It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate

Timely Analysis of Immediate Health Policy Issues

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Summary

There will be a one-year delay in the implementation of employer penalties for large employers (50 or more workers) who do not offer affordable coverage to their full-time workers (30 or more hours per week) under the Affordable Care Act (ACA). Some viewed the employer responsibility requirement as a key part of the ACA and the penalties as being an important tool for securing employer based insurance coverage once other reforms to the nongroup market are implemented. However, our analysis shows otherwise. In addition, some have suggested that it is unfair to leave the individual mandate in place while delaying the employer mandate. Our analysis shows that the different requirements have dramatically different implications for cost and coverage under reform.

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), a state-of-the-art microsimulation model for estimating the cost and coverage implications of an array of changes to the health care system. The analysis compares the distribution of coverage under the full ACA, the ACA without an employer mandate, and the ACA without an individual mandate. We show that the employer mandate delay has almost no effect on overall coverage under the ACA or the distribution of that coverage across public and private sources of coverage. Eliminating the individual mandate, however, would significantly increase the number of uninsured compared to full implementation of the ACA, decreasing employer coverage as well. These findings are consistent with the evidence in Massachusetts, where coverage reforms were implemented beginning in 2006. The delay of the employer mandate also has little effect on government spending on subsidies or Medicaid, but does result in a slight reduction in government revenue.

While a delay of one year in the implementation of the employer mandate will not have a discernible effect on coverage or government spending on insurance, delaying the individual mandate would undermine a critical component of the coverage expansion in the ACA. Combined with the Medicaid expansion, insurance market reforms, and subsidies to assist those with modest incomes to purchase private insurance through the health insurance exchanges, the ACA's individual responsibility requirement provides stability to insurance pools and financial access to adequate coverage for a broad swath of the population disadvantaged by the prior system.

Introduction

On July 2, the Obama administration announced a one-year delay in the implementation of employer penalties for large employers (50 or more workers) who do not offer affordable coverage to their full-time workers (30 or more hours per week) under the Affordable Care Act (ACA).[1] Under the law, a penalty is imposed on larger employers if at least one of their full-time employees purchases coverage through one of the new nongroup health insurance exchanges (or marketplaces) and uses a federal subsidy to do so. The announcement of the delay was met with some suggesting that the employer penalties amounted to a key component of the ACA and, as such, inferring that the delay was further evidence that the law was unworkable.[2] Some members of Congress and some health policy analysts expressed their feelings that it was "unfair" to delay the penalty on employers but to leave the penalty on individuals in place, indicating that the individual responsibility requirement ought to be delayed as well.[3]

In contrast, our analysis compares the effectiveness of the two policies and shows that the employer responsibility requirement is not central to expanding insurance coverage and does not have substantial effects on the public and private costs associated with the coverage expansion. That is, the ACA can achieve all its major objectives without the employer responsibility provisions. On the other hand, the individual mandate is clearly a central component of the law and its anticipated coverage expansion.

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we show that the employer mandate delay has almost no effect on overall coverage under the ACA or the distribution of that coverage across public and private sources of coverage. Eliminating the individual mandate,

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Table 1: Health Insurance Coverage Distribution of the Nonelderly, With and Without Reform

