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The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act

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Kathryn L. Moore*

The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act

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* Laramie L. Leatherman Distinguished Professor of Law, University of Kentucky College of Law. The Author would like to thank Kathy Cerminara for her comments on an earlier draft of this Article and Gwendolyn Junge for her research assistance. The Author would also like to thank Paul Secunda for his invitation to participate in the panel entitled: The Role of ERISA in Health Care Reform, at the 2010 Southeastern Association of Law Schools' Annual Conference's Employee Benefits Workshop, for which this Article was written. Finally, the Author would like to thank the other panelists and participants for their comments and insights.

"The future of employment-based insurance is one of the most important issues in health care reform." BOB LYKE, CONG. RESEARCH SERV., RL 34767, THE TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE: POLICY ISSUES REGARDING THE REPEAL DEBATE 11 (2008).

I. INTRODUCTION

In the United States, unlike in all other advanced industrial states,[1] health care is financed principally through employment-based health insurance.[2] In 2009, more than 156 million individuals under the age of sixty-five, or 59% of that population, were covered by employment-based health insurance.[3]

On March 21, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA).[4] Described as seminal as the enactment of the Employee Retirement Income Security Act (ERISA),[5] PPACA fundamentally reforms the American health care system. PPACA, however, does not eliminate the system's reliance on employment-based health insurance. Instead, it builds on, and arguably

1. *See* Jacob S. Hacker, *Review Article: Dismantling the Health Care State? Political Institutions, Public Policies and the Comparative Politics of Health Reform*, 34 BRIT. J. POL. SCI. 693, 697 (2004) (noting that the United States is the only advanced industrial state to rely principally on voluntary employment-based health insurance).
2. This Article will use the terms employment-based health insurance and employer-sponsored health care plans interchangeably even though many employer-sponsored health care plans are self-funded. *Cf.* KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2010 ANNUAL SURVEY 154–56 (2010) (noting that slightly over one-half of workers covered by an employer-sponsored health care plan are in a self-funded health plan) [hereinafter KAISER 2010 SURVEY].
3. Paul Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2010 Current Population Survey*, EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 347 (Emp. Benefit Res. Inst., Washington, D.C.), Sept. 2010, at 4. In contrast, 21.1% of that population was covered by public programs, and 6.3% purchased insurance directly from an insurer. *Id.* Almost 19% of the under-65 population was uninsured. *Id.* For individuals aged 65 and over, Medicare is the principal source of health insurance. *Id.* In 2009, just over 36 million individuals aged 65 or over, or 93.5% of that population, was covered by Medicare. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 79 tbl.C-3 (2010). A sizeable percentage of the population 65 and over—34%—also has employment-based coverage. *Id.*
4. Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, 124 Stat. 119 (2010). A week later, the President signed the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. 111-152, 124 Stat. 1029, the sidecar reconciliation bill that modified the PPACA. This Article will refer to these statutes together as PPACA.
5. Janet Cecelia Walthall, *New Health Care Law Likely to Pose Challenges for Employers, Attorneys Say*, 37 BNA PENSION & BENEFITS REP. (Bureau of Nat'l Affairs, Arlington, Va.), May 18, 2010, at 1152.

strengthens, the employment-based system.[6] This Article discusses how PPACA is likely to affect employers' willingness to sponsor employment-based health insurance.

The Article begins by providing a brief history of employment-based health insurance in the United States. It then discusses the advantages and disadvantages of this system. In doing so, it focuses on four separate aspects of employment-based health insurance: (1) its favorable tax treatment, (2) its cost, (3) the fact that the employer acts as an agent for its employees when it purchases health insurance, and (4) the labor incentives it creates. The Article then turns to the three incentives PPACA creates with respect to the provision of employment-based health insurance: (1) the large employer "pay-or-play" mandate, (2) the small employer tax credit, and (3) the excise tax on so-called "Cadillac" plans. It describes and discusses how each of these incentives is likely to affect employers' willingness to offer employment-based health insurance. It concludes that, at least in the short run, PPACA is unlikely to change the American health care system's reliance on employment-based health insurance.

II. GROWTH OF EMPLOYMENT-BASED HEALTH INSURANCE[7]

The current system of employment-based health insurance is often described as the result of historical accident.[8] Prior to World War II,

6. *See* Edward A. Zelinsky, *The Health-Related Tax Provisions of PPACA and HCERA: Contingent, Complex, Incremental and Lacking Cost Controls*, *in* 2010 N.Y.U. REV. EMP. BENEFITS & EXECUTIVE COMPENSATION 7-1, 7-3 (2010) (stating that PPACA and HCERA "build upon—indeed, extend—the existing system of private health insurance and employer-provided health care"); *cf.* DOUGLAS HOLTZ-EAKIN & CAMERON SMITH, AM. ACTION FORUM, LABOR MARKETS AND HEALTH CARE REFORM: NEW RESULTS 2 (2010), *available at* http://www.heartland.org/custom/semod_policybot/pdf/27712.pdf (noting that "[p]roponents of the PPACA insisted that a key tenet was to build on this system of employer-sponsored coverage").
7. For a detailed discussion of the origins and evolution of employment-based health insurance, see COMM. ON EMPLOYER-BASED HEALTH BENEFITS, INST. OF MED., EMPLOYMENT AND HEALTH BENEFITS: A CONNECTION AT RISK 49–86 (Marilyn J. Field & Harold T. Shapiro eds., 1993).
8. *See, e.g.*, Susan Adler Channick, *Will Americans Embrace Single-Payer Health Insurance: The Intractable Barriers of Inertia, Free Market, and Culture*, 28 LAW & INEQ. 1, 33–34 (2010); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 25 (2001); Jon R. Gabel, *Job-Based Health Insurance, 1977–1998: The Accidental System Under Scrutiny*, 18 HEALTH AFFAIRS 62, 63 (1999); Jeffrey Ralph Pettit, *Help! We've Fallen and We Can't Get Up: The Problems Families Face Because of Employment-Based Health Insurance*, 46 VAND. L. REV. 779, 784 (1993). *But see* William S. Custer et al., *Why We Should Keep the Employment-Based Health Insurance System*, 18 HEALTH AFFAIRS 115, 120 (1999) ("The employment-based health insurance system is not a historical accident. Its characteristics flow di-

some employers offered health insurance to their workers and their families, but these employers were the exception, rather than the rule.[9] According to one estimate, about four million Americans, or approximately 3% of the U.S. population, had employment-based coverage in 1930.[10]

Employment-based health insurance began to grow rapidly during World War II and is now the principal source of health insurance for most individuals. Commentators often attribute the growth of employment-based health insurance to two principal factors: (1) wage and price controls instituted during World War II and (2) its favorable tax treatment.[11] In addition, unions and the military's return to civilian life are also thought to have played a role in the development of employment-based health insurance.[12]

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rectly from our society's desire to maximize access to health care, our commitment to voluntary private markets, and the market advantages of employer-sponsored health insurance.").

9. Hyman & Hall, *supra* note 8, at 25.

10. *Id.; see also* COMM. ON EMPLOYER-BASED HEALTH BENEFITS, *supra* note 7, at 66 ("Nationwide, by 1930, plans sponsored by employers, employees or both covered only an estimated 1.2 million employees and 1 to 2 million dependents.") (citation omitted). The medical profession vehemently opposed the practice and sought to limit the spread of such arrangements. Hyman & Hall, *supra* note 8, at 25. Organized medicine opposed these early "independent plans" because they "'tied' physicians to contract rather than to fee-for-service practice and 'tied' patients to particular physicians." RASHI FEIN, MEDICAL CARE, MEDICAL COSTS: THE SEARCH FOR A HEALTH INSURANCE POLICY 12 (1986).

