

IMPLEMENTING INDIVIDUAL AND EMPLOYER MANDATES

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Large-scale health reform can involve the adoption of a number of mechanisms, including mandates, that operate much like other tax, expenditure, and regulatory schemes. Reformers have often ignored problems related to making these mechanisms work. While employer and individual mandates share some common goals and justifications, their design and implementation are vastly different.

Employer mandate issues. Implementation of an employer mandate, such as that in President Clinton's plan, generally applies per employee, per employer. Economists believe that employees pay the cost of these mandates. People who have more than one full-time job and families with more than one worker may find themselves effectively paying for insurance twice or more. Thus, an employer mandate can carry an especially strong disincentive for workers to obtain a second job within a household.

An employer mandate raises the effective minimum wage that an employer must pay. In so doing, it can adversely affect jobs for workers in smaller firms in particular, since these firms tend to provide fewer health benefits and have lower-than-average wage levels.

Plans that subsidize employers of low-income workers rather than subsidize the low-income workers themselves can segregate the labor

market, with rich and poor workers becoming increasingly separated by type of employer. Thus, when only small firms receive subsidies for hiring low-wage workers, larger firms begin hiring fewer low-wage workers, contracting out the work those workers otherwise would have provided.

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Individual mandate issues. The most difficult implementation issue for individually based mandates is enforcement. The type of penalty to be assessed and the means to measure noncompliance are complicated. Yet, unless kept simple, the administrative and enforcement costs of such a system would be extremely high and perhaps unacceptable. Moreover, government must know whether an individual purchased health insurance. Any information system—like tax and health information systems—will be only partly accurate and will operate with time lags.

Many proposals for individual mandates include a set of subsidies, relating the size of mandates and subsidies to income levels of individuals. However, such adjustments by income level can

be quite difficult. Welfare systems tend to have monthly accounting periods, but the income tax has an annual accounting period and most people know their previous year's income only when they file their tax returns.

Interaction of two systems. No plan relies solely on an employer mandate because it is insufficient to address the uninsured who do not work or work only part-time. Most proposals for universal coverage, therefore, contain some individual mandate. But when an employer mandate is coupled with an individual mandate, implementation problems are compounded. The attempt to distinguish between those subject to an employer mandate and those subject to an individual mandate can render a meshed plan unworkable.

Noncompliant and low-income individuals. Millions of people will fall outside of either mandated system, just as they fail to file income tax returns. Thus, a significant portion of the problem of dealing with low-income persons will still remain and will have to be dealt with through means other than individual or employer mandates and subsidies.

In sum, clearly, there are strict limits on how much the government can control or implement. Legislation favoring health mandates has often been derailed by inattention to implementation issues such as these.

See “Implementing Employer and Individual Mandates,” by C. Eugene Steuerle, Health Affairs, Spring 1994, pp. 55-68.