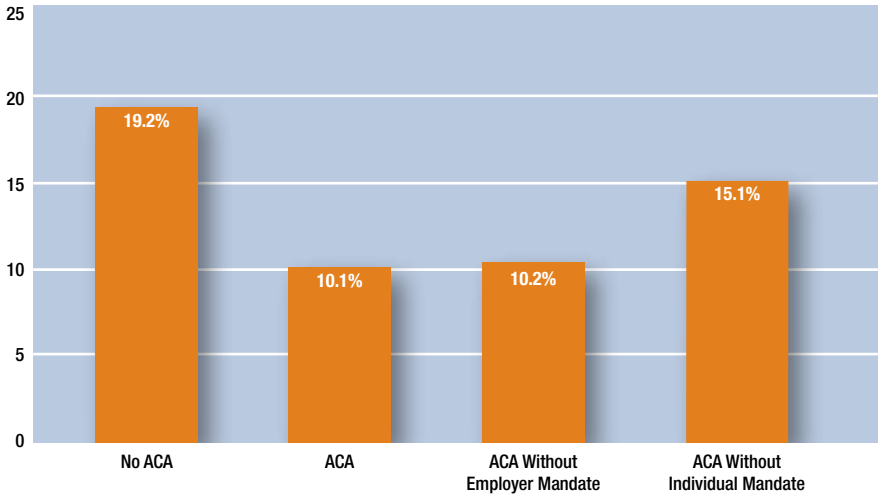
	No ACA		ACA		ACA Without Employer Mandate		ACA Without Individual Mandate	
	N	%	N	%	N	%	N	%
Insured	224,255,000	80.8%	249,541,000	89.9%*	249,206,000	89.8%	235,500,000	84.9%
Employer (Non-Exchange)	153,914,000	55.5%	148,203,000	53.4%	147,303,000	53.1%	142,839,000	51.5%
Employer (Exchange)	0	0.0%	10,112,000	3.6%	10,925,000	3.9%	9,009,000	3.2%
Employer Total	*153,914,000*	*55.5%*	*158,315,000*	*57.1%*	*158,228,000*	*57.0%*	*151,848,000*	*54.7%*
Nongroup (Non-Exchange)	15,218,000	5.5%	2,660,000	1.0%	2,658,000	1.0%	2,043,000	0.7%
Nongroup (Exchange)	0	0.0%	15,881,000	5.7%	15,671,000	5.6%	11,483,000	4.1%
Nongroup Total	*15,218,000*	*5.5%*	*18,541,000*	*6.7%*	*18,329,000*	*6.6%*	*13,526,000*	*4.9%*
Medicaid/CHIP	*46,317,000*	*16.7%*	*63,879,000*	*23.0%*	*63,843,000*	*23.0%*	*61,320,000*	*22.1%*
Other (including Medicare)	*8,807,000*	*3.2%*	*8,807,000*	*3.2%*	*8,807,000*	*3.2%*	*8,807,000*	*3.2%*
Uninsured	53,214,000	19.2%	27,928,000	10.1%	28,264,000	10.2%	41,969,000	15.1%
Total	277,469,000	100.0%	277,469,000	100.0%	277,469,000	100.0%	277,469,000	100.0%

Source: Urban Institute analysis, HIPSM 2013

Note: The ACA simulated as if fully implemented in 2013.

however, would significantly increase the number of uninsured compared to full implementation of the ACA, decreasing employer coverage as well. These findings are consistent with the evidence in Massachusetts, where coverage reforms were implemented beginning in 2006. The delay of the employer mandate also has little effect on government spending on subsidies or Medicaid, but does result in a slight reduction in government revenue.

Figure 1: Share of the Non-Elderly Who are Uninsured Today Compared with Reform



Source: Urban Institute analysis, HIPSM 2013

Note: The ACA simulated as if fully implemented in 2013.

Approach

We use the Urban Institute's HIPSM to estimate the effects of health reform among the nonelderly population.[4] The Urban Institute has more than 10 years of experience using detailed microsimulation models to simulate the effects of changes in health policy, including analysis of Massachusetts' landmark health reform law. HIPSM is our latest model, and it has been used in more than 40 publications and research reports since its launch in 2009. National ACA results using HIPSM are generally comparable to those of other commonly used models, such as that used by the Congressional Budget Office (CBO).

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model estimates changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully phased in today (2013).[5] Individuals age 65 and over eligible for Medicare are excluded from the analysis. Results are simulated as if each state eventually chooses to participate in the Medicaid expansion; this assumption has no effect on the relative differences across the policy options examined here.