11. *See, e.g.*, FEIN, *supra* note 10, at 21–22; Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, 18 HEALTH AFFAIRS 124, 124 (1999); Jonathan Gruber, *The Tax Exclusion for Employer-Sponsored Health Insurance* (Nat'l Bureau of Econ. Research, Working Paper No. 15766, 2010); David A. Hyman, *Employment-Based Health Insurance: Is Health Reform a "Game Changer?"* (Univ. Ill. Law & Econ. Research Paper No. LE10-010, June 2010); *cf.* Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance*, 93 AM. ECON. R. 1373, 1373 (2003) (crediting development of employment-based health insurance to wage and price controls, favorable tax treatment, and insurance companies' ability to counter adverse selection by selling to employees groups). *But see* BOB LYKE, CONG. RESEARCH SERV., RL 34767, THE TAX EXCLUSION FOR EMPLOYER-PROVIDED HEALTH INSURANCE: POLICY ISSUES REGARDING THE REPEAL DEBATE 10 (2008). Specifically, Lyke contends:

> The historical argument about the importance of tax and regulatory policies may be overstated. Enrollment in group plans expanded steadily from 1939 onwards, starting prior to the tax ruling and regulatory changes mentioned above and increasing roughly in tandem with increases in enrollments in individual policies. If employment-based insurance supplanted individual market coverage, it was not evident at the time.

Id. (citation omitted).

12. Some commentators offer additional explanations for the growth of employment-based health insurance. For example, Jacob Hacker attributes the rise of employment-based insurance to a range of influential groups, including doctors, hospitals, insurers, and employers, who saw it as a way of achieving their goals while simultaneously reducing the pressure for compulsory governmental insur-

During World War II, the Office of Price Administration instituted wage and price controls in an attempt to deal with inflation.[13] Excluded from the definition of wages, however, were fringe benefits, such as employer contributions to health insurance and pension funds.[14] As a result, employers sought to compete for scarce labor by enhancing their fringe benefits and offering employees health insurance and pension benefits.[15] "Health insurance offered a straightforward way for employers to sweeten their compensation package in a manner that would be quite appealing to potential employees."[16]

Employment-based health insurance has long been accorded favorable tax treatment.[17] In an August 26, 1943, ruling, the Internal Revenue Service declared that the premiums employers paid on group health and accident insurance policies were excludable from the income of such employees.[18] Employers, however, were still entitled to deduct the premiums as ordinary and necessary business expenses and were not required to include the premiums in wages for employment tax purposes.[19] As the marginal tax rates during World War II

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ance. *See* JACOB S. HACKER, THE DIVIDED WELFARE STATE: THE BATTLE OVER PUBLIC AND PRIVATE SOCIAL BENEFITS IN THE UNITED STATES 219 (2002). Alain Enthoven and Victor Fuchs contend that the survival of employment-based health insurance in recent decades has depended upon the existence of Medicare and Medicaid. Alain C. Enthoven & Victor R. Fuchs, *Employment-Based Health Insurance: Past, Present, and Future*, 25 HEALTH AFFAIRS 1538, 1540–41 (2006). As critics of employment-based health insurance, Enthoven and Fuchs believe that Medicare and Medicaid have forestalled the adoption of national health insurance. *Id.* Had Medicare and Medicaid not been adopted, they argue, more than 25% of the population, rather than the current 16% or so, would be uninsured, and this would cause intense pressure to replace the current system of employment-based insurance with national health insurance. *Id.*

13. Hyman & Hall, *supra* note 8, at 25.
14. *See* The Stabilization Act of 1942, Pub. L. 77-729, § 10, 56 Stat. 765, 768. Although fringe benefits were exempted from the wage and price controls, the exemption was limited; employers could only raise fringe benefits up to 5% of total payroll. *See* KIP SULLIVAN, THE HEALTH CARE MESS: HOW WE GOT INTO IT AND HOW WE'LL GET OUT OF IT 15 (2006).
15. Hyman & Hall, *supra* note 8, at 25.
16. *Id.*
17. For a discussion of the tax treatment of employer-based health insurance prior to 1954, see LYKE, *supra* note 11, at 7–8; Comment, *Employer Health or Accident Plans: Taxfree Protection and Proceeds*, 21 U. CHI. L. REV. 277, 279–80 & n.8 (1954); Comment, *Taxation of Employee Accident and Health Plans Before and Under the 1954 Code*, 64 YALE L.J. 222 (1954).
18. *See Employer Health or Accident Plans: Taxfree Protection and Proceeds*, *supra* note 17, at 279–80 & n.8. The exception, however, did not apply to premiums paid on individual policies or to group policies which contained a savings feature. *Id.* at 279–80.
19. FEIN, *supra* note 10, at 22; Hyman, *supra* note 11, at 7.

could be as high as 85%, the real cost of a dollar of health insurance premiums could be as low as fifteen cents for the employer.[20]

The 1943 ruling was withdrawn in 1953,[21] but it was quickly replaced with a statutory exemption in 1954.[22] Since 1954, section 106 of the Internal Revenue Code has excluded employer-provided health insurance from employees' income,[23] and section 105 has excluded benefits received under employer-provided accident and health plans.[24] In contrast, individuals who purchase health insurance on their own must pay for the insurance with after-tax dollars. Individual medical care expenses are only deductible if they exceed 7.5% of annual adjusted gross income, and only the amount that exceeds 7.5% of annual adjusted gross income is deductible.[25] Although employment-based benefits do not constitute taxable income to employees, employer contributions to fund health insurance remain deductible expenses to the employer,[26] and the contributions do not constitute

20. FEIN, *supra* note 10, at 22. Under standard economic theory, the cost of health insurance is passed on to workers in the form of lower wages. *See* MARK V. PAULY, HEALTH BENEFITS AT WORK: AN ECONOMIC AND POLITICAL ANALYSIS OF EMPLOYMENT-BASED HEALTH INSURANCE 15–16 (1997) (providing a brief statement of the economic model). *But see* LINDA J. BLUMBERG, URBAN INST., EMPLOYER-SPONSORED HEALTH INSURANCE AND THE LOW-INCOME WORKFORCE: LIMITATIONS OF THE SYSTEM AND STRATEGIES FOR INCREASING COVERAGE 6 (2007) ("While the best empirical evidence available indicates that, at least in large part, employer payments are passed back to workers via reduced wages, . . . most employers do not believe this is the case.") (citations omitted); Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance*, 81 MILBANK Q. 5, 5–6 (2003) (contending that there is little data to support the standard economic theory). Regardless of the validity of this theory, when the wage and price controls were in effect, workers did not bear the cost of health insurance in the form of lower wages. Rather, employers sought indirect ways to increase workers' wages, and health insurance was a permissible and nontaxable way to increase workers' wages.
21. Hyman & Hall, *supra* note 8, at 25.
22. *See* Internal Revenue Code of 1954, Pub. L. 83-951, 68A Stat. 1, 32.
23. *See* LYKE, *supra* note 11, at 7. Section 106(a) of the Internal Revenue Code currently provides, "Except as otherwise provided in this section, gross income of an employee does not include employer-provided coverage under an accident or health plan." I.R.C. § 106(a) (2006). Although the wording of the provision has changed and subsections have been added to section 106, the substance of this provision has not changed since it was enacted in 1954. *See* LYKE, *supra* note 11, at 7. Section 125 of the Internal Revenue Code extends the exclusion to premiums paid by employees under premium conversion plans. I.R.C. § 125(a) (2006).
24. I.R.C. § 105(b) (2006).
25. *Id.* § 213(a). In 2005, about 35% of all individual income tax returns had itemized deductions, and of these, less than 21% of these claimed a medical expense deduction, which accounted for about 7% of all tax returns. *See* LYKE, *supra* note 11, at 18. The self-employed may also deduct the premiums they pay for health for themselves and for their families. *See* I.R.C. § 162(l) (2006). Less than 3% of all individual income tax returns take this deduction. *See* LYKE, *supra* note 11, at 18.
26. *See* I.R.C. § 162 (2006); Treas. Reg. § 1.162-10(a) (1960).

