with mostly low-wage workers.¹⁹ Some FTEs are deemed by the firm to be ineligible for offered coverage, for various reasons.²⁰

By similar reasoning, an employer whose health insurance policy was restrictive in eligibility may decide to include earlier ineligible FTEs in the policy (and workers who were offered coverage earlier will decide to take up coverage now) provided the amount of the fine is greater than the subsidies the worker would receive in the exchange. Noncompliant employers face three options:

1. **Provide health insurance (or make existing coverage more generous) to avoid the fine.** Firms with higher-income workers who do not qualify for large subsidies in the exchange may consider this option, especially if the decision to offer health insurance was a close call in the first place. That is, suppose workers at the firm would be willing to give up \$4,000 a year for single coverage, but because the employer cost was \$5,000, the firm opted not to provide coverage in the past. When a fine of \$2,000 per worker and \$695 as the individual fine is imposed, the “value” of coverage has now risen to \$6,695

(the direct benefit, plus the avoidance of the fines). Since the cost of an employer policy is now lower than the benefit to workers, the employer will react to the fine by providing coverage.

- 2. Pay the fines, passing the costs on to the workers through lower wages.** If a firm has very low-income workers who qualify for premium and cost-sharing subsidies in the exchange in excess of \$2,000, this firm and its employees may decide to incur the fine because the benefit of participating in the exchange is greater. In both the case of the first and the second option, the new employer costs translate into wage decreases, provided that their wages were not so low to begin with that the employer is unable to pass the new costs on in this manner. The increase in the per-worker costs due to health reform could be viewed similar to a minimum wage increase, and it could have similar disemployment effects. For instance, a firm that pays a fine of \$2,000 per FTE who works 2,000 hours a year will view this as a \$1 per hour rise in the minimum wage.
- 3. Attempt to downsize the number of FTEs to 50 if close to it and not offering coverage or experiencing low take-up.** There are some provisions in the law that restrict the extent to which this could occur. For instance, a firm cannot replace full-time employees with part-time employees; although part-time employees are not covered by the mandate, they count towards the calculation of firm size. There may also be some limits to the extent that large firms could create small subsidiaries or contract out some activities to appear like a small firm. In reverse, a smaller nonoffering firm considering adding on further workers also considers the implications of crossing the 51st worker threshold. The employers at that margin would face a steep tax for the additional worker hired, as it would now be liable for a fine of \$42,000 as long as at least one of the 51 FTE receives a subsidy in the exchange.

The requirement that children can remain on a parent's employer policy until age 26 (unless offered coverage by their employer) is also an employer mandate of sorts. While employers earlier tended to phase dependents off policies prior to age 26, the new law means that more young adults will be covered by employers. These are likely not high-cost individuals given their ages.

Employer mandates proposed several years ago by other states, such as the case in New York State and California, applied to smaller firms with lower rates of offers. Researchers have commented on the impacts they may have on wages, health insurance, and levels of employment. The findings in a recent review suggest that depending on how an employer mandate is structured, it could increase the coverage rate of the population but also have substantial negative impacts on hiring because of the interaction between these laws and the minimum wage laws.²¹

The current employer fines are much lower than these earlier proposals—an annual \$2,000 fine per FTE would translate to \$1 per hour. In contrast, previous analysis demonstrated that if an employer is required to contribute \$3 an hour to health insurance provision, jobs

paying near the minimum wage may be eliminated. The current law also contains a provision that amends the Fair Labor Standards Act to prevent the firing of workers who trigger fines for the employers. To the extent that disemployment (or not adding workers that otherwise would be hired) were to occur, Katherine Baicker of Harvard University and Helen Levy of the University of Michigan find that workers who may lose their jobs as a result of an employer mandate are more likely to be high school drop outs, minority, and female.²²

Jared Bernstein and Elise Gould of the Economic Policy Institute note that while this is true, the net impact on these groups must take into consideration the fact that the mandate would also confer large increases in health insurance levels to members of these groups whose jobs are not lost.²³ To the extent that small firms are exempt as in the case of the current federal law, the number uninsured who will gain new employer insurance does not increase by as much because of the concentration of uninsured workers in small firms.

In summary, the employer mandate in the health reform law applies to a rather small fraction of the currently uninsured employees because of the small-firm exemption, and involves a fine that is substantially less than the full cost of coverage, but may interact with the other aspects of coverage expansions such as income-based subsidies and individual mandates. In addition, the low take-up rate at large employers with low-wage workers may trigger fines unless those workers have coverage from Medicaid or other sources. There are a host of other factors that employers will consider in their response to the mandate, thus policymakers will need to monitor both the intended and unintended consequences of the new law.

Subsidies to small employers

Under the new law, small firms (fewer than 25 workers) with lower-wage employees (under \$50,000 in annual average pay) will receive a refundable tax credit for a maximum of four years if they offer health insurance in 2010, and a maximum of two years if they offer health insurance anytime after 2014. The maximum credit in 2010 to 2014 (35 percent of employer portion of contributions to health insurance) is available to firms with fewer than 10 employees with workers who earn on average \$25,000 per year or less. When fully phased in, the maximum rate is 50 percent instead of 35 percent. Currently, only about 18 percent of low-wage firms with fewer than 10 employees offer health insurance to their workers.²⁴

There is mixed evidence from economic research on whether small firms that do not currently offer health insurance will do so when subsidies are offered. On the one hand, experimental studies suggest that even when half of the cost of coverage is subsidized, small firms are reluctant to offer health insurance. (See Appendix C on page 30). Work by Roger Feldman and colleagues at the University of Minnesota also finds relatively inelastic demand.²⁵ In surveys, small employers also say that the cost would have to be reduced quite substantially for them to offer health insurance.²⁶

Health economists Jon Gruber and Michael Lettau find greater price elasticity, noting that small firms would decrease their offers of health insurance by 7 percent for every 10 percent increase in the price of health insurance.²⁷ This suggests that small employers may also be responsive to subsidies. But given the current cost of a comprehensive policy and the temporary nature of the subsidies in health care reform law, even a 50 percent subsidy may not reduce the net cost to a level that currently uninsured small firms feel they could pay.

A more relevant question that low-wage small firms will face is whether to *drop* coverage, explicitly choosing between utilizing the new employer subsidy or taking advantage of the subsidies their workers may get in the exchange. For example, a worker earning about \$20,000 (roughly 133 percent of FPL for a family of two) whose employer contributes about \$3,000 towards a single policy costing \$4,000 total, would get a maximum of \$1,500 per worker for two years through the small employer subsidy. This same worker would be eligible for larger subsidies for the family in the exchange (or for Medicaid) and would receive higher wages if the firm did not provide them with health insurance.

The workers in these low-wage firms are likely to see wages increase because of the exchange and the subsidies available there, more so than because of the small employer health insurance tax credit. Of course, to the extent that some low-wage small employers do not drop coverage, they will receive a subsidy. Subsidies, like taxes, ultimately fall on workers, thus these small employer subsidies should lead to temporary and small wages increases for qualifying low-wage small firms that currently offer health insurance.

An individual mandate

As alluded to in several places already, the new law requires individuals obtain coverage that meets minimum standards. Individuals who remain uninsured will pay a tax penalty unless they fall into an exemption category based on financial hardship (costs greater than 8 percent of income) or religion. This penalty would equal \$695 per person per year, to a maximum of \$2085 per family or 2.5 percent of family income when fully phased in by 2016.

As early results in Massachusetts demonstrate, these penalties are likely to reinforce employer coverage. In the first two years of implementation, more workers received an offer of employer-sponsored coverage compared to the period before reform, and more workers enrolled in this coverage.²⁸

For a higher-income, healthy individuals in small firms without current offers of health insurance, paying a fine may be preferable to purchasing near-community-rated health insurance. This incentive for selection is limited somewhat by the fact that someone without coverage will not be able to buy coverage the moment they fall ill as there will be one open enrollment period in a year. The amount of the penalty, and the threshold for hardship exemptions are fairly low relative to the cost of buying health insurance, allowing this proposed requirement to be characterized as a “loose” mandate. But as we have seen, they are relevant for employers to consider as they reinforce the employer fines for large firms.