We provide coverage and spending simulation results under four scenarios:

- No ACA;
- Full implementation of all the ACA's policies;
- ACA with no employer mandate (individual mandate and all other coverage-related reforms in place); and
- ACA with no individual mandate (employer mandate and all other coverage-related reforms in place).

Table 2: Health Care Spending of Government and Employers, With and Without Reform (in millions)

	No ACA	ACA	ACA Without Employer Mandate	ACA Without Individual Mandate
Government Spending				
Medicaid/SCHIP[a]	$284,253	$344,105	$344,276	$337,955
Federal Share	$162,984	$224,464	$224,694	$220,325
State Share	$121,269	$119,642	$119,582	$117,630
Premium Subsidies	$0	$37,473	$37,036	$31,808
Cost-Sharing Subsidies	$0	$4,166	$4,161	$3,328
Employer Subsidies	$0	$4,368	$4,343	$4,035
Individual Mandate Penalties	$0	-$3,540	-$3,552	$0
Employer Mandate Penalties	$0	-$3,717	$0	-$6,108
Net Government Spending	**$284,253**	**$382,856**	**$386,263**	**$371,018**
Employer Spending				
ESI Premiums	$597,669	$612,743	$613,138	$571,039
Employer Mandate Penalties	$0	$3,717	$0	$6,108
Employer Subsidies	$0	-$4,368	-$4,343	-$4,035
Net Employer Spending	**$597,669**	**$612,092**	**$608,795**	**$573,112**

Source: Urban Institute analysis, HIPSM 2013

Note: The ACA simulated as if fully implemented in 2013.

[a] Spending on acute care costs for the nonelderly.

Results

Coverage. Table 1 shows the distribution of insurance coverage for each of the four policy scenarios: no ACA, full ACA, ACA without the employer mandate, and ACA without the individual mandate. The share of the population uninsured under each policy scenario is also shown graphically in Figure 1. Under the full implementation of the ACA, the share of the nonelderly population uninsured is estimated to decline from 19.2 percent absent any reform to 10.1 percent. Nongroup and employer coverage both increase, but the reason for more than half of the decline in the uninsured is the increase in Medicaid coverage, under our assumption that all states participate.[6] This impact on overall coverage is essentially unchanged if the employer mandate is removed from the rest of the ACA's reforms; the share uninsured falls to 10.2 percent instead of 10.1 percent under the full reform.

Eliminating the employer mandate has very little effect on the distribution of coverage; it remains virtually identical to the case when the full ACA is in effect.[7] In particular, there is no large movement from employer-based coverage to the nongroup exchanges. Most employers offer coverage today, when they face no penalty, and they will, by and large, continue to do so under the ACA.[8] The bottom line: most workers' firms will be dominated by workers who will receive better benefits and, through the tax system, better subsidies through the tax exclusion for employer-provided coverage than for coverage purchased through newly created insurance exchanges. If employers were to drop coverage, over time they inevitably would make their most valued workers worse off. If those workers sought employment elsewhere as a result, then the firm would be worse off as well. Thus, under the ACA, the employer penalty is not what keeps employers offering coverage; it is the preferences of their workers, the same reason large employers are very likely to offer coverage even before implementation of health care reform.[9]

Eliminating the individual mandate has a much greater impact, with insurance coverage declining significantly. Without the individual mandate, the share of the nonelderly population uninsured would only fall to 15.1 percent of the population. In contrast, under the full ACA, the uninsured falls to 10.1 percent of the population. This difference in coverage means that an extra 13.7 million people would be uninsured under the ACA without an individual mandate compared to the situation with no employer mandate. Even without an individual mandate, insurance coverage remains above the levels with no reform at all, since some individuals will take advantage of increased eligibility for Medicaid and subsidized insurance coverage in the nongroup exchange even without a requirement to do so.[10]

In the absence of an individual mandate, the rate of employer-sponsored insurance coverage (exchange and nonexchange combined) would be lower than under the full ACA: 54.7 percent of the nonelderly compared to 57.1 percent of the nonelderly. Nongroup coverage and Medicaid/CHIP coverage would be lower as well.