wages for purposes of the employment tax.[27] The Joint Committee on Taxation has identified the income tax exclusion for employer contributions for health care, health insurance premiums, and long-term care insurance premiums[28] as the single largest tax expenditure[29] for fiscal year 2009, with an estimated loss of $94.4 billion in tax revenue in 2009 alone.[30]

In addition to the wage and price controls instituted during World War II, and favorable tax treatment, unions are often cited as a factor contributing to the growth of employment-based health insurance during the 1940s and 1950s.[31] Although initially suspicious of employment-based health insurance,[32] labor unions, by the late 1940s, aggressively bargained for health insurance.[33] In industries dominated by a few large companies, unions bargained for generous health insurance benefits for their workers.[34] In industries consisting of many small employers, "unions organized industrywide labor-management health insurance plans that provided considerable cross-subsidization among firms and among individual employees within firms by charging uniform premiums regardless of expected utilization."[35]

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27. *See* I.R.C. § 3121(a)(2) (2006). The Joint Tax Committee estimated the exclusion reduced Social Security and Medicare taxes by about $93.5 billion in 2008. *See* STAFF OF JOINT COMM. ON TAXATION, 111TH CONG., BACKGROUND MATERIALS FOR SENATE COMMITTEE ON FINANCE ROUNDTABLE ON HEALTH CARE FINANCING, JCX-27-09, at 2 tbl.1 (2009). The contributions are similarly exempt from the unemployment tax. *See* I.R.C. § 3306(b)(2) (2006).
28. The exclusion for employer-provided coverage under accident and health plans and the exclusion for benefits employees receive under employer-provided accident and health plans are viewed as a single tax expenditure. *See* STAFF OF JOINT COMM. ON TAXATION, 111TH CONG., ESTIMATES OF FEDERAL TAX EXPENDITURES FOR FISCAL YEARS 2009–2013, JCS-1-10, at 6 n.14 (2010).
29. Tax expenditures are defined as "revenue losses attributable to provisions of the Federal tax laws which allow a special exclusion, exemption, or deduction from gross income or which provide a special credit, a preferential rate of tax, or a deferral of tax liability." *Id.* at 3 (citation omitted).
30. *Id.* at 41. The tax expenditure for fiscal years 2009–2013 combined is estimated to be $568.3 billion. *Id.*
31. *See, e.g.*, COMM. ON EMPLOYER-BASED HEALTH BENEFITS, *supra* note 7, at 70; Enthoven & Fuchs, *supra* note 12, at 1539–60; Hyman & Hall, *supra* note 8, at 25. For an analysis of the role of unions in the development of health care policy, see David Rosner & Gerald Markowitz, *The Struggle over Employee Benefits: The Role of Labor in Influencing Modern Health Policy*, 81 MILBANK Q. 45 (2003).
32. Dayna Bowen Matthew, *Controlling the Reverse Agency Costs of Employment-Based Health Insurance: Of Markets, Courts, and a Regulatory Quagmire*, 31 WAKE FOREST L. REV. 1037, 1042 (1996).
33. Hyman & Hall, *supra* note 8, at 26 (citing JOSEPH A. CALIFANO, JR., AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS? 44–45 (1986) and PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 310–15 (1982)).
34. Enthoven & Fuchs, *supra* note 12, at 1539.
35. *Id.* at 1539–40.

Employers with workforces that were not unionized offered rich health care benefits to discourage employees from joining unions.[36]

The return of military veterans to civilian life is also thought to have helped enhance the growth of employment-based health insurance during the 1940s and 1950s.[37] During World War II, military personnel grew accustomed to receiving government-issued health insurance.[38] When they returned to the civilian workforce, they sought a similar arrangement.[39]

III. ADVANTAGES AND DISADVANTAGES OF EMPLOYMENT-BASED HEALTH INSURANCE

Although World War II and its wage and price controls are long over, and unions are much less powerful than they once were, employment-based health insurance remains the dominant form of health insurance in this country. Moreover, most employees rate health insurance their most important and valuable employee benefit.[40] Yet, employment-based health insurance has been the subject of considerable criticism.

This section provides an overview of the advantages and disadvantages of employment-based health insurance and the reasons why employers voluntarily offer health insurance. At the outset, it is important to note that determining the advantages and disadvantages of employment-based health insurance depends, in large part, on the lens through which one views it. To illustrate, relative to private, individual health insurance, administrative costs may be viewed as an advantage of employment-based health insurance. Relative to a single-payer system, in contrast, administrative costs may be viewed as a disadvantage of the employment-based system.

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36. Hyman, *supra* note 11, at 8.
37. *See* Matthew, *supra* note 32, at 1041.
38. *Id.* (citation omitted).
39. *Id.* (citation omitted); *see also* FEIN, *supra* note 10, at 23 ("[A]fter the war, millions of veterans who had received free medical care, and thus experienced the remove of the financial barrier to the receipt of care, as civilians wanted the next best thing: insured care.").
40. *See, e.g.*, Press Release, Nat'l Bus. Group on Health, *Most Workers Satisfied with Health Care Benefits, National Business Group on Health Survey Finds* (April 12, 2007), *available at* http://www.businessgrouphealth.org/pressrelease.cfm?ID=87 (stating that 75% of respondents in survey of 1619 workers at large U.S. firms value their health plan as their most important benefit); *see also* John D. Banja, *The Improbable Future of Employment-Based Insurance*, HASTINGS CENTER REP., May–Jun. 2000, at 17, 17 ("[P]olls indicate that the majority of Americans believe health insurance is the most valuable benefit their employer provides and that employers, not government, should be the primary providers of health insurance.") (citation omitted); O'Brien, *supra* note 20, at 10 ("Surveys confirm that workers view employment-based health insurance as a very valuable benefit of work.").

In providing an overview of the advantages and disadvantages of voluntary employment-based health insurance, this section focuses on four separate aspects of employment-based insurance: (1) its favorable tax treatment, (2) its cost, (3) the fact that the employer acts as an agent for its employees when purchasing insurance, and (4) the labor incentives it creates.

A. Favorable Tax Treatment

One of the principal advantages of employment-based health insurance is that, as discussed above, employment-based health insurance is eligible for favorable tax treatment. The value of the tax exemption to an individual worker depends on the worker's marginal tax rate, with the exemption being more valuable to a higher-income worker with a higher marginal tax rate than to a lower-income worker with a lower marginal tax rate.[41] There is general agreement that this favorable tax treatment encourages employers to offer health insurance,[42] but economists disagree as to how significant a role tax treatment plays in employers' decisions to offer employment-based health insurance.[43]

The tax preference accorded employment-based health insurance has been subject to a great deal of criticism. Critics contend that it is inequitable because (1) individuals who do not have employment-based health insurance do not benefit from the tax exclusion,[44] and (2) the tax subsidy is more valuable for higher-income workers than it is for lower-income workers.[45] In addition, critics contend that the tax

41. Gruber, *supra* note 11, at 21 (finding that five-sixths of the benefit of the tax exclusion for employment-based health insurance flows to the top half of the income distribution).

42. According to Melissa Thomasson, codification of the exclusion of the favorable tax treatment in 1954 resulted in an increase in the amount of coverage obtained and a shift from individual to group health insurance. *See* Thomasson, *supra* note 11, at 1382.

43. *See, e.g.*, Jonathan Gruber, *The Impact of the Tax System on Health Insurance Coverage*, 1 INT'L J. HEALTH CARE FIN. & ECON. 293, 294, 302 (2001) (noting that "there is relatively little consensus about the impact of tax subsidies on insurance coverage," and finding that "the firm's decision to offer insurance is sizeably affected by the tax price of insurance; the implied elasticity of firm offering with respect to taxes is -0.7"); *cf.* Patricia G. Ketsche, *An Analysis of the Effect of Tax Policy on Health Insurance Purchases by Risk Group*, 71 J. OF RISK & INS. 91 (2004) (finding that the probability that an individual will have employment-based insurance is an increasing function of the tax subsidy and the marginal effect of the subsidy is greater for high-risk individuals and is decreasing in income).

