Women and Employer Mandates

Some health care reform proposals include an "employer mandate," which typically requires an employer of a certain size and/or with certain annual business revenue to contribute towards the health care of its employees.[1] Several states are currently considering health reform plans with an employer mandate and a number of federal proposals have also included this type of reform, but so far just three states—Hawaii, Massachusetts, and Vermont—and the city of San Francisco have enacted a policy requiring employers to pay for a portion of workers' health care costs.

What Is an Employer Mandate?

An employer mandate is a requirement that employers contribute to the cost of health insurance coverage for their employees. Employer mandates usually follow a "Pay or Play" design, which requires employers to either directly offer insurance to employees (Play) or contribute to a public fund to help cover the uninsured (Pay).[2] Employer-sponsored health insurance (ESI) is the leading source of coverage for non-elderly Americans, but the percentage of employers offering ESI to their workers is in decline; in 2000, 69 percent of employers offered health benefits, but in 2007, the portion had dropped to 60 percent.[3] Employer mandates also ensure that employers who provide health insurance for their workers do not suffer a competitive disadvantage for doing so.

What Challenges Are Associated with an Employer Mandate?

Employer mandates may generate strong opposition from businesses. It is likely that employers will organize to oppose employer mandates, since this type of reform will involve new expenses for firms that do not currently contribute anything towards the cost of their worker's health care. Indeed, business groups have presented major obstacles in states that have unsuccessfully considered "Pay or Play" policies in the past (such as California and Maryland) and some employer groups were strongly opposed to the failed national reform effort (which incorporated an employer mandate) of the early 1990's. Notably, Massachusetts legislators were able to pass a comprehensive health reform plan with the employer mandate intact and with the support of business groups. Many believe, however, that this support hinged on a relatively low (and inadequate) employer contribution requirement, since the annual employer assessment of $295 per uninsured employee is far lower than the annual costs of a worker's health coverage.

Employer mandates may unfairly penalize small businesses. Compared to large firms, small businesses are increasingly less likely to provide health benefits for their employees, largely due to cost.[4] This is particularly relevant for women, as small businesses that do not offer health benefits are more likely to have a larger proportion of female workers.[5] Most small businesses lack the purchasing power of larger employers. Reforms are necessary to ensure that small business owners have the ability to purchase quality, affordable coverage for their employees and that lower-revenue firms (which often employ low-wage workers) receive subsidies that make health insurance more affordable. In the absence of these changes, however, employer mandate policies must provide exemptions for these types of businesses so they are not unfairly penalized.

Employee Retirement Income Security Act (ERISA) may cause problems for employer mandates. A federal law known as the Employee Retirement Income Security Act of 1974 (ERISA) was enacted to make it easier for multi-state employers to administer employee benefits uniformly across states, but the legislation can also restrict states' abilities to establish "Pay or Play" employer mandates. Court challenges continue to define ERISA's limits for states pursuing health reform plans that include an employer mandate (see text box).

The *Healthy San Francisco* Program: Employer Mandates and the Employee Retirement Income Security Act (ERISA)

In 2006, San Francisco created the *Healthy San Francisco* program with the goal of providing health care services to all uninsured residents. The program is not a health insurance program; it connects uninsured adults to a medical home that provides them with basic medical care, with an emphasis on preventive care and the management of chronic conditions. The program also imposes an employer mandate by requiring that certain employers in the city spend a minimum amount on healthcare per worker per hour (in 2008, this is between $1.17 and $1.76). Employers can comply with the requirement by directly paying for health care services, providing health insurance, funding health savings accounts, or by paying a fee to the city to help fund the *Healthy San Francisco* program.

The employer mandate was challenged by a group of employers in 2006 on the premise that it violated the federal ERISA law, which effectively limits a state's ability to regulate the benefits that employers offer to workers. In September 2008, however, a three-judge panel of the Ninth Circuit Court of Appeals upheld the *Healthy San Francisco* employer mandate. In its ruling, the Ninth Circuit distinguished its decision from a 2006 ruling by the Fourth Circuit Court of Appeals. In that case, the Fourth Circuit struck down the "Maryland Fair Share Health Care" law, which would have required certain large employers to either contribute to employee health benefits or pay directly into the state's health program for the poor, ruling that the law violated ERISA. Given the likelihood of an appeal to the 2008 *Healthy San Francisco* decision, the United States Supreme Court may ultimately decide the question of what state or local governments can and cannot do with regard to requiring employers to contribute to their workers' health care.