Our earlier analysis[11] showed that the individual mandate combined with income-related financial assistance for the purchase of nongroup coverage, even in the absence of an employer mandate, increases employer-based insurance coverage. This microsimulation finding was since confirmed by survey results following implementation of comprehensive health reform in Massachusetts.[12,13] Once the individual requirement to have coverage is in place, uninsured individuals identify the best source for obtaining that coverage. For a significant number of them, their best option will be to purchase coverage through

their employer. As a result, some workers will take up offers they had previously declined, and some employers will begin to offer coverage for the first time, knowing that their employees are newly willing to trade off some of their wages in order to receive some of their compensation as health insurance.

Government and Employer Spending. Eliminating the employer mandate from the ACA has very little effect on government spending (table 2). Medicaid and spending on exchange-based premium and cost-sharing subsidies remain largely unchanged between the full-ACA and no-employer-mandate scenarios. There is about a 1 percent decrease in premium and cost-sharing subsidies paid through the exchanges, which parallels a roughly 1 percent decline in exchange-based coverage. Overall, these findings reflect the results discussed previously that there is almost no difference in the distribution of insurance coverage.

The only noticeable difference when the employer mandate is dropped is that the federal government loses the $3.7 billion in revenue that it would otherwise receive from employer penalties, a finding comparable to that of CBO.[14] Likewise, there is virtually no change in employer spending on premiums, since employer coverage stays quite constant.[15] Employers do save, however, by not paying penalties.

By contrast, eliminating the individual mandate but leaving the employer mandate in place does lead to significant differences in spending. Medicaid spending is $6.2 billion lower due to fewer individuals enrolling in the program absent the individual mandate. As has been seen in Massachusetts, even those groups who would not be directly subject to an individual mandate penalty—due, for example, to exemptions for being low income—increase their take-up of Medicaid in the presence of an individual mandate. This may stem from misunderstanding their exempt status or from changes in social expectations of coverage in the presence of a general requirement affecting others. As a result, without the individual mandate, even the number of individuals covered by Medicaid will be lower, as will spending on the program.

As a consequence of lower demand for employer-based coverage absent an individual mandate, small employers are less likely to offer coverage to their workers, lowering federal spending on small employer subsidies by about $300 million. Individual mandate penalties are eliminated in this scenario, decreasing federal revenue by about $3.5 billion relative to the full ACA case.

If the individual mandate is eliminated but the employer mandate is kept in place, employer penalties are significantly higher; federal revenues mount to $6.1 billion compared to $3.7 billion under the full ACA implementation. This results from a smaller number of workers in firms of 50 or more being offered coverage without an individual mandate. Some of these workers purchase insurance through exchanges and receive subsidies, leading to their firms being assessed penalties. Without the individual mandate, the demand for health insurance among some workers falls, and some employers no longer offer it. We estimate that about 2 million fewer workers in large firms would receive offers without an individual mandate (data not shown), and thus more large employers are subject to employer mandate penalties.[16]

Employer premium spending in the absence of the individual mandate is lower than under the full ACA, as fewer workers and dependents are covered. Large employers' spending on penalties is higher and small employer subsidies are modestly lower, as was already discussed.

Discussion

Microsimulation results using HIPSM show that the ACA's individual mandate has a significant effect on health insurance coverage and spending by government and employers, but the employer mandate does not. Delaying or eliminating the individual mandate would significantly decrease insurance coverage relative to the full ACA's implementation, whereas delaying or eliminating the employer mandate will have essentially no effect on coverage or program costs.