44. *See* LYKE, *supra* note 11, at 17–18; Banja, *supra* note 40, at 18; Custer et al., *supra* note 8, at 117.

45. *See* STAN DORN, URBAN INST., CAPPING THE TAX EXCLUSION OF EMPLOYER-SPONSORED HEALTH INSURANCE: IS EQUITY FEASIBLE 1 (2009); LYKE, *supra* note 11, at 18–19; Banja, *supra* note 40, at 18; Reinhardt, *supra* note 11, at 127.

subsidy creates an incentive to purchase too much insurance, which distorts the health services market, causes inefficient allocation of scarce resources, and increases health care costs.[46]

B. Cost

A second advantage of employment-based health insurance is that it is typically much less expensive than health insurance individual workers can purchase on the private market. This lower cost can be attributed to three separate factors. First, administrative costs are typically much lower for employment-based insurance than for individual insurance.[47] According to David Hyman and Mark Hall, the largest employer groups typically have administrative costs of 5% or less, while the administrative costs for smaller groups may reach about 20%, and the administrative costs for individual purchasers may exceed 30%.[48] Second, through "pooling," employment-based health insurance avoids, or at least reduces, the problem of adverse selection.[49] Third, workers[50] tend to be healthier, on average, than non-workers,[51] and thus the cost of insuring them tends to be lower.[52]

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46. *See* DORN, *supra* note 45, at 1; LYKE, *supra* note 11, at 12–14; Banja, *supra* note 40, at 18; Custer et al., *supra* note 8, at 119; Paul Fronstin, *Capping the Tax Exclusion for Employment-Based Health Coverage: Implications for Employers and Workers,* EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 325 (Emp. Benefit Res. Inst., Washington, D.C.), Jan. 2009, at 5.
47. *See* Sherry A. Glied & Phyllis C. Borzi, *The Current State of Employment-Based Health Coverage*, 32 J.L. MED. & ETHICS 404, 407 (2004); O'Brien, *supra* note 20, at 9; Mark Pauly et al., *Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons,* 18 HEALTH AFFAIRS 28, 31, 33 (1999); Thomasson, *supra* note 11, at 1374; *see also* Pettit, *supra* note 8, at 785 (contending that employment-based insurance "leads to substantial savings in marketing, processing, and other administrative costs for group purchasers").
48. Hyman & Hall, *supra* note 8, at 31.
49. *See* FEIN, *supra* note 10, at 24–25; Custer et al., *supra* note 8, at 117; Hyman & Hall, *supra* note 8, at 31–32; O'Brien, *supra* note 20, at 9; Thomasson, *supra* note 11, at 1374.
50. Employment-based health insurance also covers some retirees. *See* INT'L FOUND. OF EMP. BENEFIT PLANS, HEALTH CARE REFORM: WHAT EMPLOYERS ARE CONSIDERING 23 (2010) (noting that 39.2% of surveyed single employer plans currently offer medical benefits to retired employees) [hereinafter IFEBP]. Retiree health insurance coverage, however, is much less common than it was 10 or 20 years ago. *See* KAISER 2010 SURVEY, *supra* note 2, at 163 ex. 11.1 (showing that proportion of employers with 200 or more employees offering health insurance to active employees that also offer retiree health insurance declined from 66% in 1988 to 28% in 2010).
51. To a lesser extent, workers' dependents also tend to be healthier. *See* Hyman & Hall, *supra* note 8, at 32–33.
52. *Id.* at 33; O'Brien, *supra* note 20, at 9. *Cf.* Reinhardt, *supra* note 11, at 124 (noting that although employer-based health insurance covers about two-thirds of the U.S. population, it accounts for less than one-third of national health spending, because public insurance programs cover the relative high cost populations of the elderly, poor, and disabled). Of course, this is not to suggest that all workers are

Relative to private, individual health insurance, the administrative costs and limited coverage of employment-based health insurance may be viewed as advantages because they reduce the cost of employment-based insurance. Proponents of universal health care, on the other hand, view the administrative costs and limited coverage as disadvantages of employment-based health insurance. For example, Uwe Reinhardt has noted that the administrative costs under the American health care system were $360 higher per capita than under the German health care system.[53] Alain Enthoven and Victor Fuchs, strong proponents of a universal health care system,[54] contend that under the voluntary employment-based system, "[t]he need for more than 850 health insurance companies to sell and contract with millions of employers underwriting each one, adds greatly to administrative costs."[55] Enthoven and Fuchs assert that typical administrative costs under the voluntary employment-based system are about 11%,[56] compared to costs of 0.5% for the California's Public Employees Retirement System's (CalPERS) coverage of 400,000 employees and dependents through its single annual contract with Kaiser Permanente.[57]

Ethicists contend that health care is a fundamental public good that should not depend on a voluntary system.[58] By its very nature,

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healthy. Indeed, a specific subset of workers, the chronically ill, imposes significant costs on employment-based health insurance. *See* Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform*, 9 YALE J. HEALTH POL'Y L. & ETHICS 453, 457 (2009) ("In a recent survey, over 56% of responding employers identified chronic health conditions as a top source of health care costs, topped only by the aging population at 58%.").

53. Reinhardt, *supra* note 11, at 128–29. According to Reinhardt, the German health care system is "based on private, not-for-profit sickness funds that operate within a tight statutory framework." *Id.* at 128. For a detailed discussion of the German public health care system, the oldest and arguably most successful public financing system in the world, see TIMOTHY STOLTZFUS JOST, DISENTITLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 235–64 (2003).
54. "The implicit standard by which we analyze job-based insurance is what we believe could be accomplished by a system of universal health insurance based on tax-financed premium support, managed competition, and responsible consumer choice of health plans/delivery systems, broadly resembling the Federal Employees Health Benefits (FEHB) program." Enthoven & Fuchs, *supra* note 12, at 1541.
55. *Id.*
56. *Id.* at 1541 & n.8 (citation omitted).
57. *Id.* at 1541. According to one authority, administrative costs for Canada's government-run single-payer system are about 3% of total costs. *See* David Pratt, *The Past, Present and Future of Health Care Reform: Can It Happen?*, 40 J. MARSHALL L. REV. 767, 771 (2007) (citation omitted).
58. *See* Banja, *supra* note 40, at 17; *see also* Universal Declaration of Human Rights, G.A. Res. 217(III)A, U. N. Doc. A/RES/217(III) at 71, Art. 25(1) (Dec. 10, 1948) ("Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical

voluntary employment-based health insurance cannot and does not cover the entire working population, let alone the entire U.S. population.[59] For example, lower-income workers are less likely to have employment-based health insurance than are higher-income workers,[60] and individuals who work for small employers are less likely to have employment-based health insurance than are individuals employed by large firms.[61] In addition, workers in certain industries, such as manufacturing, professional services, and the public sector, are more likely to have health insurance than are workers in other industries, such as agriculture, food services, and entertainment.[62] Indeed, under the country's voluntary employment-based health insurance system, almost 19% of the U.S. population under the age of 65 was uninsured in 2009.[63] According to proponents of universal health care, this is a fundamental failure of voluntary employment-based health insurance.

C. The Employer as Agent for Its Employees

A third advantage of employment-based health insurance, from the standpoint of employees, is that employers, acting as agents for their employees,[64] can help employees avoid transaction costs in the selec-

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care and necessary social services, and the right to security in the event of . . . sickness [and] disability . . . ."); Fazal Khan, *Towards Achieving Lasting Healthcare Reform: Rethinking the American Social Contract*, 19 ANNALS HEALTH L. 73, 73–74 (2010) (contending that in order "to achieve lasting, rational, and comprehensive healthcare reform, a political consensus in the U.S. has to form that healthcare is a basic fundamental right, and not merely an important legislative concern subject to compromise among various interests").

