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# IMPLEMENTING EMPLOYER AND INDIVIDUAL MANDATES

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by C. Eugene Steuerle

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**Prologue:** *Policy makers often rationalize their support of government mandates that require the purchase of health insurance on the basis that it is not right for some to bear the cost of coverage while others, who are equally capable of affording it, avoid such costs. On equity grounds, it simply is not fair that some workers purchase insurance, while others with equal ability to pay depend upon society to cover the unpredictable costs of illness. In this paper Eugene Steuerle discusses the complications that arise when government strives to design and implement mandates. No plan now exists that relies solely upon an employer mandate. While the focus of business concern about the Clinton plan has been on its mandate that employers purchase health insurance for their workers, for instance, the proposal also contains an individual mandate that has received far less attention. Steuerle, an economist, is a senior fellow at The Urban Institute. At the institute, he has conducted extensive research on budget and tax policy, health care, Social Security, and welfare reform. The latest of his books, coauthored with Jon Bakija, is entitled *Retooling Social Security for the Twenty-First Century* (Urban Institute Press, 1994). It has been widely recommended by former Social Security commissioners as “pathbreaking” and “undoubtedly the most comprehensive analysis of the very long-range financing problems confronting the Social Security program.” Earlier, Steuerle served in various positions in the Treasury Department over a fifteen-year period (1974-1989) under four different presidents, including service as deputy assistant secretary for tax analysis. In that post he directed the Treasury study, “Financing Health and Long-Term care: A Report to the President and the Congress.”*

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**Abstract:** As is true of automobile insurance, a strong case can be made for a mandate that requires individuals to purchase health insurance rather than shifting costs to others. A mandate by itself, however, is likely to be regressive. By dealing with individual needs through the back door, an employer mandate generally keeps costs hidden and raises employment problems, while an employer subsidy will be poorly targeted. An individual mandate, in turn, raises other difficult administrative issues of collection and enforcement. No employer mandate is sufficient without an individual mandate, and millions of Americans will fall outside of any mandated system.

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Many of the health reform bills now before Congress include some form of mandate to implement health reform. The plan of the Clinton administration, for instance, contains a mandate on both employers and individuals. Mandates or regulations regarding purchases of goods and services, however, operate very much like tax-and-expenditure schemes in their impact upon the economy. That is, a mandate to purchase health insurance is in many ways equivalent to taxing individuals and then giving each of them a product equal in value to the amount of tax each paid. For some theoretical purposes, one can make all three—individual mandates, employer mandates, and tax-and-expenditure schemes—close to identical. In practice, however, each of these approaches creates very different perceptions and usually is implemented in very different ways. Choosing from among alternative regulatory and tax approaches requires close examination of goals, the ability of each approach to meet those goals in implementation, and the size of related costs and distortions that inevitably accompany any tax or regulation.

This paper focuses mainly on employer and individual mandates and demonstrates that there are strong equity and efficiency rationales for a mandate. These are not issues of progressivity; indeed, by itself, a mandate to purchase health insurance is regressive. The paper further shows that the logic of a mandate, just like any tax or expenditure, is inherently individual in nature and shows how distortions arise in a system in which costs are hidden from individuals either by the government or by employers. It next raises tough implementation issues for both employer and individual mandates. No employer mandate, moreover, is sufficient by itself: It must be accompanied by an individual mandate. Finally, many persons fall outside of a mandated system, no matter how well designed.

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### Efficiency And Equity Considerations

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At their core, individual and employer mandates are justified by the notion that it is not right for some to bear the cost of insurance while others, who are equally capable, avoid those costs. The economic principles involved are those of horizontal equity—equal treatment of equals—and efficiency. These issues arise especially in a society that attempts to provide

some minimum level of well-being for its members. Once that minimum-support decision is made, strong efficiency and equity arguments can be made for more universal participation in the payment mechanism. Some forms of social insurance use a similar rationale to justify their design. For example, we ask workers to contribute to Social Security before retirement so that they do not later fall back upon a welfare system for the aged.<sup>1</sup>

Many persons do not now pay for their own insurance. When they become ill, they may fall back on subsidized parts of the system, such as charitable care or welfare. Even many who are not initially eligible for assistance may become so if their health conditions become severe enough or their income falls far enough. Take, for instance, a middle-income person with few assets and no health insurance. If a truly catastrophic illness occurs, the prior failure to buy insurance will mean that health care can only be obtained if adequate resources are provided by other members of society. In effect, many of those who are labeled as uninsured are in fact partially insured through backup charitable care and public assistance.<sup>2</sup>