The employer mandate is not central to the coverage goals of the ACA, though it does play a very modest financing role. Some have argued that the employer mandate will dissuade employers that currently offer coverage to their workers from stopping doing so once the rest of the reforms are in place. However, the analytic evidence and the experience in Massachusetts does not support the need for employer penalties for that purpose. Thus, a delay of one year in its implementation will not have a discernible effect in that regard.

The individual mandate, in contrast, is a critical component of the coverage expansion in the ACA. Combined with the Medicaid expansion, insurance market reforms, and subsidies to assist those with modest incomes to purchase private insurance through the health insurance exchanges, the ACA's individual responsibility requirement provides stability to insurance pools and financial access to adequate coverage for a broad swath of the population disadvantaged by the prior system. The principal objectives of the law can be met without the employer requirement, and implementation of the law should be made considerably easier without it.

Endnotes

[1] Mazur MJ. "Continuing to Implement the ACA in a Careful, Thoughtful Manner." *Treasury Notes*. July 2, 2013. http://www.treasury.gov/connect/blog/pages/continuing-to-implement-the-aca-in-a-careful-thoughtful-manner-.aspx. On July 5, 2013, the Department of Health and Human Services (HHS) announced a new rule, which included changes to the subsidy eligibility verification process for state-based exchanges. This rule includes a narrow exception for 2014 related to verification of affordable offers of employer insurance. The federal government had originally intended to conduct random sample checks of cases of individuals reporting whether they have job-based insurance, but that federal assistance will not be available until 2015. HHS is allowing the 16 states running their own exchanges to accept individuals' reports without doing sampling until HHS can begin doing it in 2015. Workers are still required, however, to provide information from their employers on coverage offered in the workplace. Judy Solomon provides a clear explanation of the verification delays at her blog, http://www.offthechartsblog.org/author/solomon/.

[2] See, for example, Calmes J and Pear R, "Crucial Rule Is Delayed a Year for Obama's Health Law," *New York Times*, July 2, 2013, http://www.nytimes.com/2013/07/03/us/politics/obama-administration-to-delay-health-law-requirement-until-2015.html?ref=politics; Kliff S, "White House Delays Employer Mandate Requirement until 2015," *Washington Post*, July 2, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/02/white-house-delays-employer-mandate-requirement-until-2015/; and Miller Z, "Obama Administration Delays Health Care Law Employer Penalty until 2015," *TIME*, July 2, 2013, http://swampland.time.com/2013/07/02/obama-administration-delays-healthcare-law-employer-penalty-until-2015/.

[3] See for example: Weisman J, "Seeing Opening, House G.O.P. Pushes Delay on Individual Mandate in Health Law," *New York Times*, July 9, 2013, http://www.nytimes.com/2013/07/10/us/politics/house-gop-pushes-delay-on-individual-mandate-in-health-law.html?_r=1&; Calmes J, "Postponing Health Rules Emboldens Republicans," *New York Times*, July 3, 2013, http://www.nytimes.com/2013/07/04/us/politics/postponing-health-rules-emboldens-republicans.html?pagewanted=all&_r=0; "GOP to White House: ObamaCare Delay for Businesses Unfair to Everyone Else," *Fox News*, July 9, 2013, http://www.foxnews.com/politics/2013/07/09/gop-to-white-house-obamacare-delay-for-businesses-unfair-to-everyone-else/; and Morgan D "Could Obama Administration Delay the Individual Mandate?" *Denver Post*, July 5, 2013, http://www.denverpost.com/breakingnews/ci_23603893/could-obama-administration-delay-individual-mandate.

[4] For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/publications/412154.html. A more technical description of the construction of the model can be found at http://www.urban.org/publications/412471.html.

[5] Ideally, we would simulate reform in a future year, such as 2017, when the ACA and the associated behavioral changes of employers and individuals would be fully phased-in. Doing so requires an array of assumptions about the growth in health care expenditures, changes in employment and incomes, and other factors. For simplicity, here we simulate the reforms fully phased-in in the current year, and the comparisons across policy options are not affected by the choice of year.