59. *See* Enthoven & Fuchs, *supra* note 12, at 1541–42. Some contend that the failure of voluntary employment-based health insurance to cover the entire working population is largely due to insufficient demand by workers rather than insufficient supply. *See* THOMAS C. BUCHMUELLER, CALIF. HEALTHCARE FOUND., THE BUSINESS CASE FOR EMPLOYER-PROVIDED HEALTH BENEFITS: A REVIEW OF THE RELEVANT LITERATURE 4–5 (2000).

60. *See* BLUMBERG, *supra* note 20, at 3.

61. *See id.* at 4; LAWRENCE A. FROLIK & KATHRYN L. MOORE, LAW OF EMPLOYEE PENSION AND WELFARE BENEFITS 11 (2d ed. 2008).

62. *See* FROLIK & MOORE, *supra* note 61, at 11.

63. *See* Fronstin, *supra* note 3, at 4.

64. "In the economic literature, an agent is defined as one acting on the behalf of another, who is referred to as the principal." Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?,* 78 MILBANK Q. 5, 5 (2000). Under traditional common law rules, an employer would not qualify as an agent for its employees because the employer is not under the direct control of its employees. *See* Gail B. Agrawal, *Resuscitating Professionalism: Self-Regulation in the Medical Marketplace*, 66 MO. L. REV. 341, 370 (2001). Nevertheless, legal commentators, as well as economists, frequently refer to the employer as an agent, or reverse agent, in this context. *See, e.g.*, Hyman & Hall, *supra* note 8, at 26–30 (detailing the "mismatches" between employers and employees with regard to providing employment-based health insurance). *See generally* Matthew, *supra* note 32, at 1037–74 (using an agency model to describe

tion of their health insurance policies. Shopping for individual health insurance can be time consuming because employees may be required to assess and compare the benefits of many different plans.[65] Employers assist employees by offering employees a limited choice among plans.[66] In addition, employers, acting as agents for their employees, can aggressively bargain for discounts for their employees, effectively advocate for employees in the case of coverage disputes, and generally obtain more valuable coverage for the same money than employees could on their own.[67]

In a focus group study of large employers in Pittsburgh and Cleveland, four researchers[68] found that employers generally do a good job as agents for their employees in the health insurance market.[69] For these purposes, an employer was considered to be a good agent if (1) the employer understood its employees' health plan preferences, (2) the employer incorporated its employees' preferences into its health plan designs, and (3) employees valued their employer's role as an agent in purchasing health insurance benefits.[70]

On the other hand, the fact that employers act as agents for their employees is sometimes viewed as a fault of employment-based health insurance. According to David Hyman and Mark Hall, staunch sup-

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the employer's relationship with employees in the context of an employment-based health insurance system).

65. *See* O'Brien, *supra* note 20, at 10. Some states, however, limit the number of standardized benefit packages that may be sold in the individual market. *See* Pauly et al., *supra* note 47, at 31 & n.2.

66. *See* KAISER 2010 SURVEY, *supra* note 2, at 60–61 ex. 4.1 (showing that 84% of firms that offer health benefits only offer employees one type of plan, 14% offer two types of plans, and only 2% offer employee three types of plans); *see also* Gruber, *supra* note 11, at 4 (noting that employees value the ease of plan choice and administration of employment-based health insurance). *See generally* Judith R. Lave et al., *Changing the Employer-Sponsored Health Plan System: The Views of Employees in Large Firms*, 18 HEALTH AFFAIRS 112, 114–16 (1999) (finding that most focus group participants preferred to have some choice among plans but did not want to go out on the market and shop for themselves.). On the other hand, lack of choice is sometimes said to be a disadvantage of employment-based insurance. *See* Glied & Borzi, *supra* note 47, at 406; Pauly et al., *supra* note 47, at 31; Reinhardt, *supra* note 11, at 128.

67. *See* Hyman & Hall, *supra* note 8, at 30; *see also* Lave et al., *supra* note 66, at 115 (confirming that large employers have been able to bargain aggressively to get lower prices and do act as advocates for their employees); Peele et al., *supra* note 64, at 5–6 ("Analysts point out that many employees view their employer's agency role favorably because employers can negotiate better terms when purchasing goods, such as health insurance and other employment benefits, than employees can obtain on their own."); Pettit, *supra* note 8, at 785 ("Group insurance promotes competition among insurers because of employers' increased ability to evaluate potential plans and make informed decisions.").

68. The researchers were Pamela B. Peele, Judith R. Lave, Jeanne T. Black, and John H. Evans III. Peele et al., *supra* note 64, at 5.

69. *Id.* at 5, 16–20.

70. *Id.* at 7.

porters of employment-based health insurance, most of the problems associated employment-based health insurance arise, at least in theory,[71] from the fact that employers rather than employees—the ultimate consumers of health care—are responsible for making most of the decisions with respect to coverage and cost.[72] The fear is that employers, particularly in a weak economy, may be more motivated by cost considerations than the wishes of their employees in negotiating health care contracts.[73] Indeed, a few critics contend that agency cost problems are a significant cause of the health care crisis.[74] Specifically, they contend that incentives under the voluntary employment-based system create a zero sum game where employers and insurers lose when employees are granted benefits.[75]

D. Labor Incentives

A fourth potential advantage of employment-based health insurance is that it may help employers attract and retain high-quality workers.[76] To the extent that workers value employment-based health insurance, they may be better, more productive, and more loyal

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71. *See* Hyman & Hall, *supra* note 8, at 30 & n.52 (contending that agency problems are often more theoretical than real and citing surveys and studies that show that employers do a reasonably good job reflecting the values and preferences of their employees).
72. *See id.* at 26–30; *see also* Matthew, *supra* note 32, at 1055–61 (citing a 1967 empirical study by Mark Pauly and Gerald Goldstein in support of the argument that employers have different insurance preferences and will make different insurance decisions than employees would make for themselves).
73. *Cf.* Kathy L. Cerminara, *Contextualizing ADR in Managed Care: A Proposal Aimed at Easing Tensions and Resolving Conflict*, 33 LOY. U. CHI. L.J. 547, 570 (2002) ("[A]n employer is susceptible to certain conflicts of interest when negotiating a health care coverage contract for its employees. For example, the employer may be either more or less willing to trade off price for quality than its employees.").
74. *See* John Bronsteen et al., *ERISA, Agency Costs, and the Future of Health Care in the United States*, 76 FORDHAM L. REV. 2297, 2311–19 (2008); *see also* Enthoven & Fuchs, *supra* note 12, at 1542 (contending that "employer insurance has helped perpetuate the inefficiencies inherent in the fragmented, uncoordinated fee-for-service (FFS) small-scale practice model that still accounts for most of health care delivery").
75. *See* Bronsteen et al., *supra* note 74, at 2308–09. *But see* Custer et al., *supra* note 8, at 119 (contending that employers as purchasers of insurance play an important role in keeping down health care costs).
76. *See* BLUMBERG, *supra* note 20, at 2–3; O'Brien, *supra* note 20, at 12–16; *see also* AM. BENEFITS COUNCIL, CONDITION CRITICAL: TEN PRESCRIPTIONS FOR REFORMING HEALTH CARE QUALITY, COST AND COVERAGE 6 (2009) ("In this system, employers have strong incentives to offer health care coverage to recruit and retain a talented workforce to best meet their unique needs."); Hyman, *supra* note 11, at 6 ("[E]mployers use [employment-based health insurance] to help them attract and retain qualified workers, lower absenteeism, sick pay and disability costs, and increase productivity.").

employees if their employers provide health insurance benefits.[77] Indeed, employers report that they believe that offering health insurance has a positive impact on the overall success of their business.[78]

Whether employment-based health insurance leads to a better, more productive workforce and has a positive impact on the employer's bottom line is subject to debate. In 2000, Thomas Buchmueller reviewed the existing literature and concluded that there was little evidence that employment-based health insurance dramatically increases worker productivity or reduces workers' compensation costs and employee absenteeism.[79] On the other hand, Ellen O'Brien reviewed the literature and found some support for the proposition that offering health insurance results in gains in worker quality and productivity.[80] Nevertheless, O'Brien recognized that there are substantial gaps in the research and contended that economists should make more of an effort to assess the relationship between health insurance coverage and its effect on overall business success.[81]

On a related note, employment-based health insurance has been criticized for distorting the labor market by encouraging employees to remain in jobs solely to retain their health insurance, a phenomenon referred to as "job lock."[82] Congress has enacted two laws to reduce job lock. The first, the Consolidated Omnibus Budget Reconciliation Act (COBRA),[83] requires employers with health insurance to offer "qualified beneficiaries,"[84] who would otherwise lose coverage under the plan due to a "qualifying event,"[85] the right to continue their

77. *See* Paul B. Ginsburg, *Employment-Based Health Benefits Under Universal Coverage*, 27 HEALTH AFFAIRS 675, 677 (2008); Matthew, *supra* note 32, at 1044.

