

**Testimony before the Health Subcommittee of the House Ways & Means
Committee**

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Delaying the ACA Employer Mandate

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Summary

The employer mandate does not further the Affordable Care Act's goal of expanding access to health insurance coverage. Indeed, the mandate effectively penalizes employers for hiring low-income Americans. Delaying the employer mandate by one year does not alter these long-term incentives, but it does complicate the implementation of ACA exchange subsidies and enforcement of the individual mandate.

H.R. 903, the American Job Protection Act, is a bipartisan bill that would repeal the employer mandate. That bill, if enacted into law, would eliminate these perverse incentives. It would also encourage a transition away from employer-sponsored health coverage into individually-purchased coverage, a transition that health care economists have long advocated. The Congressional Budget Office believes that such a transition would not meaningfully affect the net fiscal cost of the Affordable Care Act, because increased exchange subsidies would be offset by a reduction in lost revenue from the tax exclusion for employer-sponsored insurance.

H.R. 903 could be improved by taking into accounts its impact on exchange subsidies and the individual mandate. For example, the individual mandate could be replaced with a more limited open-enrollment period for participating in ACA-certified insurance plans.

We all want an economy in which those at the bottom of the ladder have the opportunity to find gainful employment and good health care. The employer mandate harms those it is intended to help. Instead of delaying it, we should repeal it.

Written Statement

Chairman Brady, Ranking Member McDermott, and members of the Health Subcommittee: thanks for inviting me to speak with you today about the Affordable Care Act's employer mandate.

My name is Avik Roy, and a Senior Fellow at the Manhattan Institute for Policy Research, in which capacity I conduct research on health care and entitlement reform.

In my remarks today, I'll focus on three questions. First, does the employer mandate help the Affordable Care Act achieve its goals? Does it work? Second, what are the ramifications of the White House's decision to delay the employer mandate by one year? Third, what would be the policy impact of H.R. 903, the American Job Protection Act, which would repeal the employer mandate in its entirety?

Does the employer mandate work?

While the Affordable Care Act strives to achieve many things, the law's primary goal is to move the United States as close as possible to universal health insurance coverage. Does the employer mandate help to achieve this goal? My view, and the view of many others across the spectrum, is that it does not.

According to the Medical Expenditure Panel Survey, 97 percent of firms with 50 or more workers already offer health benefits. 97 percent is not 100 percent, of course, and not all firms offer coverage to every employee. But the ACA's employer mandate, perversely, incentivizes employers to avoid hiring low-income workers, precisely the type of workers who tend to be uninsured. As the Center on Budget and Policy Priorities put it in 2009, "In essence, affected firms would pay a tax for hiring people from low- or moderate-income families."

The penalties associated with the employer mandate are only triggered if a worker is not offered what the ACA deems "affordable" coverage, and if the worker then gains subsidized coverage on

an ACA-sponsored insurance exchange. As a result, employers have four incentives: (1) to hire fewer full-time workers; (2) to offer so-called “unaffordable coverage,” for which the penalties are lower; (3) to hire workers from high-income families, who are not eligible for exchange subsidies; and (4) to hire illegal immigrants, who are also ineligible for subsidies.

In sum, the employer mandate penalizes firms for hiring low-income Americans. Through the Affordable Care Act, these individuals would still be able to gain subsidized health insurance. But they will be tagged with a scarlet “S”—for gaining those subsidies—because, to employers, hiring subsidized individuals will be far more costly than hiring unsubsidized ones.

What is the impact of the one-year delay?

A one-year delay of the employer mandate does give the Treasury Department more time to implement the law. But a delay does not fundamentally alter the perverse incentives I have just described. It simply gives employers an additional year to restructure their workforces accordingly.

A one-year delay does, however, impact other important provisions of the Affordable Care Act. In order to gain eligibility for subsidized coverage on the exchanges, an individual must prove that he has not been offered “affordable” coverage from his employer. But now that the reporting requirements of the employer mandate have been delayed, it may be difficult for him to prove or disprove that.

Hence, it appears that CMS will rely on applicants’ attestations—the “honor system”—to dispense subsidies in some cases. Similarly, the ACA’s individual mandate only works if the government can verify whether or not a worker is full-time or part-time, whether he has been offered “affordable” or “unaffordable” coverage, or none at all.

Delaying the employer mandate’s reporting requirements, therefore, affects the implementation of the subsidized exchanges and the individual mandate.

Is it desirable to repeal the employer mandate?