Who pays for this insurance? Where public assistance is involved, the taxpayer pays. In other cases, individuals pay extra when they cover their own medical bills or buy their own insurance. This private cross-subsidization is achieved through devices such as higher hospital charges and higher insurance premiums for those who are insured. Significant inefficiencies are introduced by this system of cross-subsidization. Indeed, the additional costs of covering the costs of the uninsured are like a hot potato that different insurers, risk groups, and providers try to pass on to others. The backup insurance system, moreover, gives everyone some incentive to avoid purchasing insurance. Many employer and employee groups that are considering support of health reform are led in part by the notion that reform will be a means of reducing their costs of subsidizing others.

The ability of some to ride free on others' payments of taxes and higher insurance premiums is a problem that applies at all income levels.<sup>3</sup> Economists generally argue that insured workers earn the value of their cash wages plus employee benefits. If health insurance is worth \$4,000, for instance, then insured workers with cash compensation of \$10,000 are really earning \$14,000 but giving up substantial amounts of cash wages to buy insurance. On equity grounds, it is not fair that some \$14,000-a-year workers purchase insurance, while others with equal ability to pay depend more on society.<sup>4</sup>

Similar considerations of equity and efficiency underlie the requirement that almost all automobile drivers must purchase automobile insurance. While the mandate is not perfect-reckless drivers still take more from the system than they pay into it—at least the requirement protects society and injured parties from having to bear the full cost that would be imposed by uninsured motorists who are capable of buying insurance.<sup>5</sup>

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**Progressivity**

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Although some find it surprising, neither individual nor employer mandates can be justified on grounds of progressivity. The goal of redistributing to the poor, for instance, can be achieved through a redistribution of money. Suppose, for example, that one were to choose between granting \$4,000 in cash or \$4,000 of health insurance to the poor. If greater income is desired for low-income persons, then why require that income to be spent on health insurance or, more specifically, health insurance with particular characteristics specified by the government? Each goal-greater progressivity and required health insurance-must be justified in its own right.<sup>6</sup>

In any case, employer and individual mandates by themselves generally are not progressive. Relative to current law, they usually redistribute net income away from lower-income persons. This is a direct consequence of the backup insurance policy provided through government or charitable care. Suppose, for instance, that the cost of comprehensive health insurance is \$4,000 and that a person of modest means does not buy this insurance. The backup insurance that this person has, even though it might be quite inadequate, still has some value. Let us suppose that it is only available in catastrophic situations and that its expected value is only \$1,500. If the person is required to purchase a comprehensive policy, then he or she will pay \$4,000 for a policy perhaps worth \$4,000, but the net gain in insurance is at best only \$2,500. There is a loss of income equal to the value of the backup insurance policy that used to be provided free but now is not required.<sup>7</sup>

Turning to an employer mandate does not solve this problem. Economists generally believe that the worker pays the cost of such a mandate through lower wages. An employee producing goods and services worth \$14,000, for example, is not going to be paid \$14,000 in cash wages and an additional \$4,000 in health benefits simply because the government calls the mandate an "employer" mandate. Cash wages will fall toward \$10,000, or the loss-producing job eventually will be eliminated.

Most health packages, including those that contain mandates, achieve redistributive goals through mechanisms other than the mandate. For instance, subsidies are provided to help individuals meet the mandate. Because of the regressive nature of the mandate, however, the net redistribution of a combined package-say, one with a progressive tax-is often quite small. Sheila Zedlewski and colleagues found that the Clinton plan and other proposals containing mandates on employers typically achieve only a minor amount of redistribution to the poorest 20 percent of the population.<sup>8</sup>

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## **An Inherently Individual Logic**

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The goal of health reform is to improve individual well-being, not the well-being of some legal construct or form of organization such as a corporation or business employer. The same can be said about the efficiency and equity principles that underpin the rationale for a mandate: They are inherently principles that apply to individuals.<sup>9</sup>