78. *See* Paul Fronstin, *The Future of Employment-Based Health Benefits: Have Employers Reached a Tipping Point?*, EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 312 (Emp. Benefit Res. Inst., Washington, D.C.), Dec. 2007, at 13; Paul Fronstin & Ruth Helman, *Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey*, EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 253 (Emp. Benefit Res. Inst., Washington, D.C.), Jan. 2003, at 7.

79. BUCHMUELLER, *supra* note 59, at 10–17.

80. O'Brien, *supra* note 20, at 16–28.

81. *Id.* at 29–35.

82. *See* Reinhardt, *supra* note 11, at 127 ("Because the employer-based system ties health insurance to a particular job, it can induce employees to remain indentured in a detested job simply because it is the sole source of affordable health coverage."). For a review of the economics literature on job lock, see Jonathan Gruber & Brigitte C. Madrian, *Health Insurance, Labor Supply, and Job Mobility: Critical Review of the Literature*, *in* HEALTH POLICY AND THE UNINSURED 97 (Catherine G. McLaughlin ed., 2004).

83. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82.

84. "Qualified beneficiaries" include the covered employee, the covered employee's spouse, and the covered employee's dependent child. 29 U.S.C. § 1167 (2006).

85. "Qualifying events" include the death of the covered employee, the termination—except in the case of gross misconduct—or reduction in the hours of the covered

health coverage for a specified period of time[86] by paying 102% of the cost of coverage.[87] Employees who terminate employment—whether voluntarily or involuntarily—may generally continue coverage for up to eighteen months.[88] Although COBRA may have reduced job lock,[89] it has its limitations. First, it requires that employees pay the premiums,[90] and many employees find the premiums prohibitively expensive.[91] Second, even for those employees who can afford to pay the premiums, coverage is only provided for a limited period of time.

The Health Insurance Portability and Accountability Act (HIPAA),[92] the second law intended to reduce job lock,[93] was enacted in 1996. HIPAA limits the ability of employers to limit or exclude coverage for conditions that were present prior to the time the individual enrolled in the employer's health care plan by (1) limiting the types of conditions that may be excluded and (2) limiting the length of time health care plans may impose preexisting condition exclusions. First, HIPAA provides that unless "medical advice, diagnosis, care, or treat-

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employee's employment, and divorce or legal separation from the covered employee. *Id.* § 1163.

86. If the qualifying event is termination of employment, or reduction in hours, the maximum period of continuation coverage is eighteen months. *Id.* § 1162(2)(A)(i). In other cases, the maximum period is generally thirty-six months. *Id.* § 1162(A)(iv).

87. 29 U.S.C. § 1162(3) (2006). After 18 months of continuation coverage, the plan sponsor may charge up to 150% of the applicable premium. *Id.*

88. *Id.* § 1162(2)(A)(i).

89. *Cf.* Jonathan Gruber & Brigitte C. Madrian, *Health Insurance and Job Mobility: The Effects of Public Policy on Job-Lock*, 48 INDUS. & LAB. REL. REV. 86, 95–100 (1994) (using state-wide variation in continuation coverage laws to find twelve months of continuation coverage increased the job mobility of workers with health insurance coverage by 10%).

90. In February 2009, Congress created a temporary program pursuant to which the federal government agreed to pay 65% of COBRA premiums, initially for up to nine months and later for up to fifteen months. The program was extended three times and ultimately expired in May 2010. For a discussion of the program and early evidence showing that fewer individuals than expected sought this assistance, see Paul Fronstin, *Examination of the Short-term Impact of the COBRA Premium Subsidy and Characteristics of the COBRA Population*, 31 EMP. BENEFIT RES. INST. NOTES (Emp. Benefit Res. Inst., Washington, D.C.), June 2010, at 8. *See also* RANDALL R. BOVBJERG ET AL., URBAN INST., FEDERAL SUBSIDY FOR LAID-OFF WORKERS' HEALTH INSURANCE: A FIRST YEAR'S REPORT CARD FOR THE NEW COBRA PREMIUM ASSISTANCE (2010) (finding that more employees claimed COBRA benefits after subsidy enacted but noting that take-up rates vary among different populations).

91. Pendo, *supra* note 52, at 460 ("[A] recent study found that although most unemployed workers are eligible, fewer than one in ten extends coverage under [COBRA].").

92. Health Insurance Portability and Accountability Act, Pub. L. 104-191, 110 Stat. 1936 (1996).

93. Among other things, HIPAA was intended "to improve portability and continuity of health insurance coverage in the group and individual markets." *Id.*

ment was recommended or received" for a condition within six months prior to enrollment in the new plan, the health care plan cannot treat the condition as a preexisting condition.[94] In addition, HIPAA limits the maximum period for a preexisting exclusion to twelve months.[95] HIPAA permits individuals to offset the twelve month period with any period of prior "creditable coverage."[96] "Creditable coverage" is defined broadly,[97] but creditable coverage is forfeited if there is a sixty-three day period during which the individual did not have any health care coverage.[98] Thus, HIPAA prohibits a plan from imposing any preexisting condition exclusion with respect to any individual who has at least twelve months of prior health care coverage, enrolls in the new plan at the first opportunity, and did not experience a sixty-three day lapse in coverage. HIPAA neither requires plans to provide specific benefits nor restricts the premiums plans may charge to all participants.[99] It allows plans to establish limits or place restrictions on the amount, extent, or level of a plan's coverage and benefits for "similarly situated individuals" in the plan.

While COBRA and HIPAA may have reduced job lock,[100] they have not entirely eliminated it. For example, COBRA and HIPAA do not require that employers provide retiree health insurance.[101] Thus, workers with employment-based health insurance may elect to delay retirement until they are eligible for Medicare if their employer does not offer retiree health insurance.[102] Similarly, a worker may forgo a

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94. 29 U.S.C. § 1181(a)(1) (2006). PPACA expands HIPAA's preexisting condition exclusion provisions. *See* PPACA § 1201, 124 Stat. at 154 (adding PHSA § 2704). Effective for plan years beginning on or after January 1, 2014, preexisting conditions are defined to include preexisting conditions regardless of whether any medical advice, diagnosis, care, or treatment was received for the condition at any time prior to enrollment. 29 C.F.R. § 2590.701-2 (2010); 45 C.F.R. § 144.103 (2010).
95. *Id.* § 1181(a)(2). The exclusion period is extended to eighteen months for a late enrollee. *Id.*
96. *Id.* § 1181(a)(3).
97. *Id.* § 1181(c)(1).
98. *Id.* § 1181(c)(2)(A).
99. HIPAA does prohibit a plan from charging one individual a higher premium than the premium charged to a similarly situated individual already enrolled in the plan on the basis of any health status related factors. *Id.* § 1182(b)(1).
100. *But see* Anna Sanz-de-Galdeano, *Job-Lock and Public Policy: Clinton's Second Mandate*, 59 INDUS. & LAB. REL. REV. 430, 436 (2006) (using data from the 1996 panel of the Survey of Income and Program Participation (SIPP) and finding the impact of HIPAA on job-lock to be small and statistically insignificant).
101. COBRA requires that employers offer employees the opportunity to continue their health insurance after retirement, but, as noted above, employees must pay for that continuing coverage, and the continuing coverage is only available for a limited period of time. *See supra* notes 83–91 and accompanying text.
102. *See generally* Richard W. Johnson et al., *Health Insurance Costs and Early Retirement Decisions*, 56 INDUS. & LAB. REL. REV. 716 (2003) (describing studies that show that the availability of health insurance and/or Medicare after retire-

job change if the prospective employer does not offer health insurance, if the prospective employer's health coverage is inferior to the current employer's coverage, or if the prospective employer's plan is more expensive than the current employer's plan.[103] Moreover, an employee may decide not to change jobs if the prospective employer's plan does not provide access to the same physicians and medical facilities as were available under the current employer's plan.[104]