H.R. 903, the American Job Protection Act, is a bipartisan bill that was introduced last February by Representatives Boustany, Tiberi, Barrow, and Black, and referred to this Committee. It would repeal the employer mandate by striking Sections 4980H and 6056 of the Internal Revenue Code, and subsection (c) of Section 1513 of the Affordable Care Act.

Repealing the employer mandate would eliminate the perverse incentives I described earlier. Most importantly, it would encourage a transition away from costly, inefficient employer-sponsored coverage, and towards portable, individually-owned insurance policies. As you all know, economists have long advocated for this transition, and repealing the employer mandate would go a long way toward achieving it. In this way, the passage of H.R. 903 could emerge as a major policy advance.

Some analysts have raised concerns that such a transition would increase the fiscal cost of the Affordable Care Act, due to increased spending on exchange subsidies. However, in March 2012, the Congressional Budget Office estimated that if an additional 14 million workers moved from employer-based to exchange-based coverage, the deficit would actually decrease by \$13 billion over ten years. This is because the increase in exchange subsidies is offset by a reduction in lost revenue from the tax exclusion for employer-sponsored insurance.

It will be important for H.R. 903 to be adjusted in order to take into account its impact on the disbursement of subsidies and the individual mandate. The individual mandate, for example, could be replaced with a more limited open-enrollment period for participating in ACA-certified insurance plans. This would achieve the individual mandate's goal of curbing adverse selection, without the mandate's intrusiveness.

The employer mandate harms those it is intended to help

I will conclude by recalling that scarlet “S.” We all want an economy in which those at the bottom of the ladder have the opportunity to find gainful employment and good health care. The employer mandate harms those it is intended to help. Instead of delaying it, we should repeal it.

Thanks again for having me. As an addendum to my written testimony, I’ve included three articles from *Forbes*, in which I further expand on these issues.

I look forward to your questions, and to being of further assistance to this committee.

Addendum: Excerpts from Avik Roy Articles at Forbes.com

May 21, 2013: Employers Can Minimize Their Exposure To Obamacare's Penalties By Offering Low-Cost 'Skinny' Coverage

<http://www.forbes.com/sites/theapothecary/2013/05/21/employers-can-minimize-their-exposure-to-obamacares-health-insurance-mandate-by-offering-low-cost-skinny-coverage/>

The employer mandate gives employers “an incentive to offer coverage that is either ‘unaffordable’ according to Obamacare or that fails to meet the law’s ‘minimum essential requirements.’” Let’s delve into that further, as this aspect of Obamacare is likely to have far-reaching consequences for the way that employers offer health coverage in the future.

Poll after poll shows that Americans who have health insurance—most through their employers—are happy with the health coverage they have. According to Gallup, around 70 percent consider their coverage to be “excellent” or “good.” Democrats’ push to nationalize health care in the early 1990s, led by Hillary Clinton, failed largely because the vast majority of voters who have health insurance feared that it would be too disruptive to their existing arrangements.

That’s why President Obama, in his Obamacare pitch, repeatedly promised that “if you like your health care plan, you can keep your health care plan.” And it’s why the Affordable Care Act includes an employer mandate. Because Obamacare subsidizes private coverage for the uninsured, Democrats wanted to make sure that employers didn’t have an incentive to drop coverage for workers and send them onto the new subsidized exchanges.

So they put in an employer mandate to force employers to continue covering their workers; if workers ended up accepting exchange subsidies, employers would face significant fines.

However, due to some technicalities in the way that the employer mandate works, the actual consequence of the law will be to incentivize employers to offer de minimis coverage for their

workers, coverage that some workers will then reject by seeking more favorable terms on the Obamacare exchanges.

The strong penalty vs. the weak penalty

The employer mandate actually consists of two different penalties, based on two different categories of employer behavior. These originate from Section 4980H of the Affordable Care Act. Subsection (a) requires steep penalties for employers who offer no coverage at all. Subsection (b) requires modest penalties for employers who offer “minimum essential coverage under an eligible employer-sponsored plan.” This difference—between the strong penalty in 4980H(a) and the weak penalty in 4980H(b)—is crucial to understanding how things will play out in the future.

Under the strong penalty, in which an employer “fails to offer to its full-time employees...the opportunity to enroll in minimum essential coverage,” and “at least one full-time employee” enrolls in an exchange, the employer has to pay a fine of \$2,000 times the total number of full-time-equivalent employees at the firm, minus 30. (The employer mandate only applies to firms with 50 or more full-time-equivalent workers.) So if you employ 50 workers, that’s a fine of $20 * \$2,000 = \$40,000$. And the fine isn’t tax-deductible, adding to the pain.