Once one tries to assess an individual tax or subsidy on a particular form of organization, rather than on the individual, there are inevitable efficiency costs. Return to the analogy with automobile insurance. No one seriously suggests that employers provide workers with automobile insurance instead of requiring them to purchase health insurance. Parallel arguments are made in other parts of the economics literature on public finance. For example, it is generally believed that taxation of corporations is a poor way to try to tax individuals. Relative to an individual tax of equal yield and progressivity, this type of back-door tax forces reorganization of the business sector, encourages debt over equity financing, discriminates against low-income persons who own corporate stock, and so forth. However, administrative considerations are important in choosing among alternatives.<sup>10</sup>

A political argument is often made for an employer mandate. Although an employer mandate is equivalent in many respects to a tax, the tax would not flow through government accounts (although the debate over what is a "tax" in the president's plan is made more complex with respect to money that might be made to flow through quasi-government agencies or alliances).<sup>11</sup> Similarly, even though economists believe that individuals pay for employer mandates, the cost is more hidden and, hence, believed by some to be more politically acceptable.

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## **The Hidden Nature Of Health Insurance Costs**

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One consequence of an employer mandate, as well as of Medicare-type government plans, is that the cost of insurance is hidden from individuals. Whatever one thinks about the ability of individuals to restrain costs once an illness strikes, individuals can constrain costs at the time that they buy insurance. Removing the individual from this decision-making process is one reason for the rise in health insurance costs. Few persons are now given the opportunity to choose a lower-cost plan and to pocket the savings. That choice, however, might mean later that they will only have access to \$200,000-a-year surgeons and three attendants and nurses in the operating room rather than \$400,000-a-year surgeons and five attendants and nurses-hence driving down the cost of health care.<sup>12</sup>

While individuals inevitably are the source of funds for health insurance,

most of their payments are not made directly, but indirectly in the form of taxes and lower wages (Exhibit 1). The current system has led most households to believe that \$1,000 or \$2,000 in health costs is catastrophic, when the average amount spent per U.S. household is now about \$9,500.<sup>13</sup>

One of the consequences of a system with hidden costs is that it becomes politically difficult to implement a reform that reveals those costs. For example, if we forced individuals with \$14,000 a year in total compensation to buy insurance for \$4,000, or if we taxed them \$4,000 to support a government plan, there would be a loud howl of protest. Yet this level of cost is paid by many with moderate incomes today—they simply do not realize it. Households will contribute on average about \$6,700 in fiscal year 1994 in taxes and reduced cash wages to support the nation's health care systems. These numbers are higher on average for those who actually pay.

**Exhibit 1**  
**Estimated Total Health Care Spending In The United States, Fiscal Year 1994**

	Average per household <sup>a</sup>	Percent of GDP <sup>b</sup>	Percent of personal income	Percent of money income	Total spending <sup>c</sup>
Paid indirectly					
Taxes (federal Hospital Insurance payroll tax)	\$ 920	1.4%	1.6%	2.1%	\$ 90.8
Taxes (other federal, state, and local) <sup>d</sup>	3,790	5.8	6.6	8.9	375.3
Reduced wages (paid by employers) <sup>e</sup>	2,010	3.1	3.5	4.7	199.2
Other <sup>f</sup>	270	0.4	0.5	0.6	27.0
Paid directly					
Personal contributions (to private health insurance) <sup>g</sup>	620	0.9	1.1	1.4	61.0
Out-of-pocket payments	1,720	2.6	3.0	4.0	170.6
Premiums (federal Supplemental Medical Insurance)	170	0.3	0.3	0.4	17.3
<b>Total</b>	<b>\$ 9,510</b>	<b>14.5 %</b>	<b>16.7%</b>	<b>22.2%</b>	<b>\$941.2</b>

**Source:** Author's calculations based on data from the Health Care Financing Administration Office of the Actuary (1993); the office of Management and Budget (1993); and the Joint Committee on Taxation.

**Note:** Mean GDP per household is \$65,510; mean income per household is \$57,050; and mean money income per household is \$42,820.

<sup>a</sup> Average household size in the United States was 2.62 persons in 1991, and there will be approximately ninety-nine million households in 1994.

<sup>b</sup> Gross domestic product.

<sup>c</sup> Billions of dollars.

<sup>d</sup> Includes taxes needed to finance direct government health spending out of general revenues, plus the amount general taxes must be raised to compensate for revenue lost due to special tax treatment of certain health-related income (about 26 percent of the total).

<sup>e</sup> Employer contributions for health insurance, less government tax subsidies.

<sup>f</sup> Nonpatient revenue for the health care industry, including charitable donations, interest income, hospital parking and gift shops, and so on.