IV. PPACA'S IMPACT ON EMPLOYMENT-BASED HEALTH INSURANCE

The Patient Protection and Affordable Care Act regulates the substance of employer-provided health care plans in a number of ways.[105] For example, PPACA requires any group health plan that provides dependent coverage to continue to make that coverage available to a child until the child turns twenty-six.[106] In addition, PPACA prohibits group health plans from imposing annual or lifetime limits on "es-

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ment affects the timing of retirement). *Cf.* Kanika Kapur & Jeannette Rogowski, *The Role of Health Insurance in Joint Retirement Among Married Couples*, 60 INDUS. & LAB. REL. REV. 397, 404 (2007). Kapur and Rogowski utilized data from the Health and Retirement Study (HRS) to determine the effect of retiree health insurance for wives on "joint retirement"—that is, whether husbands and wives would retire at the same time. *Id.* at 397–403. The authors found that "the presence of retiree health insurance for the wife significantly increased the probability of joint retirement relative to the husband retiring first. Couples in which wives had retiree health insurance were also significantly more likely to retire jointly than to postpone retirement." *Id.* at 404.

103. In 2008, some 25% of the respondents to the Employee Benefit Research Institute's Health Confidence Survey reported that either they or an immediate family member had passed up another job opportunity, stayed at a job they would otherwise have quit, or delayed retirement because of the need to retain health insurance. *See* Paul Fronstin & Murray N. Ross, *Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider*, EMP. BENEFIT RES. INST. ISSUE BRIEF NO. 330 (Emp. Benefit Res. Inst., Washington, D.C.), June 2009, at 19; *see also* EMP. BENEFIT RES. INST, THE 2001 HEALTH CONFIDENCE SURVEY SUMMARY OF FINDINGS 7–8 (2001) (noting reasons most frequently cited for job lock are respondents "could not afford health insurance on their own (28 percent) or the potential employer did not offer health insurance (15 percent), the potential employer offered fewer benefits (20 percent), and they or a family member had a medical condition that would not be covered by a potential employer's plan (18 percent)").

104. *See* Lave et al., *supra* note 66, at 112–13 ("[B]ecause specific health plans are typically not portable from company to company, changing jobs may mean losing access to a provider and interrupting continuity of care.").

105. For an overview of PPACA's regulation of employment-based health insurance, see Kurt L.P. Lawson, *Provisions of Interest to Employers in the Patient Protection and Affordable Care Act*, 64 BNA PENSION & BENEFITS DAILY (Bureau of Nat'l Affairs, Arlington, Va.), Apr. 6, 2010, at 1.

106. Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, § 1001(5), 124 Stat. 119, 132 (2010) (adding Public Health Service Act (PHSA) § 2714, as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA),

sential benefits."[107] These substantive provisions are likely to affect the number of individuals covered by employment-based health insurance as well as the willingness of employers to sponsor health care plans by increasing the cost of such plans. Other provisions of PPACA, such as the mandate that individuals purchase health insurance or pay a penalty[108] and PPACA's subsidy for health care coverage for low-income individuals,[109] are likely to affect the demand for employment-based health insurance.

This section will not attempt to analyze all the ways in which PPACA is likely to impact employment-based health insurance and employers' willingness to offer such plans. Instead, it will focus on three separate provisions of PPACA that were specifically intended to influence employers' willingness to offer health insurance: (1) the large employer "pay-or-play" mandate, (2) the small employer tax credit, and (3) the excise tax on so-called "Cadillac" plans. This section describes and discusses how each of these incentives is likely to affect employers' willingness to offer health care plans.

A. Large Employer "Pay-or-Play" Mandate[110]

PPACA does not mandate that employers provide employees with health care coverage. Beginning in 2014, however, it imposes an excise tax on "applicable large employers" who fail to offer employment-based health insurance. This section begins by describing the penalty to which employers are subject if they fail to offer coverage. It then discusses whether employers are likely to "pay" the penalty or "play" by offering employment-based health insurance.

Pub. L. 111-152, 124 Stat. 1029, 1082) (to be codified as amended at 42 U.S.C. § 300gg-14).

107. PPACA § 1001(5), 124 Stat. at 131 (adding PHSA § 2711, as amended by PPACA § 10101(a), 124 Stat. at 883) (to be codified as amended at 42 U.S.C. § 300gg-11)

108. PPACA § 1501(b), 124 Stat. at 244 (adding I.R.C. § 5000A, as amended by PPACA § 10106(b), 124 Stat. at 909, and HCERA § 1002, 124 Stat. at 1032) (to be codified as amended at I.R.C. § 5000A). At the time this Article went to press, four district courts had rendered decisions in suits challenging the constitutionality of the individual pay-or-play mandate. Two courts upheld the mandate. S*ee* Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010); Liberty Univ. v. Geithner, No. 6:10-cv-00015-nkm, 2010 WL 4860299 (W.D. Va. Nov. 30, 2010). Two courts declared it unconstitutional. *See* Virginia v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010); Florida v. HHS, No. 3:10–cv–91–RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011). For an analysis of the Commerce Clause arguments at issue in these cases, see Mark A. Hall, *Commerce Clause Challenges to Health Care Reform*, 159 U. PENN. L. REV. (forthcoming June 2011).

109. PPACA § 1401(a), 124 Stat. at 213 (adding I.R.C. § 36B, as amended by PPACA § 10105(a)–(c), 124 Stat. at 906, and HCERA § 1001, 124 Stat. at 1030) (to be codified as amended at I.R.C. § 36).

110. This provision is sometimes referred to as a "free-rider assessment." *See, e.g.*, Helen Darling, *Health Care Reform: Perspectives From Large Employers*, 29 HEALTH AFFAIRS 1220, 1221 (2010).

1. *Overview of "Pay-or-Play" Mandate*

PPACA imposes an excise tax on "applicable large employers" who fail to satisfy their "shared responsibility" of offering employees the opportunity to enroll in "minimum essential coverage"[111] under an eligible employer-sponsored plan.[112] For these purposes, an "applicable large employer" is generally defined as an employer[113] who employed an average of at least fifty full-time employees[114] during the preceding calendar year.[115] Full-time employees are generally defined as employees who perform, on average, at least thirty hours of service per week.[116]

An employer may fail to meet its "shared responsibility" in one of two ways: (1) the employer does not offer its full-time employees and their dependents the opportunity to enroll in minimal essential coverage under an eligible employer-sponsored group health plan for a month, and at least one full-time employee is certified to claim a premium assistance tax credit or cost sharing reduction,[117] or (2) the employer offers its full-time employees and their dependents the opportunity to enroll in minimum essential coverage under an eligible

111. Beginning in 2014, PPACA requires that individuals maintain "minimum essential coverage." PPACA § 1501(b), 124 Stat. at 244 (adding I.R.C. § 5000A(a)) (to be codified at I.R.C. § 5000A). "Minimum essential coverage" includes coverage under an "eligible employer-sponsored plan." PPACA § 1501(b), 124 Stat. at 248 (adding I.R.C. § 5000A(f)(1)(B)) (to be codified at I.R.C. § 5000A). Eligible employer-sponsored plans include any "plan[s] or coverage offered in the small or large group market within a State." PPACA § 1501(b), 124 Stat. at 249 (adding I.R.C. § 5000A(f)(2)(B)) (to be codified at I.R.C. § 5000A).