[6] Ten percent of the population is estimated to remain uninsured for various reasons: some are exempt from the individual mandate because they do not have an affordable coverage option available to them, some are undocumented immigrants ineligible for new coverage options or financial assistance, and others have affordable coverage options available to them but choose not to enroll. See Buettgens M and Hall M. "Who Will Be Uninsured After Health Insurance Reform?" Washington: The Urban Institute, 2011, available at http://www.urban.org/UploadedPDF/1001520-Uninsured-After-Health-Insurance-Reform.pdf.

[7] One noticeable exception is that a slightly larger share of employer coverage is expected to be purchased through the small group exchanges without the employer mandate. This occurs due to changes in source of coverage for a small number of families with one working spouse in a large firm and one in a small firm. In the absence of the employer mandate, a slightly smaller share of large-firm workers will have offers of coverage from their employer; consequently, if their spouse has an offer through a small employer, the family is more likely to obtain their coverage that way. There is also a very slight decrease in nongroup coverage through the exchange of about 1 percent. When the number of workers offered declines by even a very small number, families change coverage decisions in both the group and nongroup markets, which have very small secondary effects on premiums in those markets, which lead small numbers of other individuals and families to change their coverage decisions. Microsimulation models capture these interactions and secondary effects, but they are very small and not meaningful.

[8] Blumberg L, Buettgens M, Feder J and Holahan J. "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act." *Timely Analysis of Immediate Health Policy Issues*. Washington: The Urban Institute, 2011, available at http://www.urban.org/publications/412428.html.

[9] The ACA with employer penalties in place may, however, provide incentives for employers to reduce premium contributions for their lowest income workers if that is necessary to avoid penalties. If so, some employers could decrease overall premiums by modifying the plans they offer by increasing deductibles or other cost-sharing responsibilities. We do not model such potential changes to employer/worker premium divisions and cost-sharing structure of plans.

[10] Absent an individual mandate, some individuals otherwise excluded from the nongroup market will enter it, and others will leave that market due to the broader sharing of health care risk through modified community rating and other changes to insurance market rules, ultimately leaving nongroup coverage at a lower level than the case without any reforms.

[11] Blumberg LJ, Holahan J, Weil A, et al. "Toward Universal Coverage in Massachusetts." *Inquiry*, 43(2): 102–21, June 2006.

[12] Long SK, Stockley K and Nordahl KW. "Coverage, Access, and Affordability under Health Reform: Learning from the Massachusetts Model." *Inquiry*, 49(4): 303–16, Winter 2012/2013.

[13] Employers of 11 or more workers who do not make a "fair and reasonable contribution" toward their workers' health insurance can be assessed a penalty of up to $295 per worker per year. This nominal assessment is small enough to be roughly equivalent to an example of comprehensive reform with an individual mandate but not an employer mandate. Our microsimulation analysis prior to the passage of the state's 2006 reforms compared a scenario with an individual mandate and a "play or pay" employer mandate to an identical reform that excluded the employer mandate.

[14] Reports indicate that the CBO estimates lost revenue from elimination of the employer penalties at $4 billion in 2014. See Kennedy K, "Delay of Employer Penalties Could Have Unintended Effects," *USA Today*, July 7, 2013, http://www.usatoday.com/story/news/politics/2013/07/03/how-hc-delay-will-affect-budget/2486499/

[15] Our results show aggregate employer spending on premiums of roughly .06 percent higher without the employer mandate than with it. This aggregate increase is a result of average employer premiums increasing by less than 1 percent without the employer mandate, due to very modest changes in the risk pool of insured workers. That premium increase is barely noticeable, but in aggregate it leads to slightly higher overall employer spending on premiums as shown in table 2.

[16] Without an employer mandate, roughly 1 million fewer workers in large firms would have an employer offer of coverage through their own job (data not shown).

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