<sup>g</sup> Includes both employee contributions to private group health insurance plans and individual policy premiums.

In effect, health care reform confronts one of the same dilemmas that drives costs under current law. When recognized directly, the cost of health care is so astronomical that most households believe that they cannot afford it. They do pay, however, through higher taxes (or more government debt) and lower cash wages. These indirect financing systems continue to hide costs, which removes a natural barrier to health cost increases at the time that insurance is purchased. With the barrier largely removed, costs continue to increase, even fewer people are able to afford insurance, and the demand for government assistance increases.<sup>14</sup>

The absence of this cost barrier has had an important influence on approaches to reform. One approach has been to try to force recognition of cost by such methods as capping tax benefits for health insurance and offering employees savings when they purchase lower-cost health insurance.<sup>15</sup> A movement toward greater cost recognition, however, would be messy: The information market by its very nature is limited and, in the case of health care, has not been allowed to develop fully. An alternative approach is to throw in the towel on recognition of costs at the individual level. Since demand for health care at zero price may be close to infinite, this approach leads toward, perhaps requires, regulation and cost control by the government. An individual mandate fits in more easily with the former, an employer mandate or tax-and-transfer scheme with the latter. There are hybrids, however, including the plan of the Clinton administration and an earlier plan favored by Alain Enthoven.<sup>16</sup>

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### Further Issues Raised By An Employer Mandate

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Employer and individual mandates are designed and implemented in quite different ways. An employer mandate to buy insurance raises the effective minimum wage that an employer must pay. As a technical or theoretical matter, once again, the difference need not exist; that is, the cash minimum wage could be lowered by the amount of payment that is now required in the form of in-kind compensation. As an implementation matter, however, this has never been proposed. Most economic analyses show that increases in the minimum wage tend to decrease employment at that wage level, although there is much dispute about how large the effect might be.<sup>17</sup> The adverse consequences are most likely to show up in smaller firms, which tend to provide fewer health benefits and have lower-than-average wage levels. Note, moreover, that an increase of several thousand dollars in insurance costs can easily translate into an increase in the minimum wage of two dollars or more, thus hitting many employees at wage levels significantly above the current minimum wage.

Employer mandates often have their most undesirable effects on groups

that legitimately want to work for cash wages, such as spouses of employees with health plans, teenagers with family coverage, and elderly persons who may be unable to obtain jobs if their health costs must be covered by an employer rather than by Medicare.<sup>18</sup> These groups are also among those most likely to be affected by increases in the minimum wage. Probably for these reasons, the administration has moved in its plan to exempt dependent teenagers from the employer mandate.

Many of these latter problems arise because implementation of an employer mandate, such as in the president's plan, generally applies per employee, per employer. This creates problems for people who have more than one full-time job (defined, for instance, in the Clinton plan as thirty hours per week) and for families with more than one worker. They may be required effectively to pay for insurance twice or more, thus providing especially strong disincentives to obtain a second job within a household.<sup>19</sup> This approach also discriminates heavily against the harder-working of two families with equal total income. For instance, a couple with two full-time workers each earning \$40,000 per year will be required to pay substantially more for their insurance than a couple with only one spouse earning \$80,000 per year at one full-time job.

One could attribute all employer costs to the individual and allow rebates for duplicate coverage on tax returns at the end of the year. This, however, would represent a very strong step toward an individual mandate and would make obvious the hidden individual costs. If individuals get statements of exactly what is paid on their behalf, and then get rebates for excess contributions, they will view the employer mandate as one on themselves.

Individual attribution, of course, also requires individual valuation. Practically speaking, the step is easy only for direct employee contributions for employer-provided insurance. For employer contributions, formulas would be required to allocate total employer health expenses among workers. This task could require rules regarding variations according to type of plan chosen and factors such as age or geographical location.

Once an employer mandate is introduced; and the perception that the employer pays is maintained, the political process is led almost inevitably to think about employer subsidies, rather than simply individual subsidies, to help with those costs.<sup>20</sup> The Clinton administration, for instance, proposes subsidies to small employers. Aiming a subsidy at employers rather than individuals, however, again raises the inevitable efficiency cost issues.