Insurance market reforms

In addition to creating health insurance exchanges, the new health law regulates the insurance market—within and outside these exchanges—by prohibiting standard industry risk selection practices, particularly practices prevalent today in the individual and small-group markets.²⁹ Pre-existing conditions exclusions, which are currently limited by state or federal laws, will be further reduced. For a transition period, federal funding for high-risk pools will provide a temporary alternative coverage source for individuals with pre-existing conditions.

Portability provisions will be further enhanced. Ultimately insurers will be required to issue policies to all applicants, without regard to health history, and cannot vary prices based on health status. Rating rules will enable insurers to vary prices for limited characteristics, including age (to a 3-1 ratio) and tobacco use. All plans sold on the exchange (other than some young adult plans) will be required to meet certain benefit standards.

Under these provisions, there will be redistributive implications; employers whose workers are high health care users will benefit disproportionately relative to firms that have lower-cost workers. This achieves the goal that those who are in worse health should not have to necessarily pay more for health care insurance. Wharton School of Business economics professor Mark Pauly, in discussing the efficiency equity tradeoffs in community rating, notes that the goal of providing protection from the future probability of becoming a bad risk need not go hand in hand with redistribution.³⁰ Guaranteed renewability—another protection within the bill—also provides a mechanism of insuring against “reclassification risk,” or that one could be required to pay a premium every period (starting while healthy) to prevent future increases in premiums.

In addition to the redistributive implications, community rating in health insurance also raises concerns about adverse selection, where insurance may disproportionately attract high risks. The availability of different levels of generosity within coverage choices could also lead to more generous insurance products attracting higher risks than other plans. The result is that premiums would be higher than they would if the risk pool were more comprehensive, if mandates do not appear to be very binding.

States have been actively adopting guaranteed issue, rating reform, pre-existing conditions mandates, and similar policies since the 1990s to improve equity in the health insurance market for small firms. These “small group health insurance reforms” were also enacted to

a lesser extent in the individual market, and some of these state laws were models for federal laws through the 1996 Health Insurance Portability and Accountability Act legislation.

But with few exceptions, these state reforms have not meaningfully addressed pricing issues. There is some evidence that sicker and healthier groups were affected in opposite ways, but on net the impact of these laws have been very small and there is no evidence that these laws improved insurance outcomes for small firms on net.³¹

In the individual market, there is more evidence of adverse selection behavior.³² Because of these possible negative consequences of adverse selection, the reform law includes mandates for employers and individuals. To the extent these mandates are seen as binding and keep the healthy from dropping coverage, the impacts of the new laws may differ from prior experiences. In its assessment, CBO expects that adverse selection in the nongroup and small-employer plans will be fairly limited. CBO further anticipates that large groups may see an improvement in the composition of workers as some of the sicker workers may shift to the nongroup market for the subsidies, and as the individual mandate may bring some of the healthier workers who do not elect coverage and the newly eligible dependents under age 26 into their employer plans.

Expansions of public coverage

As mentioned earlier, the new health law expands public coverage under Medicaid to everyone living in families with incomes below 133 percent of the federal poverty level, or approximately \$11,000 for a single individual. Since children are already eligible under the State Childrens Health Insurance Program to more generous levels of coverage, this expansion will largely benefit adults who do not qualify for medical coverage today as eligible parents, seniors, or people with disabilities. While employers are fined when workers receive subsidized coverage in the exchange, they do not face similar fines when their workers receive coverage from Medicaid.³³

Will this lead to firms with workers newly eligible for Medicaid to drop coverage? There is a range of estimates of this “crowd-out” phenomenon from the literature on children’s expansion, with some suggesting that about half of all new enrollment in public coverage comes from reduced private employer coverage.³⁴

The extent of substitution of coverage is likely to be less than what studies of recent SCHIP expansions have found as the new expansions target a much lower income group than has been targeted in recent children’s health insurance expansions. Data from the 2009 Current Population Survey shows that among adults ages 19 to 64 in families with incomes lower than 150 percent of the federal poverty line, only 19 percent reported some form of employer coverage during 2008.³⁵ It is also the case that even if low-income workers with employer coverage substituted toward public coverage, the workers should recoup the benefits as lower out-of-pocket spending and higher wages. Another implication of public health insurance expansions, especially for small employers, is that it will become easier to attract low-wage workers (who may have earlier sought employment in large firms to find health insurance) without offering them health insurance.

The upshot: Medicaid expansions and low-income subsidies in the exchanges are likely to bring substantial benefits for small employers of low-wage workers. The extent of the crowd-out may be limited both because of the low incomes of the newly eligible populations, the employer fines for failure to cover workers who attempt to receive income-based subsidies in the exchange (but not Medicaid), and the continuing tax subsidy given only to employer-provided health insurance.

Medicare payment reforms and other improvements in delivery system quality and efficiency

The Affordable Care Act leverages Medicare payment policy and other tools to spur innovative changes in provider payment, health care delivery, and patients' experiences in the health care system. To begin with, the Act specifies two types of changes in Medicare payment. First, it includes a number of "traditional" Medicare savings proposals. Many of these provisions should reduce growth of payments for various providers, including hospitals, home health agencies, long-term care hospitals, nursing homes, and hospices.

Others will modify payment methods for Medicare Advantage plans, the private insurance plans that contract with Medicare to provide coverage to Medicare beneficiaries. Another group of proposals under this umbrella will require, over time, that payment to some providers be tied to various measures of quality, while other providers will begin submitting quality-reporting data, albeit without the financial incentives inherent to pay-for-performance payment policies.

In addition, the new law requires the Centers for Medicare and Medicaid Services to launch a series of reforms designed to transform financial incentives from the current pay-for-volume inducements of fee-for-service to payments that reward care coordination and quality. Case in point: the combined law will require CMS to launch "shared savings" approaches to paying Accountable Care Organizations—a network of providers who assume responsibility for a defined panel of patients—and to experiment with bundling payments for post-acute care.

The CBO forecasts that the new health reform law's shared-savings approach could save \$4.9 billion over 10 years. Should this initiative realize these savings, and should private payors follow suit, it could produce further savings as provider practices change in response to these new incentives. If these events come to pass, employers and workers stand to benefit from reduced cost growth.

The new health reform law includes additional demonstration authority and other strategies for enhancing payment innovations, improving efficiency, and demonstrating the degree to which new financial incentives can influence coordination of care and improved quality. This all would be done through an "innovation center" within CMS charged with testing innovative payment and service delivery models within Medicare and Medicaid, including almost all mechanisms that have been suggested as potentially cost savings, as well as

models that are not enumerated within the reform bill but that hold promise for reducing costs and maintaining or increasing quality of care. These reforms, if effective, could be implemented on a wide basis without the need to seek further approval from Congress.

The new law also envisions further use of health information technology, comparative effectiveness research, and other tools for improving health system efficiency. There is mixed evidence on whether health care costs will be reduced by adopting such programs. Former RAND economist Melinda Beeuwkes Buntin (now at ASPE) and Harvard economist David Cutler estimate that \$2 trillion could be saved in total health care spending over 10 years through system modernizations, including payment innovation and greater use of health IT.³⁶ The CBO, however, estimates that savings from health IT and comparative effectiveness research are by no means assured.

Other policy initiatives that may lead to savings include investments in comparative effectiveness research. There is a public good aspect to knowing the relative effectiveness of different medical solutions to the same problem. Currently, no one entity in the private sector has an incentive to engage in this research, thus payments are being decided sub-optimally. Public investment in comparative effectiveness research could give physicians, patients, and other parties better tools for controlling health spending, but there is a great deal of uncertainty regarding the effectiveness of the laws in being able to control costs.