Under the weak penalty, in which an employer does offer “the opportunity to enroll in minimum essential coverage,” but that coverage doesn’t meet Obamacare’s requirements for affordability or actuarial value, and at least one worker enrolls on an exchange instead, the fine is \$3,000 times the number of workers who enroll on the exchanges. So, if you employ 50 workers, and three of them get coverage on the exchange instead, the fine is a much lower $3 * \$3,000$, or \$9,000. (Technically, in subsection (b), employers pay the lesser of the weak penalty or the strong penalty, but this in most cases should be the weak penalty.)

So: Employers avoid the strong penalty and gain eligibility for the weak penalty by offering “minimum essential coverage.” So what is “minimum essential coverage?”

‘Minimum essential coverage’ is very broadly defined

The legal term “minimum essential coverage” is defined by Section 5000(A)(f) of the Internal Revenue Code. The IRC states that minimum essential coverage can consist of either (a) government-sponsored coverage, such as Medicare or Medicaid; (b) an “eligible employer-sponsored plan”; (c) a plan “offered in the individual market within a State”; (d) a “grandfathered health plan”; or (e) anything else that the Secretary of Health and Human Services deems appropriate.

So what is an “eligible employer-sponsored plan?” Paragraph 2 of Section 5000(A)(f) defines one as “a group health plan or group health insurance coverage offered by an employer to the employee which is [either a government-sponsored plan] or “any other plan or coverage offered in the small or large group market within a State.”

In other words, any health insurance plan that is legally sold within a state’s boundaries counts as an “eligible employer-sponsored plan.” In many states, insurers market inexpensive plans that cover a limited range of services. According to Obamacare, employers can offer these inexpensive plans to their workers and thereby avoid the employer mandate’s strong penalty.

This has significant ramifications for sectors of the economy that employ hourly-wage workers, such as restaurant chains McDonalds (NYSE:MCD); Burger King (NYSE:BKW); Dunkin Brands Group (NASDAQ:DNKN); Yum! Brands (NYSE:YUM), owners of Taco Bell, Pizza Hut, and KFC; and Darden Restaurants (NYSE:DRI), owners of Red Lobster, Olive Garden, and Capital Grille, among others.

Employers can minimize fines by offering ‘skinny’ coverage

All of this is the context for an article that appeared yesterday in the *Wall Street Journal*, highlighting the emerging recognition of this method for avoiding the employer mandate’s strong penalty. Reporters Christopher Weaver and Anna Wilde Mathews confirmed with federal officials that this strategy is a viable one.

Nonetheless, Obamacare’s designers expressed surprise that employers would do such a thing. “Our expectation was that employers would offer high quality insurance,” said Robert Kocher, a former Obama health care adviser.

Weaver and Mathews of the *Journal* report that Bill Miller Bar-B-Q, an excellent fast-food chain in San Antonio, will offer just such a skinny plan to avoid the strong penalty. The plan will cover preventive services, doctors’ visits and generic drugs, but not surgeries nor hospital stays, and cost less than \$600 a year:

San Antonio-based Bill Miller Bar-B-Q, a 4,200-worker chain, will replace its own mini-med with a new, skinny plan in July and will aim to price the plan at less than \$50 a month, about the same as the current policy, said Barbara Newman, the chain’s controller. The new plan will have no dollar limits on benefits, but will cover only preventive services, six annual doctors’ visits and generic drugs. X-rays and tests at a local urgent care chain will also be covered. It wouldn’t cover surgeries or hospital stays.

Because the coverage is limited, workers who need richer benefits can still go to the exchanges, where plans would likely be cheaper than a more robust plan Bill Miller has historically offered to management and that costs more than \$200 per month. The chain plans to pay the \$3,000 penalty for each worker who gets an exchange-plan subsidy.

Pan-American Life Insurance Group, the *WSJ* reporters write, is developing these bare-bones plans for the California market, along with other states. It’s almost certain that nearly all large employers of hourly-wage workers will go this route, given the clear economic incentives to do so.

Skinny coverage is a welcome development

The Oregon Medicaid experiment showed us Medicaid didn’t make people healthier, but it did provide financial protection to the uninsured. The lesson to draw from this is that the Singapore

model of catastrophic insurance and health savings accounts is the most cost-effective way to provide Americans with health security.

Obamacare incentivizes firms to dump their workers onto the exchanges, and to reduce the scale and scope of employer-sponsored coverage. Obamacare is, in fact, the most dramatic disruption to employer-sponsored health coverage in seventy years.