In the administration's plan, the employer subsidy is designed in such a way that it would lead to economic segregation of the labor market, with rich and poor workers becoming increasingly separated by type of employer. This consequence arises from subsidizing employers of low-income workers rather than the low-income workers themselves. For example, when only

small firms can receive subsidies for hiring low-wage workers, then larger firms will hire fewer low-wage workers and attempt to contract out the work those workers otherwise would have provided. This would cause low-income workers to congregate in those firms where the subsidies are the highest, while high-income employees would congregate in other firms.

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### Issues Raised By An Individual Mandate

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Although I believe that the logic of taxation and subsidization is inherently individual, individual mandates themselves raise a variety of implementation issues. Perhaps the major issue is enforcement: How does one get an individual mandate (and an individual subsidy) to work?

A mandate is only as good as its enforcement mechanisms. It is often easier to enforce a mandate on a large employer. Any employer that does not comply might be denied the right to operate or be required to pay a hefty penalty to ensure compliance. If a mandate is to operate at the individual level, however, the nature of the penalty to be assessed and the means by which noncompliance is measured are more complicated.

If an individual penalty or tax is to be paid by those who do not comply with the individual mandate, for instance, then some withholding system must be set up to ensure that those taxes are collected during the year. The Internal Revenue Service (IRS) is simply incapable of going to millions of households, many of modest means, and collecting significant penalties at the end of the year. Nor do many households have the necessary savings to pay penalties at the end of the year. The regular income tax relies upon fairly flat tax rates, exemption of moderate amounts of income from taxation, and overwithholding as ways to ensure that adequate tax is paid and collected over the course of the year. Even then, millions of nonfilers and delinquent payers (many of which are also small businesses) fail to comply.

Unless an individual mandate and subsidy system is kept relatively simple, administrative and enforcement costs would be high and perhaps unacceptable. It is very difficult to set up an entirely separate tax structure to implement health policy collection goals (just as it is very difficult to set up a separate welfare system to implement health policy expenditure goals). Each social policy in this country does not warrant its own tax system.

Many proposals for individual mandates back up the mandate with a set of subsidies. If the individual mandate is part of an attempt to establish universal health insurance, then the subsidy is required to ensure that individuals can afford to buy the insurance. Many proposals attempt to relate the size of the mandates and subsidies to income levels of individuals. Elaborate adjustment of the subsidy by income level, however, also turns out to be infeasible. Welfare systems tend to have monthly accounting

periods, but the income tax has an annual accounting period. Most people know their previous year's income only when they file their tax returns.

There are only three possible income bases to which these subsidies and penalties can be related during the course of the year: (1) a guess as to this year's total income; (2) last year's income; or (3) weekly or monthly income. None of these is very attractive. Guessing income or basing income testing upon last year's income raises significant inaccuracies. A weekly or monthly accounting system such as welfare's is notorious for its bad reporting and inability to monitor. Shorter accounting periods also tend to redistribute smaller portions of help to the long-term poor. This forces us back toward a weekly or monthly withholding and subsidy system with an annual accounting period for reconciliation. To achieve this goal, the weekly or monthly subsidies and penalties must be paid at a rate that avoids significant debts to the government at the end of the year.

Another individual implementation issue relates to the government's ability to know whether an individual has purchased health insurance. Employers and insurance companies inevitably would have to provide reports to the government so that persons without insurance could pay the appropriate noncompliance penalty. This, again, will not be easy, especially with respect to those who move from one region to another, adopt different family configurations, and switch jobs during the course of the year. The information system—like many tax and health information systems operating today—will be only partly accurate and will operate with time lags.

Let me suggest mechanisms for getting around some of these administrative problems. First, we must determine just what type of penalty could be administered at the individual level. A flat surtax rate could be applied to those without individual insurance. Such a surtax could be built onto existing withholding and estimated tax procedures. At a lesser level, a personal exemption might be denied to those who are uninsured. The Cooper plan has picked up some of these suggestions.

Individual subsidies are both more inaccurate and harder to administer if they are phased out or taxed at a high rate. With variable income and family reconfigurations, one cannot allow too large of a subsidy to be given that might later have to be paid back. The evidence with the earned income credit is that it will not be paid out during the year because there are significant probabilities of overpayment as long as families do not know their total income for the current year.

For a variety of reasons, including the need for an annual system with frequent payments and withholdings, administrative considerations favor a flat voucher system (equal-size vouchers for everyone), backed up by tax or recapture rates that do not create highly variable tax rates. Flatter vouchers and tax rates allow both subsidies and penalties to be paid at a rate requiring

little correction or reconciliation at year end. In effect, weekly or monthly subsidies and vouchers will be fairly accurate on an annual basis.