Other reform financing mechanisms of interest to employers

A feature of the health care system that economists often point to as distorting the employer role in health insurance, muting incentives to control costs, and leading to regressive subsidies is the tax subsidy provided to employer health insurance. As pointed out above, this tax subsidy is unaltered under the new law, except for the “Cadillac tax.” Under this policy, insurers are charged a tax of 40 percent on the top portion of plans that cost more than \$27,500 a year for family coverage and \$10,200 for individuals, beginning in 2018 and subject to certain exemptions. Most employers and insurers could probably adjust their plans in the near run so that they purchase a policy just below the threshold and escape the tax altogether.³⁷ This feature, however, is expected to exert some pressure to keep premium growth down, especially as the thresholds are not indexed for inflation.

Thus far, the discussion has treated the income-based exchange subsidies and Medicaid expansions as a “free lunch” to employers. These expansions are financed by a combination of new taxes, Medicare savings, and other savings provisions. The new taxes (on capital gains taxes, payroll and income taxes for the very wealthy, and on medical manufacturers) may increase the costs for businesses through direct and indirect avenues, affecting business investment decisions.

There are also features that reduce existing subsidies, such as a halving of the limit for flexible spending account contributions. But none of these are employer taxes per se, even if described as such in legislation; like all taxes, they will eventually be shared among consumers, workers, and shareholders. The bottom line is that there is diffuse incidence of costs and benefits from the new law; businesses are likely pay close attention to these in decision making regarding health insurance and other matters.

Conclusion

Employers are active agents on behalf of their employees in the U.S. health insurance markets, and the health reform legislation signed by President Obama has many implications for them. This is especially true for larger firms with workers from low-income families, whose decisions regarding offering generous coverage may be affected by health reform. Employers will be encouraged to extend or maintain their role in providing health insurance with carrots and sticks.

Ultimately, the degree to which employers' cost growth will slow will depend on the savings that could result from administrative simplifications, increased competition, and transparency in the market, weighed against the premium increases that could arise from greater coverage of services, adverse selection due to restricting price variation based on individual characteristics that are predictive of health care costs, and nonbinding mandates to purchase coverage.

Research suggests that legislation is likely to have heterogeneous impacts on different types of employers. Reforms will increase demand for employer-sponsored insurance among some workers, and decrease demand among others. Employer penalties either offset or magnify these incentives. Uncertainties in the anticipated effects depend on the take-up of public coverage and income-based subsidies, the enforcement of and reactions to individual and employer mandates, the extent to which firms tend to be homogenous in the family incomes of workers, and the extent to which premium changes may occur. Attention also needs to be paid to the incidence of taxes and subsidies—that is, recognizing that workers, not employers, ultimately pay the costs of their health insurance.

Appendix A: The current role of employers in providing health insurance

What do they do and why do they do it?

In no other country do employers play as substantial a role in health insurance as in the United States.³⁸ In the middle of the last century, wartime anti-inflation policies capped wage increases (but not fringe benefits) leading employers to play a bigger role in health insurance. In order to attract workers during a labor shortage, employers included health care coverage into the compensation package. This initial historical event, coupled with a tax system that allows health insurance costs that flow through the employer to be treated as tax-exempt payments to the worker,³⁹ and the lack of alternative mass purchasing forms or political support for an alternative caused the system to persist.

While employers are often referred to as the providers of health insurance, in reality they are third-party agents in a transaction between a health insurance company and the ultimate customer, the worker and his/her family. Group purchasing occurs in many other settings as well, such as businesses banding together to purchase raw materials in the grocery industry, where group purchasing organizations may negotiate discounts for beverage purchases on behalf of a large number of grocery store clients, or individuals banding together through nonemployer organizations to purchase homeowner's insurance. There is well-developed theory in economics pertaining to group decision making related to the level of service of "public goods" to be provided.

In the context of employers and health insurance, this theory was first put forward by Goldstein and Pauly in 1976.⁴⁰ They compare the decisions regarding employer provision of health insurance to that of a local government deciding on the level of a local public good, such as a library, which provides a broadly similar level of benefit for everyone in their group of constituents, and is excludable to constituents of other jurisdictions. Some features of employer health insurance are closer to local public goods than others. Employers usually offer broadly similar levels of coverage to all their workers (or to groups of workers). While it is commonly believed that the Internal Revenue Code requires this level of comparability, these tax provisions apply only to self-insured firms, which comprise the majority of large employers.⁴¹ But even in these self-insured plans, not everyone in a group necessarily has the same coverage because employers often offer more than one option,⁴² and some employees decide not to take up health insurance at all.

Goldstein and Pauly consider different theories of group purchasing, including one where workers sort themselves into their ideal firm in terms of the mix of benefits and wages, assuming that they can choose from firms with infinite combinations of wages/benefits. The marginal revenue product of labor (essentially the product that the worker makes times the market price for it that the firm can obtain) must equal the sum of their wage and benefit compensation that the firm incurs, the "total compensation."

How that is divided into wages and benefits is decided upon by workers. If there are workers who do not like the combination available at that firm, they will move elsewhere.⁴³ Given that there are economies of scale in providing fringe benefits, this theory predicts that employers would band together until they reached a size that minimizes the costs of fringe benefit provision. Employers could band together through an arrangement such as a Taft Hartley plan or other multiple employer plans without the firms necessarily merging. But history has shown that employers have not found suitable ways to band together for health insurance purposes, leaving small firms at a disadvantage in providing fringe benefits. The theory predicts that small firms are then more likely to offer compensation packages that involve no fringe benefits, and workers with a high preference for those fringe benefits will concentrate in large firms.

In most cases, workers do not have a choice of jobs that offer them every possible combination of wages and fringes. Firms may need to have a mix of workers of different ages, for example, which would imply different preferences for health insurance. In such a heterogeneous setting, one theory is that the “median” worker’s preference may dictate the level of fringe benefits that will be selected as the one level available to all at the firm.⁴⁴

As an alternative, the firm may choose this level so that workers are made as well-off as possible under this constrained environment (the constraint being that each worker cannot get their individually desired level of fringes because it has to be provided uniformly to all workers at the same level) and employer costs are minimized. Employers will tend to cater coverage towards potential employees in the labor market too, while unions cater towards the employees currently in the firm, in particular those who are union members.

In their empirical work, Goldstein and Pauly find that premiums per person are higher in firms with a union presence, after controlling for other variables. This suggests that where unions have more voice in the decisions relative to the employer deciding on the level of fringe benefits, more compensation in health insurance occurs. Through this theoretical and empirical work, Goldstein and Pauly provide some ways for us to think about how we can take insights from other areas of economics, namely the provision of local public goods, as theory of how employer health insurance decisions are made with the employer interacting with workers.⁴⁵ In relating this literature to whether employers will react to new health care reform by changing their decision to offer health insurance, a key question is the concentration of low-wage subsidy (or Medicaid expansion) eligible workers in certain firm, as well as the extent of subsidy for the median worker. The subsidies are only available in the exchange and not through employer-sponsored coverage, however, employers are constrained to offer fairly uniform benefits to all workers and may only change their decisions if a vast majority of the workers are likely to be eligible for substantial subsidies.

Another role that employers have taken on, in addition to purchasing health insurance for workers, is implementing disease management and health promotion programs (Gabel et al, 2009).⁴⁶ The business case for employers investing in the health of their workers is evident in case studies that find improved risk status and lower health care costs, reduced absenteeism, reduced turnover as a result of these programs. These studies suggest that employers have incentives to provide targeted and specially designed programs above and beyond the provision of regular health insurance policies. One could take the rising fraction of employers who adopt prevention and disease management programs to be evidence that employers are realizing improvements

in profitability from them. But even though employers are accustomed to making calculated decisions about whether to undertake business investments in general, they may not have enough tools at their disposal to make such calculations when it comes to health care decisions (Nicholson et al, 2005).⁴⁷ Employers also need to understand better the effect of increased cost sharing (high-deductible policies) on health care costs and productivity.