But if you step outside of the politics for a moment, and think about the policy, this disruption is actually a welcome development. Though Obamacare's exchanges are poorly designed, they at least offer Americans the opportunity to shop for insurance for themselves. A widespread shift to 'skinny' plans will do the same thing, by reducing the problem of over-insurance, and giving workers the opportunity to purchase supplemental catastrophic coverage for hospital care.

The next step in this transformation is for small businesses to press state legislatures to legalize a broader range of "skinny" health plans, so that insurers can offer the most cost-effective coverage possible.

Ultimately, Congress should repeal the employer mandate, because it makes it much costlier for employers to hire entry-level workers. And it's entry-level workers who are already suffering the most in the Obama economy. Until then, businesses will do what they have to do to compete in the real world.

March 15, 2012: Could Employer Dumping of Health Coverage Reduce the Deficit?

<http://www.forbes.com/sites/theapothecary/2012/03/15/if-employers-stop-paying-for-health-care-who-wins-maybe-everyone/>

One of the biggest concerns with the Affordable Care Act has been that the law will drive employers to stop sponsoring health insurance for their workers, instead dumping those workers on to the new law's subsidized insurance exchanges. The Congressional Budget Office, in a

provocative new report, believes that such behavior could, in some circumstances, actually reduce the deficit.

The ACA's exchange subsidies will lead to employer dumping

A number of credentialed budget wonks, most notably Gene Steuerle (a former Treasury Department official), Jim Capretta (a former health-care specialist at the White House Office of Management and Budget), and Doug Holtz-Eakin (a former director of the CBO), have pointed out that the ACA strongly incentivizes employers to drop coverage for their lower-to-middle-income employees, because those employees get a better deal by seeking out coverage on the law's new exchanges. "Droves of employees—potentially tens of millions—are likely to shift out of employer-provided insurance in the next decade or two," wrote Steuerle in a widely-cited report.

Indeed, the new CBO report agrees that the exchanges offer a better deal for the vast majority of people who qualify for the exchange subsidies. According to CBO's estimates, someone making \$50,000 a year (200 percent of the federal poverty level) would benefit \$11,300 a year by going onto the exchanges; someone making \$74,000 (300%) a year would benefit by \$3,000; and someone making the maximum \$99,000 a year (399%) would only lose \$700: a rounding error.

It's these numbers that drove the findings in the now-famous McKinsey survey that found that 50 percent of employers with a "high awareness of reform" would "definitely or probably" stop offering employer-sponsored insurance in the years after 2014. The McKinsey report detailed a number of creative strategies that companies could use to take advantage of the subsidies, such as increasing the use of part-time employees, and splitting a company into two parts: one that provided coverage for higher-income employees, and one that dumped lower-income workers onto the exchanges.

The fiscal risk of employer dumping

The big worry is that employer dumping could explode the deficit. “The CBO projects that the premium-assistance program will cost about \$450 billion from 2014 to 2019,” Capretta and Holtz-Eakin wrote in 2010. “But that cost would rise to \$1.4 trillion if workers and their family members between 133 percent and 250 percent of the poverty line were to migrate out of their current plans and into the exchanges on Day One.”

This is where the new CBO report gets interesting. Last year, on the heels of the McKinsey survey, a number of senators and congressmen, led by Orrin Hatch (R., Utah) and Paul Ryan (R., Wisc.) asked the CBO to evaluate a number of different scenarios in which employer dumping was more widespread than the CBO projects. In the new report, CBO argues that dramatic increases in employer dumping would reduce, not expand, the deficit.

The CBO modeled out four different scenarios, on top of their baseline projections for the Affordable Care Act. In Scenario 1, employers dump 7 million more people onto the exchanges and other public programs (Medicaid and the Children’s Health Insurance Program). In Scenario 2, employers actually increase coverage by 8 million people, due to the law’s employer mandate: effectively the inverse of Scenario 1. In Scenario 3, employers dump 14 million more people onto the exchanges; and in Scenario 4, companies use the McKinsey restructuring strategies to dump their lower-paid employees onto the exchanges, while continuing to pay for insurance for their higher-income workers.

CBO: employer dumping could reduce the deficit

According to the CBO, the scenario with the most widespread dumping, Scenario 3, actually reduced the deficit by \$13 billion from 2012 to 2022. The two other scenarios with dumping, Scenarios 1 and 4, increased the deficit by a relatively small amount: \$45 and \$36 billion, respectively. Scenario 2, in which employers covered more people, reduced the deficit by \$82 billion.