In budget accounting, however, these approaches tend to raise budgetary measures of both subsidies and taxes. For instance, if phaseouts of subsidies are abandoned in favor of a higher income tax rate, then the measure of tax burden will rise. When the phaseouts are kept in the expenditure system, no taxes are recorded, tax rates are hidden, and measures of expenditures are reduced. Thus, phaseouts in existing welfare programs and in Medicaid have been allowed to rise so high as to create confiscatory tax rates on work and extraordinary marriage penalties for many low-income persons. Such problems would be extended in a number of the health bills before Congress, including those that take a Medicaid-expansion approach.<sup>21</sup>

A possible compromise is to start with vouchers for children and let the normal tax system worry about recapturing the value of those vouchers. Along with a stiff individual surtax for those persons who do not buy insurance and some insurance reform to guarantee the availability of coverage to everyone, I believe that such an approach could substantially reduce the number of uninsured persons. This approach solves many administrative problems but not the insurance issue for low-income adults who would be without vouchers and would be subject to little or no surtax.

To take advantage of the existing system of employer insurance, I suggest requiring employers to help administer any individual mandate or subsidy; that is, they would be required to withhold a penalty from those without insurance and make available insurance on which any government subsidy could be spent. This system would not be without its own administrative and other costs. For instance, it, too, requires some regulation of what is acceptable insurance and requires some auditing to limit abuse. Again, this suggestion has been incorporated into a number of congressional bills.

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### **Employer And Individual Mandates Combined**

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No plan exists that relies solely upon an employer mandate. Despite the attention given in the administration's health plan to mandate that employers purchase health insurance for their workers, the proposal also contains an individual mandate that has been given much less attention. Regardless of merit, an employer mandate is insufficient to address the lack of health insurance throughout the population. Many persons without insurance do not work or work only part time. Most proposals for universal coverage, therefore, contain some individual mandate.<sup>22</sup>

If an employer mandate is not backed by an individual mandate, then universal coverage could be obtained only if all nonworkers were completely subsidized even while modest-wage workers paid for their insurance

through lower wages. The idea of providing insurance to millionaires who decide not to work, however, is not appealing. Once it is decided that millionaires must pay some portion of cost, then the issue of an individual mandate is engaged and a whole series of related decisions is required.<sup>23</sup>

The Clinton administration tries to solve this issue by meshing together an employer mandate, an employer subsidy, an individual mandate, and an individual subsidy. Needless to say, this brings to the fore all of the implementation problems in both systems. In fact, it adds other problems due to interactions. First, the subsidies for workers and nonworkers are based upon different schedules of income; they also are dependent on size of employer. In effect, there are incentives to move back and forth among employers and between employment and unemployment depending upon variable subsidies. Standards of horizontal equity are violated partly because they are never established in the first place. Some standard is needed to distribute burdens and subsidies between workers and nonworkers who are viewed to be equally capable or incapable of paying for health insurance.

One of the worst problems of interaction, one that leaves the current administration plan unworkable, derives from its attempt to distinguish between those subject to an employer mandate and those subject to an individual mandate. Take the case of uninsured persons who work only part time. A system of combined mandates must be created for them. In the administration's proposal, the employer mandate would cover a share of insurance cost proportional to the number of hours worked per week divided by thirty hours. The individual, in turn, would be responsible for two remaining components: (1) the share of the employer mandate (a maximum of 20 percent) that is collected by the employer from all employees, and (2) the portion of total health insurance cost that was not covered through the employer mandate. For example, suppose that an employee worked fifteen hours per week and that the employer generally split the cost of insurance with workers on an eighty-twenty basis. Then the employer would cover 80 percent of half of the total cost, or 40 percent of the total. The employee would be required to pay the remaining 60 percent—fifty percentage points deriving from the individual mandate and ten percentage points as the matching payment required under arrangements with the employer (that is, 20 percent of the half required under the employer mandate). On top of this, the administration proposes separate schemes for subsidizing or capping employer payments and for subsidizing individuals separately for their own payments.

This particular scheme of mixing and matching employer and individual mandates and subsidies not only is confusing, it probably cannot be administered. Among other reasons, there is no reliable system for measuring hours worked and for penalizing misreporting, and the employer mandate

depends upon both of these. In addition, the hours worked one week may be different than the hours worked the next week, so that the required size of the mandate and the subsidy either would vary constantly over time or would be constantly inaccurate.