The employer's health insurance decisions—a series of tradeoffs

Employer health insurance decisions are influenced by supply and demand factors such as the prevailing price of a health insurance policy (which depend on cost of health care, the content of the policy, and the firm's characteristics) and the workers preferences for health insurance (which depend on the availability of outside options, the workers' productivity, and their health status). Like any economic decision, employer health insurance deliberations come down to cost-benefit calculations at the margin, comparing supply and demand factors.

Since policy can affect several supply and demand side features (through changing tax policy, or through the generosity of alternative options), employers may react to legislative reforms by changing their health insurance decisions. Evidence from prior economic studies will help in anticipating the nature of the effect. For instance, small employers who did not earlier offer health insurance may react to the availability of subsidies that lower their premiums, but the subsidies will have to be very large and sustained, based on evidence from prior studies that suggest employer decision to offer new coverage is not highly elastic with respect to price. Employers may similarly reduce their generosity of health insurance when Medicaid expansions and income-based subsidies in the exchange commence.

Congressional agencies and private think tanks have developed microsimulation models (both ones based on elasticities from previous literature, as well as ones that estimate parameters within the model) that will be very helpful in anticipating the costs and net newly insured from different proposals.

Employers make a decision about whether to offer health insurance or not (except in Hawaii where there is a stringent employer mandate in place, and to a lesser extent in Massachusetts where there is a small mandate in place) considering various tradeoffs. An employer has a certain amount of net revenue to distribute as compensation to workers, in the form of wages and benefits. As Summers (1989) pointed out, if workers value health insurance at exactly the cost to the employer, then when health insurance is provided, the wage decreases by the full cost of health insurance and employment levels remain unchanged. Thus, if workers value health insurance at more than the full cost to the employer (perhaps because their alternative option is more expensive), then employment levels could actually rise as a result of offering health insurance.

In reality, workers may value health insurance more or less than the cost to the employer, but the exact magnitude of this tradeoff has been difficult to pinpoint, mostly because of a lack of suitable experimental designs.⁴⁸ The possible reasons for recent increases in health care costs range from improved technology to increased obesity.⁴⁹ We do not know precisely how much workers value what this higher cost health care buys them, in terms of wages they are willing to forego. When workers do not value the increase in costs at least dollar for dollar, the number of jobs will fall for similar reasons, even aside from binding minimum wage considerations.

Researchers have found it difficult to document how employers and workers tradeoff wages and health insurance because the two tend to be tightly correlated. That is, it is hard to find the equivalent

job that does and does not offer health insurance; jobs tend to be “good” or “bad.” Using husband’s job characteristics as exogenous determinants of a wife’s compensation package (which assumes that married couples do not make joint labor market decisions), Olson estimates that the magnitude of the tradeoff is a 20 percent lower wage for the wife when she accepts a job with health insurance benefits relative to one without.⁵⁰ It is also not possible to say whether the incidence of health insurance costs themselves occurs at the level of the individual employee or by groups of employees. Gruber and Sheiner find evidence that groups with higher health care costs see lower wages (women and married men in the Gruber example that studies the imposition of a maternity coverage mandate, and older workers in the Sheiner example where she studies variation in health care costs across cities).⁵¹ It is unlikely the employer makes this tradeoff at the individual worker level, but the group level at which the tradeoffs occur (occupation within the firm, or demographic groups such as age or gender bases) is not known.

There is also evidence that employees do not view health insurance as something they can tradeoff for wages easily in the labor market from the literature on “job lock,” a phenomenon where workers want to leave the employer for a better productivity match elsewhere, but feel locked in because the new employer may not provide health insurance. Studies by Madrian and Gruber for example,⁵² provide evidence that having employers provide health insurance creates such hurdles to job mobility, but other papers such as Kapur (1998) does not.⁵³ Evidence on the effect of health insurance on retirement behavior, on the other hand, unanimously finds that individuals are less likely to retire early from jobs with health insurance (Blau and Gilleskie, 1997).⁵⁴

But it is not clear that providing health insurance enhances productivity (relative to an equivalent amount in wages), e.g. by retaining needed employees and improving morale.⁵⁵ The literature on job

lock views increased turnover as being positive because workers (particularly older or sicker workers or those with such dependents) then move to the best options rather than being locked in to a certain job due to health insurance. For the efficient functioning of the labor market, mismatched workers need to be able to move to better suited jobs.

There is evidence from labor economics literature that workers who change jobs, particularly the young, experience wage growth.⁵⁶ If younger workers switching firms produces efficiency gains for the economy, then job lock due to health insurance (which would affect older workers more) is not as serious a consequence for labor market efficiency. For an individual firm, reduced turnover (by the most valued workers) would be profit enhancing. Evidence of job lock means health insurance reduces turnover, but more so for sicker than healthier workers. Research in this area would add great value; since it is difficult to empirically identify the effect of offering health insurance on labor productivity, we do not yet know the answer to this question. In a later section, I review the literature on wellness and disease management, which has some results pertaining to improved health and reduced absenteeism.

The trade-offs that employers see in providing health insurance will depend on what alternatives exist. Employers realize that if they do not offer health insurance to their workers, those workers will typically not be able to take the equivalent cash wage (on which they will have to pay income taxes) and find a policy of even near equivalent generosity on the individual market. But there are some workers for whom public health insurance is an option, and for those workers (or their dependents), the alternative is not the expensive individual products market.

In a similar way, employers may be more likely to stop offering health insurance and provide higher wages if a good alternative existed outside of the employment relationship. This is more likely to

occur as public health insurance eligibility limits rise, as has been shown by the extensive literature on the effects of Medicaid expansions on health insurance. Policy makers are aware of the possibility of insurance reforms unintentionally crowding out employer coverage, and employer mandates or other employer requirements represent, in part, one attempt to prevent this response.

Empirical determinants of whether a firm offers health insurance

Many papers look at what predicts or is correlated with whether an employer offers health insurance. These include studies like that by Feldman and colleagues who look at the causal effect of premiums on health insurance offer decisions after making econometric corrections for the fact that only a select sample are observed, those who have bought policies, to reduced-form studies like those by Gabel and Jensen or Simon, who study the effect of state policies on small firm decisions to offer health insurance using variation in timing of the laws.⁵⁷ Also included are descriptive reports like those by Kaiser Family Foundation/HRET that present offer rates of insurance by employer characteristics. There are also many studies that look at the individual level determinants of whether someone has private-employer-provided health insurance.

The most striking finding regarding the employer's decision to offer health insurance is that small firms (25 workers or fewer) are home to the vast majority the full-time-working families who are without access to employer health insurance offers.⁵⁸ The Kaiser/HRET Employer Health Benefits Survey surveyed 1,997 employers and found the percentage of small employers (3 to 9 workers) who offered health insurance dropped from between 50 percent and 60 percent in the early 2000s, to 45 percent by 2007. For large firms of 200 or more workers, this stayed at 99 percent. Exhibit 2.3 of their study shows offer rates

by further breakdowns of firm size. The percentage of firms with 10 to 24 workers that offer health insurance is 76 percent (relative to 45 percent for 3 to 9 workers) indicating how different very small firms are. Firms with 25 to 49 workers are at 83 percent, and firms with 50 to 199 workers are at 94 percent.⁵⁹ Reflecting these concerns that health insurance costs are particularly burdensome for small employers, the Senate HELP Committee recently held hearings on the topic of increasing health insurance costs facing small businesses.⁶⁰

There are various reasons other than firm size for the differences in health insurance between small and large firms, including the fact that small firms tend to be dominated by lower-skilled jobs, higher turnover, etc. (Abraham, Deleire, Royalty, 2009).⁶¹ Other factors correlated with employer health insurance offers in 2007 from the Kaiser/HRET survey include region, with a high of 69 percent offer rates for employers in the Northeast and 52 percent in the South. In terms of industries, the lowest offer rate is 38 percent in retail and highest is 90 percent in state/local government.