What Is "Shared Responsibility" and What Does an Employer Mandate Have to Do with It?

Reform proposals often include both an employer and an individual mandate[6] (a requirement that individuals obtain acceptable health insurance) along with efforts to expand publicly-sponsored insurance options funded by the government. The term "shared responsibility" refers to these types of policy combinations, since employers, individuals, and the government all share the duty of providing or obtaining health coverage; each plays a significant role in increasing the number of people with health insurance.

If implemented together with sufficient safeguards, employer and individual mandates can result in a major reduction in the number of uninsured people. Alone, however, each type of mandate presents a problem in achieving universal coverage:

- An individual mandate places responsibility for obtaining coverage on an individual. It does not address whether health insurance is available to that individual or whether the coverage is affordable. If employer participation in the health insurance marketplace is not also mandatory and the costs of coverage continues to grow, employers will continue to shift the burden of cost increases to their workers or could decide to forgo offering employee health benefits altogether. This would make it more difficult for individuals to meet the mandatory insurance coverage requirement, since fewer workers would be able to obtain affordable coverage through their jobs and more individuals would bear the entire cost of their coverage.

- An employer mandate alone has the potential to leave many individuals uninsured, such as non-workers, workers who are eligible for employer plans but choose not to enroll, workers who do not fulfill the minimum "full-time" requirements, and employees at small or low-revenue firms that may be exempt from the mandate. This point is particularly relevant for women, since they are more likely to be among those potentially "left-out" of an employer mandate; when compared to men, women are more likely to be non-workers or to work part-time (i.e. fewer than 35 hours per week),[7] and they also hold the majority of low-wage jobs.[8] Moreover, while an employer mandate may exempt small and low-revenue firms from compliance, it does not address the challenges these firms face in finding affordable health coverage for their workers; in 2007 nearly three-quarters of small firms that did not offer employee health benefits cited high premiums as a "very important" reason for not doing so.[9]

Lessons from the States:

Massachusetts Adopts an Employer Mandate as Part of a Comprehensive Health Reform Plan

Massachusetts enacted health reform in April 2006 which included shared responsibility between the Massachusetts government, employers, and individuals. In addition to expansions of public programs and premium subsidies for low-income families, the state adopted a "Pay-or-Play"-style employer mandate. The policy requires employers with 11 or more employees who do not contribute a "fair and reasonable" amount towards employee health benefits to pay the state a "Fair Share Contribution" of $295 per year for each full-time worker. For 2008, "fair and reasonable" is defined as having 25 percent of full-time employees enrolled in an employer-sponsored insurance plan, or contributing at least 33 percent towards employee premiums. Employers with 10 or fewer workers are exempt.

It is unclear whether the employer mandate has had any significant impact on expanding coverage in Massachusetts. Although health insurance coverage rates are increasing (as of March 2008, over 350,000 of the estimated 450,000 uninsured had obtained health care coverage[10]), over 60,000 people have received exemptions from the individual mandate.[11] These individuals remain uninsured and are presumably not getting the health care that they need. If the state had more money, it could provide higher subsidies to help these exempt (and currently uninsured) people better afford coverage.

The current required employer contribution of $295 per employee per year is viewed by many as inadequate because it is considerably less than the cost of employee health benefits; a more substantial employer contribution would mean increased revenue to finance reform efforts, and may even prompt more firms to offer coverage to their workers directly. In 2007, Massachusetts spent $636 million to provide health care coverage to employees of large companies that did not offer health benefits.[12]

Additionally, for individual and employer mandate reforms to be successful, governments must establish systems for assessing whether the target group is in compliance with the mandate and institute appropriate penalties for those who do not comply. Neither type of mandate will achieve its goal if it is not appropriately enforced.