How could dumping more people onto the subsidized exchanges, in the case of Scenario 3, actually reduce the deficit? Because people who get insurance through the exchanges, rather than

their employers, would no longer be able to take advantage of the tax deduction for employer-sponsored health insurance.

So, for example, in Scenario 3, the CBO assumes that the government will spend \$310 billion more on the exchanges, and \$65 billion more on Medicaid and CHIP. On the other hand, the government will gain \$351 billion in tax revenue because of a reduction in the size of the employer tax exclusion, and \$45 billion in penalties from the employer mandate. Similar math, on a smaller scale, applies to the other scenarios.

If the CBO's analysis is correct, it would be encouraging news for the fiscal soundness of our new health law. But is it correct?

The CBO's critical assumptions: wage substitution and low premium growth

It appears that the CBO has made a critical assumption in its calculations: that employers who dump health coverage will replace that coverage, on a dollar-for-dollar basis, with increased cash wages. So, for example, if your boss is paying you \$50,000 a year, and spending \$20,000 a year on your health insurance, under the ACA, he'll drop your health coverage and give you \$70,000 in wages. Since you'd be paying income taxes on that extra \$20,000 of wages, whereas you weren't paying taxes on your employer-sponsored health insurance, the CBO estimates that the subsidies you'd get from the exchange are offset by new income taxes on your extra wages.

If the CBO is right, and we have little to worry about with regards to the fiscal risks of employer dumping under the ACA, this would be a very good thing. Indeed, if we could do so in a fiscally neutral way, moving people out of the employer-sponsored system into one in which individuals bought their own insurance would do a lot to bring choice and competition to our health-care system.

March 31, 2012: What's Democrats' Plan B If the Individual Mandate Goes Down?

<http://www.forbes.com/sites/theapothecary/2012/03/31/whats-democrats-plan-b-if-the-individual-mandate-goes-down/>

As I have noted in my several write-ups of this past week's oral argument at the Supreme Court, there is a reasonable chance that the Court will vote to strike down Obamacare in its entirety. But what happens if it doesn't? What happens if, instead, the Court strikes down only the mandate, leaving the rest of the law intact, or doing what the Administration suggests, and striking down the mandate and two limited provisions? And, in each of those cases, what could the law's supporters offer as a backup plan?

Strike One: The Supremes strike down the individual mandate only

Howard Dean and Paul Starr have been lonely voices on the Left in calling attention to the constitutional vulnerability of the individual mandate. "The American people aren't going to put up with a mandate," said Dean in 2010. "I've made this prediction before, and I'm going to make it again: by the time this thing goes into effect in 2014, I think the mandate will be gone. Either through the courts, or because it's unpopular."

In December, in a piece entitled "The Mandate Miscalculation," Starr noted that "the Court's general movement in restricting use of the commerce clause should have made Democrats wary of resting the mandate's constitutionality primarily on that basis, when they could have almost certainly have made the law bulletproof by [imposing] a tax to pay for health care, while providing an offsetting credit to those with insurance.

As Starr points out, this taxation-and-deduction method would have been equivalent to the mandate in policy terms, but would have been far sounder from a constitutional standpoint. I know that to many on the Left, this difference seems pedantic or trivial, but it most certainly is not: granting Congress the power to directly force Americans to enter into private contracts would be a dangerous, and unprecedented, act.

It's ironic that, given the fact that the mandate may end up bringing down the whole law, it's a weak mandate that might not have even successfully addressed the problem of adverse selection: people gaming the system in order to only buy insurance when they're sick.

In 2009, Starr proposed an alternative solution that would have easily passed constitutional muster: instead of a mandate, Obamacare could have adapted a German provision that requires those who opt out of insurance to wait five years before being able to gain guaranteed-issue insurance that doesn't exclude pre-existing conditions:

But Congress could address this problem more directly. The law could give people a right to opt out of the mandate if they signed a form agreeing that they could not opt in for the following five years. In other words, instead of paying a fine, they would forgo a potential benefit. For five years they would become ineligible for federal subsidies for health insurance and, if they did buy coverage, no insurer would have to cover a pre-existing condition of theirs.

The idea for this opt-out comes from an analogous provision in Germany, which has a small sector of private insurance in addition to a much larger state insurance system. Only some Germans are eligible to opt for private insurance, but if they make that choice, the law prevents them from getting back at will into the public system. That deters opportunistic switches in and out of the public funds, and it helps to prevent the private insurers from cherry-picking healthy people and driving up insurance costs in the public sector.