There are also important differences by wage level of the workers, percent of workers who are part time, presence of union workers, and age of the workers. When smaller firms (size 3 to 199) are asked the reason for not offering health insurance, the reason most cited as being "very important" is high premiums (72 percent).⁶² Other reasons include the firm being too small, employees being covered elsewhere, and the ability to obtain good employees without offering health insurance. (Firms were allowed to designate more than one issue as being a very important reason).

When these employers (with 3 to 199 workers and not offering health insurance) were asked about employee preferences for wages over health insurance, 71 percent said they believe employees would prefer higher wages over health insurance, another

6 percent said they don't know, and only 23 percent said that employees would prefer health insurance (but presumably not at the premium that is available to the firm, or else the firm would have offered health insurance). There are follow-up questions asking how much employers and employees feel they may be able to pay for coverage, but these questions do not specify a wage offset. That is, every employer who pays workers above minimum wage a year could in theory take all that money to purchase health insurance instead (they could legally "afford" to) but the labor demand conditions they face may not allow them to view that amount as what they feel they can afford, and a large fraction (39 percent) say they do not know.

Employers' role as health insurance agents involves many decisions beyond the basic one of whether to offer any coverage. Some parameters are under the employer's control, while others are dictated by law.

What design decisions do employers make?

Once employers decide to offer coverage, they must make secondary decisions, such as:

- Who qualifies for coverage?
- How much coverage will they offer?

This section briefly outlines this decision tree, and considers existing evidence—when available—on these decisions within the current system.

Who gets covered by what health insurance plan within a firm?

Typically, all employees within a firm who meet some attachment criteria (months served, or hours worked) are covered by the plans within a firm.⁶³ The Employee Retirement Insurance Security Act,

or ERISA, states that self-insured employers must not provide health insurance to highly compensated workers on more favorable terms than to lower-compensated workers.⁶⁴ In addition, all firms offering health insurance must abide by federal laws such as the Americans with Disabilities Act, employment discrimination laws as enforced by Equal Employment Opportunities Commission,⁶⁵ and the Health Insurance Portability and Accountability Act's injunction against differentiating between sick and healthy employees in health insurance design, including the type of plans and benefits they offer, and the share of premium paid by employees. Some states require insurers to offer coverage to all applicants—that is, guaranteed issue—and restrict the degree to which insurers may vary premiums.⁶⁶ These restrictions are similar to those now in federal law.

What amount of health insurance shall be offered? Will there be choice of plans?

There are some constraints on the terms of coverage that can be offered, for commercial insurance. State laws (and some federal laws) stipulate minimum levels of coverage, if health insurance is offered at all. Plans must include required services, such as maternity coverage (at the federal level) and items such as infertility services (at the state level).⁶⁷ States also regulate commercial insurance in many other ways, such as collecting premium taxes and requiring proof of solvency of insurance plans. Firms that self-insure have considerable flexibility, but don't appear to take advantage of that flexibility to evade benefit mandates.

In fact, self-insured plans are often more generous than commercial plans and often offer nonmandated benefits. Plan choice goes up with firm size.⁶⁸ Apart from the regulations related to mandates, the generosity of coverage is left up to employers to decide upon in the context of their business and labor market conditions.

Of the premium, what share shall the employee pay?

The 2009 Kaiser/HRET Employer Health Benefits Survey found the average premium to be \$4,824 for single plans and \$13,375 for family plans. The employee share was 17 percent for single plans and 27 percent for family plans, thus the fraction paid by the employee is typically smaller for individual coverage than family.⁶⁹ There is not much literature that examines how employers determine this split; there is some evidence on what rule employers appear to make when they have multiple offers.⁷⁰ They sometimes offer the cheapest plan at zero contribution.

Small firms tend to require less as a share from employees (ERIU, 2008) because they want to make sure as many of their employees sign up as

possible in order to get the lowest per-person price. Insurers would be cautious that otherwise, they get only the sickest employees in the firm, thus they establish these “minimum participation ratios” for small employers. Given the discussion above about the tradeoff between wages and health insurance (ultimately, all health insurance costs are borne by workers through lower wages), this split in the nominal cost sharing is of importance only for the workers who do not accept health insurance that is offered—by having selected into a job that offers health insurance, workers who do not take up coverage that is offered can only recoup between 17 percent to 27 percent of the cost of health insurance, the portion they would have paid as a co-premium.

Appendix B—How do employers react to increasing health care/health insurance costs?

Health insurance costs represent an increasing component of labor input costs, a fact that has been brought to attention by automakers in union negotiations; auto manufacturers point out that health care costs per car now outweigh the cost of steel that goes into a car. The cost of the average family policy bought by an employer in 2007 is \$12,106 (Kaiser/HRET, 2007), which is 24 percent as large as median family income, \$50,233 in 2007 (U.S. Census Bureau, 2008).⁷¹

In order to accept an offer of employer health insurance, the median family must spend roughly 6.5 percent of their income, not counting out-of-pocket expenses not covered by insurance and not counting the amounts by which their wages are lower to account for the employer portion of the premium. From 2008 to 2009, according to the Kaiser/HRET employer survey, family premiums for employer-sponsored insurance grew 5 percent. This was the fifth year in which year-to-year growth rates fell. The 2008-2009 growth in premiums approaches historically low levels of premium growth—the last year that saw similarly low year-to-year growth was 1999—but growth in premiums continues to outpace both earnings and general inflation and applies to a large base of employer health insurance payments.

Researchers point out that it is important to consider the reasons for the rise in health insurance costs to understand employers' responses. If the increase in health care costs and health insurance premiums is due to changing quality of health care, and if workers value this improved health care, then

wages should in theory adjust downward by the amount of the increase in costs, and employment levels and all other outcomes would stay the same. Others, such as Gruber (2000), argue that there is more to consider in understanding employer responses to growing health care costs. Employers, according to Gruber, have significant discretion around hiring and benefit decisions, including whether to substitute part-time for full-time workers, whether to shift to using more capital than labor, how to design their total benefits package, and whether to offer health insurance at all.

Gruber also notes that employers may be constrained by minimum wage laws and union contracts from reducing wages, and wages may not adjust for rising health care costs at the specific worker level versus at a broader level of aggregation. These factors suggest that an increase in the health care costs may lead to other changes in behavior, such as reduced hiring of full-time workers, rather than just reduced wages for the group whose health care costs rose.

One strand of empirical research that comments on the issue of cost examines how sensitive employers are in their decision to offer health insurance when premiums change. This price elasticity of demand has been estimated by Feldman et al (1997) to be such that a 1 percent increase in premiums would decrease the probability that a firm offers single coverage by 3.91 percent for single coverage and 5.82 percent for family coverage. Conflicting evidence came from the Robert Wood Johnson demonstration projects,⁷² which found that even if small employers were given

premium reductions of 25 percent to 50 percent, few would start to offer health insurance. Gruber and Lettau also find more modest elasticities—on the order of -0.25.

Gruber and Washington (2005) examine what happens when employees are provided with tax subsidies (when the co-premium is made pre-tax).⁷³ They find that making employee contributions cheaper by protecting them from taxes does not change the take-up decision much, but instead increases tax expenditures.