**Noncompliant and low-income individuals.** A variety of additional enforcement and coverage problems are common to employer and individual mandates and subsidies. First, the mandates by themselves cannot deal well with low-income individuals. Employer mandates must be backed up by individual mandates to deal with part-time workers and nonworkers. Individual mandates, in turn, must be backed up by substantial subsidies for low-income persons who cannot afford the cost of insurance. Also, many persons already do not comply with the tax or welfare laws, and health reform is likely to add to, rather than subtract from, these numbers.

Millions of persons will fall outside of either an individual- or employer-mandated system, just as they fail to file income tax returns. In effect, a significant portion of the problem of dealing with low-income persons remains and must be dealt with through means other than individual or employer mandates and subsidies.

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## Conclusion

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Large-scale health reform involves the adoption of mechanisms, including mandates, that operate much like other tax, expenditure, and regulatory schemes. One of the biggest mistakes that reformers can make is to ignore problems with making these mechanisms work. If these problems are solved, however, health reform will look very different than its idealized versions.<sup>24</sup> There are strict limits on how much government can control or implement. The trick, I believe, is to stop viewing health reform as a once-and-for-all decision. Too much debate takes place over the furniture in the penthouse when implementation issues force us back toward considering carefully how to design even the basic building blocks. As long as government is so heavily involved in the health sector—as it already is—it is going to be constantly changing, reforming, and attempting to improve its efforts. Whatever structure is adopted in the near term, it must leave room for future reforms and improvements in a health sector that itself is rapidly redefining its very character.

## NOTES

1. See C.E. Steuerle and J. Bakija, *Retooling Social Security for the Twenty-First Century* (Washington: Urban Institute Press, 1994). For retirement income, a mandate to save privately would not have solved the problems of persons who had not saved enough (or had lost their savings in the Depression) when Social Security was created.
2. See, for instance, B.C. Spillman, "The Impact of Being Uninsured on Utilization of Basic Health Care Services," *Inquiry* (Winter 1992): 457-466.
3. The Employee Benefit Research Institute (EBRI) found that 39.6 percent of the uninsured had incomes in excess of twice the poverty level. EBRI, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1993 Current Population Survey*, Issue Brief 145 (Washington: EBRI, January 1994), 33. Earlier, Katherine Swartz found that 22.9 percent of the uninsured have family incomes of three times the poverty level or more. K. Swartz, *The Medically Uninsured: Special Focus on Workers* (Washington: The Urban Institute, 1989), 10.
4. One reason that employers self-insure or form relationships with preferred provider organizations is that they wish to minimize the impact of free riding on the cost of their plans. Other covered workers may not be as able to avoid bearing the costs of free riders.
5. Automobile insurance also presents some interesting comparisons for attempts to move toward community rating. See C.E. Steuerle, "Community Rating and Health Costs," *TaxNotes* (24 May 1993): 1121-1122; and "Community Rating of Health: How Much Is Appropriate?" *Tax Notes* (31 May 1993): 1269-1270.
6. In the federal budget, a strong argument can be made that health care is now displacing other help for the poor, such as education, training, and expansion of Head Start.
7. The economics literature presents fairly strong evidence that many in-kind benefits are worth less than their cost. On the other hand, sometimes government or an employer can purchase goods and services (especially insurance) more cheaply than an individual can. The example in the text ignores these differentials.
8. S. Zedlewski, J. Holahan, and C. Winterbottom, *The Clinton Health Plan: Who Would Pay?* (Washington: The Urban Institute, 1994); and S. Zedlewski et al., "Redistributing the Cost Burden under Health System Reform," *Policy Bites* (Washington: The Urban Institute, June 1993).
9. Other papers in this volume of *Health Affairs* address the issue of whether the cost of health insurance is paid for by the employee. Even if this were not true, however, the goal of health reform is still to help individuals, not entities. If the incidence of mandates and subsidies on institutions is uncertain, then the case for imposing burdens on them or subsidizing them is hardly established: The net distribution of benefits, particularly on low-income workers, would be unknown. Long-run incidence, of course, may differ remarkably from short-term results.
10. A simplified corporate tax, with a single rate, might be worth adopting in lieu of any individual tax on corporate income. This simplification, however, requires modest violation of some other principles. See U.S. Department of the Treasury, *Integration of the Individual and Corporate Tax Systems* (Washington: US. Government Printing Office, 1992). Although the topic of corporate/individual tax integration may seem unrelated at first, it displays many of the same problems as a health mandate (tax) that is attempted between an employer and individual sector. In truth, it is the size, efficiency, and accounting capability of the large firm that government often attempts to capture in implementing a number of its tax-and-expenditure functions.
11. The fine line over what is or is not a tax is difficult to make. For these reasons it is better to discuss the economic effects of what is being done, regardless of label.
12. See U.E. Reinhardt, "The Effect of Health Care Reform on the National Economy and Jobs" (Statement before the House Ways and Means Committee, 15 December 1993),