What Can Women's Advocates Do to Ensure That Employer Mandates Work for Women?

Women's advocates can promote concepts of "Shared Responsibility" between government, employers, and individuals.
Health reform plans that require these three entitities to share the duty of providing or obtaining health coverage build on the existing system of health financing.

Women's advocates can promote policies that improve access to affordable and comprehensive coverage for small and low-revenue businesses.
Small businesses lack the purchasing power of their larger counterparts and health insurance is often prohibitively expensive. Advocates should promote policies that would help businesses with a very small number of workers, those with low revenue, and those that employ a large percentage of low-wage workers purchase high-quality and affordable health insurance for their employees.

Women's advocates can insist that an employer mandate policy include a simplified process for obtaining an exemption from the mandate when appropriate.
In the absence of changes to ensure that small business owners have the ability to purchase quality, affordable coverage, employer mandate policies must not require small and low-revenue businesses to offer health insurance that they cannot afford.

Women's advocates can support employer contributions that are adequate.
Significant funding may be required for health reform initiatives that extend coverage to previously uninsured people or that improve the quality and efficiency of health care. Employer contributions generate funding for these initiatives and play an important role in making (and keeping) a health reform plan financially sustainable; inadequate contribution requirements can threaten the viability of health reform plans.

For further reading, see:

Patricia A. Butler, California HealthCare Foundation, *Fact Sheet: ERISA Implications for State "Pay or Play" Laws* (July 2007), http://calhealthreform.org/pdf/ERISAfactsheetButlerP.pdf.

Kaiser Family Foundation, *Fact Sheet: Healthy San Francisco* (March 2008), http://www.kff.org/uninsured/upload/7760.pdf.

Community Catalyst and Families USA, *The Consumer Guide to State Health Reform: Pay-or-Play Worksheet*, http://www.communitycatalyst.org/projects/schap/links?id=0049 (last visited Jul. 16, 2008).

References

1 Mandate is a commonly-used word in the debate about health care reform. It is important to note the difference between a mandate to purchase or offer health insurance (the individual and employer mandates) and a mandate that requires health insurers to provide specific benefits to policyholders ("mandated benefits"). See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.

2 Reform plans might also require that, at a minimum, employers offer their workers the option to establish a Section 125 plan (also known as a "cafeteria plan") to purchase health insurance with pre-tax dollars.

3 The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Summary of Findings* (2007), http://www.kff.org/insurance/7672/upload/Summary-of-Findings-EHBS-2007.pdf.

4 The Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey* (2007), http://www.kff.org/insurance/7672/upload/76723.pdf.

5 Paul Fronstin et al., Employee Benefit Research Institute, *Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey* (Jan. 2003), http://www.ebri.org/pdf/briefspdf/0103ib.pdf.

6 See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.

7 In 2006, about 25 percent of employed women were part-time workers, compared with 11 percent of employed men. See: US Department of Labor, Bureau of Labor Statistics, *Charting the US Labor Market in 2006* (Sep. 28, 2007), http://www.bls.gov/cps/labor2006/.

8 Marlene Kim, *Women Paid Low Wages: Who They Are and Where They Work*, Monthly Labor Review Online, 123 (9): (Sept. 2000), http://www.bls.gov/opub/mlr/2000/09/art3exc.htm.

9 *Employee Health Benefits*, *supra* note 4.

10 The Henry J. Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured, *States Moving Toward Comprehensive Health Care Reform* (Apr. 3, 2008), http://www.kff.org/uninsured/statehealthreform/ma.cfm.

11 Massachusetts Department of Revenue, *Preliminary Data on the Individual Mandate, Tax Year 2007* (as of June 2, 2008), http://www.mass.gov/Ador/docs/dor/News/PressReleases/2008/HC_Data_Report_FINAL.pdf.

12 Executive Office of Health and Human Services, Division of Health Care Finance and Policy, *Employers Who Had Fifty or More Employees Using MassHealth, Commonwealth Care, or the Uncompensated Care Pool in State FY07* (May 2008), http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/08/50_plus_employees_05-08.pdf.

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