Baicker and Chandra use the exogenous variation created by medical malpractice growth to identify the impact of rising health insurance costs on the labor market.⁷⁴ It is important to note that this source of rise in health insurance cost is one that workers may not value, as it does not come from improved medical technology. They find that a 10 percent increase in premiums would reduce wages by 2.3 percent for those who continue to receive employer provided health insurance. This paper also shows evidence of rising premiums constraining employment opportunities, a 10 percent rise in premiums reducing the level of employment by 1.2 percent, argued on the basis that employers cannot cut health insurance only for some workers because of nondiscrimination laws, thus resort to cutting jobs or reducing hours to convert some full-time positions to part-time jobs. In a 1998 paper, Cutler and Madrian found that employers respond to rising health insurance costs by shifting to more full-time labor, taking advantage of this fixed cost nature of the fringe benefits.⁷⁵

Other than accepting health insurance costs passively and dropping health insurance coverage or changing labor market outcomes, employers also respond in more active ways. Larger firms have more bargaining power and can actively engage in cost-reducing negotiations more than small firms, but all employers think about how to deliver health insurance at the lowest cost possible, shopping around

for services through brokers and experimenting with innovative strategies. Some such responses are discussed below.

Whether to self-insure health benefits

Self-insuring health benefits is an option that lowers costs, but is only available for large firms since it requires use of in-house capital, or the use of expensive stoploss (“reinsurance”) insurance policies. Studies that examine the decision to self-insurance have found mixed evidence for the influence on mandates on firm decisions to self-insurance.

Gruber⁷⁶ finds that benefit mandates have little impact on insurance coverage; this could be because mandates do not appear to be especially binding, while earlier work by Gabel and Jensen (1989) finds that mandates are responsible for lack of health insurance in 1/6 small firms that are uninsured, and 50 percent of large firms that convert to self-insurance. Due to the administrative simplifications and cost savings associated with self-insurance, most large firms (62.7 percent of firms with 50 or more workers who offer health insurance in 2008) currently self-insure at least one product.⁷⁷

Whether to use disease management and employee wellness programs

Recently, there has been an increase in interest among employers in implementing disease management and wellness programs. Many (28 percent) employers thought that disease management programs were “very effective” (Kaiser/HRET, 2007). Only between 12 to 16 percent thought that tighter managed care networks, CDHPs, and higher employee cost sharing was “very effective,” and a similar number thought they were “not at all effective.” However, close to half thought that these strategies were all “somewhat effective.”

Data from the UBA 2008 Employer Opinion Survey,⁷⁸ which polled 1,664 employers, finds a large number desire wellness programs and chronic disease management programs, indicating employers buy into the idea that these programs will impact the business. According to William Stafford, vice president of member services for UBA “This survey illustrates that employers have a high level of confidence in their ability to control health care costs and that their employees can make informed choices if given the additional tools necessary to do so.” The survey also finds that employers are increasing their use of wellness programs. In 2008, 9.8 percent of employers offered wellness programs, while in 2007 this was 7.4 percent.

There are three related issues to consider in thinking of the scope for reducing health care costs through these programs. One is to what degree does modifiable health behavior and management of treatable conditions with better preventive/early care affect health care costs. Second issue is how successful are options available to employers to affect health behaviors and ensure better management of diseases. Third is the time frame during which these benefits occur—are they short term enough that current employers recoup the benefits? Employers have some benefit in serving the role of health promotion manager because employees are physically present (for example, in establishing on site exercise facilities).

Researchers have explored the impact of wellness programs and disease management tools on health status, health care costs, productivity, absenteeism and turnover, finding some reason for cautious optimism that such programs might produce desirable outcomes if adopted on a large scale. However, it must be noted that this evidence is from case studies.

First, there is evidence that health risks affect employer costs and productivity in significant ways. A series of papers by Goetzel and colleagues using data on workers linking health care and employee

productivity measures found that after controlling for demographic and other factors, those with risky behaviors were found to incur higher health care costs.⁷⁹ There are numerous reviews (ones by Pelletier) showing that employer interventions have lead to beneficial outcomes.⁸⁰ How much of this is causal is hard to pin down.

A recent study that overcomes these estimation difficulties is Loepke et al (2008),⁸¹ who use an experimental/control group setup where 543 employees of a large company were provided with health risk assessment programming while two sets of control group workers were not. The authors found that those who received the risk assessment were found to be in better health after the study period (years 2003 to 2005), particularly in cholesterol, diet, substance abuse, high blood pressure, stress management, and activity and obesity rates. They also found that these benefits persisted after the controlled study ended (2006 data), and that improved health was associated with reduced absenteeism.

The evidence on whether employers, providers, or the government could reduce health care costs by encouraging quality improvements in health care is less certain. Other active strategies employers could pursue to lower health care costs include attempting to improve quality and obtain more transparency on the provider side, as was tried by the Leapfrog group (Galvin et al, 2005), an attempt by large employers that has not been viewed as a notable success.⁸²

Manipulating plan design

Some elements of plan design are covered by state and federal law regarding specific benefit mandates. Federal policy mandated that large employers offer an HMO on the menu as long as one existed in their area.⁸³ This law’s provisions for employers expired in the 1990s, and managed care has generally fallen from favor and morphed into the preferred provider

organization, or PPO, form that allowed greater freedom, but uses incentives to keep patients within network (Kaiser/HRET, 2007).

A new wave of plan design innovation has been come to be called “consumer directed health care” plans, or CDHPs. While there are slight variations in what one would refer to as a CDHP, it is commonly a high-deductible insurance plan (typically a deductible of \$1,000 or more), which maybe offered in tandem with a personal health account (such as a tax-preferred Health Savings Account that can only be used for qualified medical expenses). As Christianson et al discuss in a recent *Health Affairs* article,⁸⁴ adoption of “consumerism” through CDHPs has been seen as a way to reduce health care costs after the retreat of managed care strategies than put the onus on the insurer. These plans have experienced significant growth in recent years.⁸⁵

A review of the impact of HSAs and CDHPs by RAND researchers published in *Health Affairs* in 2006 shows that there is some selection into these plans by the healthy, and lower health care costs; effects on quality are mixed.⁸⁶ More recent evidence in 2007 by Greene and colleagues using claims data from one employer finds that those enrolled in CDHPs were less likely to continue use of chronic care medications.⁸⁷ However, Rowe et al find that those in CDHPs (with free preventive and screening services) were not less likely to use preventive and chronic illness services relative to a control group in PPOs.⁸⁸

On net, the jury is still out on what CDHPs will accomplish. The issues that are raised are the likely selection by healthy, leaving the risk pool worse for

other insurance plans; the possible decreased use of preventive care, unless such services are exempt from the deductible; the lack of needed information on which consumers will base health care decisions; and the fact that by definition, high-deductible plans will not affect catastrophic costs which are where the bulk of U.S. health expenditures lie.

Encouraging workers to take alternative options

Employers have incentives to encourage the use of alternative means of payment (other than the employers policy) to cover health care costs. This could be pushing workers on to spouses’ coverage⁸⁹ or onto public insurance options such as Medicaid and CHIP. Employers’ decisions on retiree coverage are also likely to be influenced by the availability of Medicare. Employers generally adjust their health insurance plans to retirees to be the secondary payer once Medicare eligibility is reached at age 65. This could be viewed as a form of substitution of coverage because employers would otherwise have provided the usual coverage. There is a contemporary issue in this area with Medicare Part D offering subsidized coverage for prescription drugs. Employers were given the option of receiving a two-thirds subsidy from the federal government for continuing their coverage of prescription drugs in retiree plans for those over age 65.⁹⁰ Thus, not all health care costs of the employed (or retired) population need to be covered under employment-based coverage because of the existence of alternative public programs that are designed to meet the needs of these populations.

Appendix C—What do employers say when asked about their opinions regarding health insurance and reform?

There now exists some data from surveys that have asked employers their opinions regarding their role as health insurance providers, and their possible reactions to future changes in health care features. In 2002, the Employee Benefits Research Institute commissioned a survey and focus groups of employers. The findings showed that employers think of offering health insurance as a way to attract workers, but are also cognizant of wanting to improve the health status of their workers. They want to be competitive in the labor market but also recognize that when there are dual workers in a family, they would rather not be the plan that is chosen for the family.