13. This figure includes many items that often are not covered by insurance, such as medical research and long-term care.
14. See H.J. Aaron, *Serious and Unstable Condition: Financing America's Health Care* (Washington: The Brookings Institution, 1991). This does not take away their ability to make reasonable price-conscious decisions at the point of purchasing insurance.
15. Xerox and Digital Equipment have been among the few to implement plans in which cost savings could be most easily detected by individuals. Robert Moffit also emphasizes experience with plans offered to federal employees. R. Moffit, *Consumer Choice in Health: Learning from the Federal Employee Health Benefit Program* (Washington: The Heritage Foundation, 9 November 1992). One difficulty in interpreting the empirical evidence is that such options have never been widely available. The argument is raised, therefore, that the existing evidence is selective and involves adverse selection. In truth, for selective populations, cost-consciousness likely leads to both efficiency gains and adverse selection. For estimation purposes, the two components are difficult to separate without knowing what happens to costs for the rest of the population.
16. See, for example, A. Enthoven and R. Kronick, "A Consumer Choice Health Plan for the 1990s," *The New England Journal of Medicine* (5 January 1989): 29-37, and (12 January 1989): 94-101.
17. Estimates of employment effects range from 212,000 to two million jobs lost. J.E. O'Neill and D.M. O'Neill, *The Employment and Distributional Effects of Mandated Benefits* (Washington: American Enterprise Institute, 1994); and A.B. Krueger, "Observations on Employment-Based Government Mandates, with Particular Reference to Health Insurance" (Unpublished manuscript, Princeton University, 1993). Recent findings show negligible effects of minimum wage changes. L.F. Katz and A.B. Krueger, "The Effect of the Minimum Wage on the Fast Food Industry," *Industrial Relations Labor Review* 46, no. 1 (October 1992): 6-21; and D. Card, "Using Regional Variation in Wages to Measure the Effects of the Federal Minimum Wage," *Industrial Relations Labor Review* 46, no. 1 (October 1992): 22-37.
18. This "health earnings test" actually implies a much higher tax on earnings than does the regular "earnings test" in Social Security, which provides for various actuarial increases in later benefits for reductions in cash benefits.
19. In fact, the additional subsidies provided by families with more than one job reduce the cost of insurance per individual worker below its actuarial value. Thus, within the pool of families who cover the cost of family policies, there are more payers than there are families to be insured. Hence, average cost per payer is lower than average cost per family. Subsidies also may reduce the full cost paid by families receiving those subsidies.
20. As an economic matter, it is at least theoretically possible to design a mandate, backed by a corresponding subsidy, that is equivalent to a tax. For instance, I can mandate that you pay \$100 and reimburse you \$40, or I can tax you \$60 from the start. When it comes to implementation, however, the two start to diverge.
21. Regarding high tax rates in reform plans, see K. Davis, "Mandating Universal Coverage: Employer or Individual" (Talk before the Alliance for Health Reform, Annapolis, Maryland, 7 January 1994). A similar problem in President Bush's 1992 health proposals was examined in C.E. Steuerle, "Beyond Paralysis in Health Reform: A Proposal to Focus on Children," *National Tax Journal* (September 1992): 357-368.
22. In social insurance schemes such as Medicare, the mandate is implicit in the requirement to participate in the program.
23. In a tax-and-transfer scheme, of course, the tax itself could be used to pay for any insurance or subsidy provided.
24. See M.V. Pauly, "Why Is Health Care So Hard to Reform?" in *American Health Policy: Critical Issues for Reform*, ed. R.B. Helms (Washington: American Enterprise Institute, 1993), 317-333.