Many questions of employer opinions are asked as part of a series of surveys conducted by Gabel and colleagues nationally. In the one state that has actually implemented reforms recently, Massachusetts, Gabel et al (2008)⁹¹ conducted a special survey of employers in 2007 about their support for health reform. This survey of 1,056 employers was conducted after the reform legislation was enacted in that state but before the parts that affect employers were implemented, and thus serves as a baseline for later surveys of employers in the state.

All employers with more than 10 full-time workers are required to provide health insurance or pay a nominal fine of \$295 per employee per year. The survey found that employers, smaller ones in particular, were not well aware of the reforms (with only 14 percent of firms in the 3 to 10 worker category saying they understood the plan very well; for firms in the 11 to 50 size category this was 18 percent).

About 75 percent to 80 percent of employers under the 50-employee size reported that the media was their main source of information about reform, while larger employers were more likely to mention their brokers than the media.

Smaller firms (50 or fewer employees) were between 31 percent and 39 percent more likely to strongly agree that all employers bear some responsibility for providing health benefits to their workers. Between 43 percent and 40 percent of small employers responded that they somewhat agree with this proposition. Regardless of firm size, the support for employers with 11 or more workers paying a fine of \$295 per employee without health insurance was strongly agreed to by about one-third of respondents. When employers not offering health insurance were asked whether they would limit pay raises to maintain their employees eligibility for subsidies, very few indicated they were very likely to do so (17 percent among firms with 3 to 10 workers and 10 percent among firms with 11 to 50 workers). These results suggest that employers are fairly responsive to the reforms in Massachusetts, although there is low awareness of the details. It will be important for comparison with responses after the reform plan has gone into effect for employers.

A survey similar to the one in Massachusetts was fielded in early 2008 in New York, a state that has not enacted large-scale reform. Simon and White (2008)⁹² find that New York employers of all firm sizes agree strongly or somewhat strongly that they bear some responsibility for providing health

insurance to their workers, ranging from 72 percent for small firms (2 to 9 employees) to 79 percent for medium firms (10 to 49 employees) and 88 percent for large firms (50 or more employees). Employers also state they agree that individuals above the poverty level bear some responsibility for buying insurance, ranging from 79 percent for small and medium firms to 87 percent for large firms. To supplement the survey, focus groups were conducted.

When asked whether employers are in favor of an employer mandate, in one focus group, a small firm owner commented:

“I think everyone would agree here that doing business, especially for small businesses in New York State is very tax burdening. To do business in New York State compared to other states... imposing another responsibility like this would just add financial pressure on us, especially as a small business.” (Ithaca)

In 2007 a survey of employers was conducted by the California HealthCare Foundation in California, another state that considered health reform.⁹³ When employers were asked whether they supported California’s “pay or play” legislation, 7 percent of large firms “strongly” supported it while 18 percent of small employers (defined as under 200 workers) strongly supported it. Thirty-five percent of small firms and 38 percent of large firms “somewhat” supported it. Twenty-one percent of small firms and 13 percent of large firms “strongly” opposed it.

Yet 33 percent of small firms and 48 percent of large firms strongly agreed that all firms bear some responsibility for providing health benefit; overall two third of all firms strongly or somewhat agreed on this. Eighty-two percent of all firms agreed that all individuals above the poverty level bore some responsibility for buying health insurance.

Appendix D—Employer coverage by firm size

Distribution of nonelderly U.S. Workers and Potential Access to Employer Coverage, by Firm Size and Family Income

	<133%FPL	133-150	150-200	200-250	250-400	>400
Firm Size	Distribution of workers					
<10	0.166	0.031	0.092	0.091	0.222	0.398
10-24	0.150	0.031	0.092	0.100	0.234	0.394
25-99	0.117	0.031	0.084	0.092	0.236	0.439
100+	0.090	0.022	0.067	0.078	0.229	0.513
	Current Rate of Access to Employer Insurance					
<10	0.169	0.307	0.365	0.453	0.609	0.750
10-24	0.224	0.336	0.415	0.583	0.740	0.865
25-99	0.307	0.450	0.565	0.701	0.828	0.916
100+	0.360	0.527	0.661	0.774	0.878	0.950

Notes: Based on 2008 data from the March CPS of 2009. Fractions add up to 1 in each row in the top segment of the table. Uses sample weights.

The table above considers the distribution of workers, and potential access to employer provision of health insurance today across different firm sizes and family incomes, in order to see how small firms compare to large firms. The CPS does not have a 50-employee firm size classification, but data from the MEPSIC shows that roughly 50 percent of workers in the 25 to 99 size category are in firms of 25-50 workers (AHRQ20101, Table I.B.1).⁹⁴

First, this table shows that smaller firms have a greater fraction of their workers belonging to low-income families. The rows add up to 1, thus these data tell us that 17 percent of workers in a firm with under 10 employees come from families under 133 percent FPL, while in firms over 100 workers this is only 9 percent. The next set of rows show potential access to employer health insurance for the worker, defined as having at least one family member

covered by employer health insurance currently. This does not show whether people were offered employer coverage that they refused, as the March CPS does not collect that. Smaller employers (those with fewer than 25 workers) in the lowest income families have very low access to health insurance currently (17 percent and 22 percent), whereas for the same income category, being in a large firm increases potential access to employer health insurance to 36 percent. Even among families with higher than 400 percent FPL, access to employer health insurance is lower in small firms. The unequal distribution of the uninsured and the low-income workers across small and large firms are two factors (combined with small firms' temporary subsidies and lack of an employer mandate fine) that imply small firms and their workers stand to experience greater gains from the new law relative to larger firms.

Endnotes

- 1 The Patient Protection and Affordable Care Act of 2010, Public Law 111-148, 111th Cong., 2nd sess. (March 23, 2010), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 111th Cong., 2nd sess. (March 30, 2010), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872enr.txt.pdf.
- 2 The numbers in this paragraph come from Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2009 Current Population Survey" (Washington: Employee Benefit Research Institute, 2009), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_9-2009_No334_HI-Cvg1.pdf.
- 3 The Congressional Budget Office Senate bill analysis of November 2009 forecasts that the exchanges would experience some economies of scale. However, they are still likely to be less than what large employers receive since contracting in the exchanges is done at an individual level. Prior research has failed to uncover substantial economies of scale from purchasing pools, but were based on more limited attempts than the planned state-based changes. Elliot K. Wicks, Mark A. Hall, and Jack A. Meyer, "Barriers to Small-Group Purchasing Cooperatives" (Washington, D.C.: Economic and Social Research Institute, 2000).
- 4 David Cutler, "Health Reform Passes the Cost Test" *The Wall Street Journal*, March 9 2010, available at <http://online.wsj.com/article/SB10001424052748703936804575108080266520738.html>.
- 5 Agency for Healthcare Research and Quality, "Table I.D.1 (2008) Average total family premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size and selected characteristics: United States, 2008," available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tid1.htm. AHRQ data is used for employer premium growth, and Bureau of Labor Statistics, "Productivity change in the nonfarm business sector, 1947-2009," available at <http://www.bls.gov/lpc/prodybar.htm> was used for productivity growth numbers. Bureau of Labor Statistics, "Consumer Price Index-All Urban Consumers," available at http://data.bls.gov/PDQ/servlet/SurveyOutputServlet?data_tool=latest_numbers&series_id=CUUR0000SA0&output_view=pct_1mth, was used for inflation figures.
- 6 Only 3.5 percent of firms with 50 or more workers do not offer coverage in 2008; Agency for Healthcare Research and Quality, "Table I.A.2: Percent of private-sector establishments that offer health insurance by firm size and selected characteristics: United States, 2008," available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2.htm. The new law applies to firms with more than 50 full-time equivalent workers, thus since coverage tends to rise with firm size, fewer than 3.5 percent of these firms lack offers of coverage. The very few large firms that do not provide health insurance pay a fine of \$2,000 per FTE (on all FTEs minus the first 30) the moment that at least one FTE takes government subsidized coverage in the exchange. Given the generosity of the subsidies, it is very likely that all (of the few) large firms who do not offer health insurance would have at least one FTE who receives a subsidy. In the extreme, if an employer of 51 FTEs does not offer coverage, but has 50 FTEs who receive coverage through, say, spousal employer coverage, and only one FTE who received subsidized coverage in the exchange, this employer pays an annual fine of \$2000*(51-30)=\$42,000.
- 7 Large employers who offer coverage but do not have 100 percent take-up pay the lesser of: \$3,000 for every FTE who receives a subsidy in the exchange, or \$2,000 per FTE (minus 30). In most cases, the lesser amount is likely to be the \$3,000 per FTE who receives a subsidy in the exchange. Employees of firms that offer coverage are not allowed to receive a premium or cost-sharing subsidy in the exchange (and thus trigger fines for their employer) unless their employer coverage does not cover at least 60 percent in actuarial value, or if the employee co-premium exceeds 9.5 percent of family income. If the worker is under 400 percent of the FPL, and if the employee premium contribution is between 8 and 9.8 percent of income, the employer is required to provide the worker with a voucher equal to the employer contribution towards health insurance, with which they may shop for unsubsidized coverage. The legislation also contains provisions restricting waiting periods for employer coverage to no more than 30 days.
- 8 Agency for Healthcare Research and Quality, "Table I.B.3.b.(2): Percent of private-sector full-time employees that are enrolled in health insurance at establishments that offer health insurance by firm size and selected characteristics: United States, 2008," available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tib3b2.htm. A low-wage employer is defined by the MEPSIC survey as one who has more than 50 percent of their employees earning \$11/hr or less, in 2008. (Of all private sector employers in the U.S. that have 50 or more employees, 35 percent are low-wage employers (Table I.A.1)). It is unknown how many of the workers who do not take up coverage in these firms would be using subsidies in the exchange once the law is enacted, as opposed to, say, receiving coverage elsewhere as a dependent or from Medicaid. MEPSIC data show that in these low-wage large firms, the employee contribution towards a family policy was on average \$3,784 and \$1,025 for single coverage. This represents about 13.5 percent and 7.5 percent of income, respectively, for family of four and for an individual, at 135 percent of the FPL -- just beyond Medicaid eligibility under the new law.
- 9 See research by Bradley Herring and Mark Pauly ("Play or Pay" Insurance Reforms for Employers", Jan 14 2010. *New England Journal of Medicine* vol 362:93-95.pp1-3) that illustrates how low-wage workers at high-wage firms that offer coverage are likely to get minimal benefits from the current tax subsidy too.
- 10 A summary of the provisions is provided by the Kaiser Family Foundation at <http://www.kff.org/healthreform/8061.cfm>, and a timeline of implementation summary is provided at <http://www.kff.org/healthreform/8060.cfm>.
- 11 All individuals without offers of employer insurance are allowed to purchase near-community rated coverage from the exchanges regardless of whether they qualify for subsidies or not. These coverage expansions are expected to alleviate some long-standing concerns regarding employer provided health insurance. Employers and employees stand to benefit from reduced "job lock"—the need for employees to stay with one company because they can not afford to lose their health insurance—when health insurance availability outside of employer arrangements improve. A related benefit is a reduction in risk that employees face during periods in between jobs.
- 12 The Congressional Budget Office forecasts that employers would still cover about five sixths of the total non-elderly health insurance market after reform, using the November 2009 version of the legislation. An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act. Letter from Doug Elmendorf to Evan Bayh, November 30, 2009, available at <http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf>.
- 13 Letter from Doug Elmendorf to Nancy Pelosi, March 20, 2010, available at <http://www.cbo.gov/doc.cfm?index=11379>.
- 14 Note that employers with workers who take advantage of the Medicaid expansion are not penalized; this "anti-crowd-out" feature that was part of draft legislation is not included in the final version. However, if at least one FTE takes a subsidy, the fine is paid on all FTEs minus 30.
- 15 The firm size threshold and the fines are both higher than in the Massachusetts reform enacted in 2006 (which used 11 workers as the threshold for defining a large firm and \$295 per full time employee as the fine). See <http://www.mass.gov/legis/summary.pdf> for a summary of the provisions.
- 16 See footnote 6 and related discussion.

- 17 Larry Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79 (2) (1989):177-183.
- 18 Agency for Healthcare Research and Quality, "Table I.A.2.c(2008) Percent of private-sector establishments that offer health insurance that offer at least one health insurance plan that required no contribution from the employee for family coverage by firm size and selected characteristics: United States, 2008," available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tia2c.htm.
- 19 Agency for Healthcare Research and Quality, "Table I.B.3.b.(2)(2008) Percent of private-sector full-time employees that are enrolled in health insurance at establishments that offer health insurance by firm size and selected characteristics: United States, 2008," available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tib3b2.htm Low wage defined at more than 50% of employees earning at or below \$11/hr in 2008.
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- 31 Simon, K. "What Have We Learned From Research on Small-group Insurance Reforms?" in Alan C Monheit and Joel Cantor eds. *State Health Insurance Market Reform* (New York: Routledge, 2004).
- 32 Losaso, A. and I. Lurie. "Community Rating and the Market for Private Non-group Health Insurance," *Journal of Public Economics* 93 (1-2) (2009): 264-279.
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- 37 Letter from Doug Elmendorf to Evan Bayh, November 30, 2009.
- 38 The history of the employer health insurance system is documented by standard health economics text authors such as Sherman Folland, Allen C. Goodman, and Miron Stano, *The Economics of Health and Health Care*, 5th Edition (New York: Prentice Hall, 2006). and in Janet Currie and Brigitte Madrian, "Health, Health Insurance, and the Labor Market," in Orly Ashenfelter and David Card, eds., *Handbook of Labor Economics*, Edition 1, Volume 3 (Maryland Heights, MO: Elsevier, 1999).
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- 41 Michael Collins. "A Primer on the Self-Insured Health Plan Nondiscrimination Rules," *Journal of Pension Planning and Compliance* 25 (2) (1999): 1-15. Collins explains that since 1978, except for the period 1986 to 1989, the nondiscrimination statues applied only to self-insured firms. From 1986 to 1989 it applied to self-insured and commercially insured plans alike.
- 42 Phillip Cooper, Kosali Simon, and Jessica Vistnes, "A Closer Look at the Managed Care Backlash," *Medical Care* 44 (5) (2006): 1-11.
- 43 In thinking about the generosity of the health insurance contract, rather than just thinking of the dollars to be spent on a policy, one can think of it as being a variable $k(x)$, which is the fraction of medical expenses that will be covered by the policy. The choice of k will depend on characteristics x like age of workers, income and education. Under perfect sorting of workers, the workers will be homogenous within a firm, thus " x "s will all be the same within the firm.
- 44 Goldstein and Pauly make a distinction between an employer decision versus a union decision. In the end, both are reflecting preferences of workers, but it could be that the workers whose voice is heard the most is different. This is a theme echoed in later work on unions (Freeman and Medoff, 1984), that unions reflect the voice of older more established workers while the employer would otherwise cater to the wishes of the employees who are most likely to leave if their wishes are not met-younger, less established workers. This also means that as retiree health insurance in particular has become very expensive, unions may concentrate more of their efforts in that area rather than health insurance for the non-elderly given the age profile of union voices.
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- 55 There is a literature that shows productivity effects of better health (R. Kessler and P. Stang (ed) 2006. *Health and Work Productivity*. Chicago. University of Chicago Press.) For a review of papers on whether health insurance increases productivity, see E. O'Brien. 2003. "Employer Benefits from Workers' Health Insurance". *The Milbank Quarterly*. Vol 81 (1)pp.5-43. Employers may try to elicit information about workers by offering health insurance even absent any other benefit to the firm (see theory by A. Marino and J. Zaboynik, 2008: "A Rent Extraction View of Employee Discounts and Benefits". *Journal of Labor Economics*, vol 26 (3). Pp.486-518)
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