112. I.R.C. § 4980H (added by PPACA § 1513, 124 Stat. at 253, and amended by PPACA § 10106(e)–(f), 124 Stat. at 910, and HCERA § 1003, 124 Stat. at 1033).

113. In identifying the employer, the aggregation rules applicable to qualified plans apply. *See* I.R.C. § 4980H(c)(2)(C)(i) (added by PPACA § 1513(a), 124 Stat. at 254, and re-designated by HCERA § 1003(d), 124 Stat. at 1033). For an overview of the aggregation rules, see, for example, FROLIK & MOORE, *supra* note 61, at 423–31.

114. Seasonal employees may be disregarded for purposes of this calculation. *See* I.R.C. § 4980H(c)(2)(B) (added by PPACA § 1513(a), 124 Stat. at 254, and re-designated by HCERA § 1003(d), 124 Stat. at 1033).

115. *See* I.R.C. § 4980H(c)(2)(A) (added by PPACA § 1513(a), 124 Stat. at 254, and re-designated by HCERA § 1003(d), 124 Stat. at 1033).

116. *See* I.R.C. § 4980H(c)(4)(A) (as added by PPACA § 1513(a), 124 Stat. at 255, and re-designated by HCERA § 1003(d), 124 Stat. at 1033). Solely for purposes of determining whether an employer qualifies as a "large" employer, full-time equivalents must be taken into account. *See* I.R.C. § 4980H(c)(2)(E) (added by PPACA § 1513(a), 124 Stat. at 254, and amended and re-designated by HCERA § 1003(d), 124 Stat. at 1033). Full-time equivalents are calculated by adding the total hours worked in a month by employees, other than full-time employees, and dividing by 120. *Id.* For example, if ten employees, who are not full-time employees, work a total of 240 hours per month for the employer, the employer will be treated as having two full-time equivalents.

117. *See* I.R.C. § 4980H(a) (added by PPACA § 1513(a), 124 Stat. at 253).

employer-sponsored group health plan for a month, and at least one full-time employee is certified to claim the premium assistance tax credit or cost sharing reduction.[118] Generally, an employee will be eligible for a tax premium credit or cost sharing reduction for health coverage purchased through the exchange if (1) the employee's household income is between 100% and 400% of the federal poverty level and (2) either (a) the employee is not eligible to participate in an employer sponsored group health plan or (b) the employee is eligible to participate in such a plan, but (i) the coverage under the employer's plan is "unaffordable," that is, the premium required to be paid exceeds 9.5% of the employee's household income, or (ii) the coverage consists of a plan under which the plan's share of the total allowed cost of benefits is less than 60%.[119]

If an employer fails to meet its "shared responsibility" in the first instance, by not offering coverage and having at least one employee obtain a premium tax credit or cost sharing reduction, the employer is subject to an excise tax for the month equal to one-twelfth of $2000, or about $167, per full-time employee.[120] Thus, if an applicable large employer does not offer coverage to its workforce, its penalty is based on its entire full-time workforce, although up to thirty full-time employees may be disregarded in calculating the penalty.[121] The penalty is indexed to the rate of premium growth after 2014.[122]

If an employer fails to meet its "shared responsibility" in the second instance, by offering coverage and still having at least one employee obtain a premium tax credit or cost sharing reduction, the employer is subject to an excise tax for the month equal to one-twelfth of $3000, or about $250, per full-time employee who opts out of the

118. *See* I.R.C. § 4980H(b) (added by PPACA § 1513, 124 Stat. at 253, and amended and re-designated by HCERA § 1003(b), (d), 124 Stat. at 1033).

119. *See* PPACA § 1401, 124 Stat. at 213 (adding I.R.C. § 36B tax credit); PPACA § 1402, 124 Stat. at 220 (adding cost sharing provisions); PPACA § 10105, 124 Stat. at 906 (amending §§ 1401 and 1402); HCERA § 1001, 124 Stat. at 1030 (amending §§ 1401 and 1402). According to Mercer, most employer-sponsored plans, other than limited medical plans, have an actuarial value greater than 60%. MERCER, HEALTH CARE REFORM: IMPACT ON EMPLOYER-SPONSORED PLANS BEGINS TO EMERGE 4 (2010).

120. *See* I.R.C. § 4980H(a), (c)(1) (added by PPACA § 1513, 124 Stat. at 253–54, and amended and re-designated by HCERA § 1003(b)(2), (d), 124 Stat. at 1033).

121. *See* I.R.C. § 4980H(c)(2)(D)(i) (added by PPACA § 1513, 124 Stat. at 254, and amended and re-designated by HCERA § 1003(a), (d), 124 Stat. at 1033). This is sometimes referred to as a "sledgehammer" penalty. *See* David R. Godofsky, *Optimizing Employee Benefit Costs Under PPACA: Avoid False Dichotomies,* 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), June 8, 2010, at 1322.

122. *See* I.R.C. § 4980H(c)(5) (added by PPACA § 1513, 124 Stat. at 255, and amended and re-designated by HCERA § 1003(b)(3), (d), 124 Stat. at 1033).

employer's plan and receives the credit or cost sharing reduction.[123] Thus, if an applicable large employer offers coverage to its workforce, its penalty will be based on the number of employees who opt out of the employer plan (and receive a premium tax credit or cost sharing reduction), rather than the employer's entire full-time workforce.[124] Moreover, the penalty is limited to the amount the employer would owe if it did not offer any coverage,[125] and it is indexed to the rate of premium growth after 2014.[126]

To illustrate, suppose that an applicable large employer has seventy-five full-time employees and does not offer its full-time employees and their dependents coverage under an eligible employer-sponsored group health plan for a month. Two full-time employees are certified to claim a premium assistance tax credit or cost sharing reduction. The employer will be subject to a penalty equal to $7500 for that month.[127] In contrast, if the same employer offered coverage and the same two employees opted out, the employer would only be subject to a penalty equal to $500.[128]

2. *Will Employers "Pay" or "Play?"*

PPACA's pay-or-play mandate is intended to encourage "applicable large employers" to offer affordable health care coverage to their employees. Whether it will do so is an open question.

The penalty PPACA imposes on employers who fail to offer employees affordable health care coverage is relatively low compared with prevailing health insurance costs. To illustrate, in 2009, the average annual health insurance premium in the United States was $4669 for single coverage, $9053 to cover the employee plus one additional family member, and $14,027 for family coverage.[129] The average annual

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123. *See* I.R.C. § 4980H(b)(1) (added by PPACA § 1513, 124 Stat. at 253, and amended and re-designated by HCERA § 1003(b)(1), (d), 124 Stat. at 1033).

124. This is sometimes referred to as a "tack hammer" penalty. *See* Godofsky, *supra* note 121.

125. *See* I.R.C. § 4980H(b)(2) (added by PPACA § 1513, 124 Stat. at 254, and re-designated by HCERA § 1003(d), 124 Stat. at 1033).

126. *See* I.R.C. § 4980H(c)(5) (added by PPACA § 1513, 124 Stat. at 255, and re-designated by HCERA § 1003, 124 Stat. at 1033).

127.

$$\left(\frac{1}{12} \times \$2000\right) \times (75\text{-}30) = \$7500.$$

128.

$$\left(\frac{1}{12} \times \$3000\right) \times 2 = \$500.$$

129. James M. Branscome, Agency for Healthcare Research & Quality, U.S. Dep't of Health & Human Servs., State Differences in the Cost of Job-Related Health Insurance 2009, at 1 (2010).

employee contribution was $957 for single coverage, $2363 to cover the employee plus one additional person, and $3474 for family coverage.[130] Thus, in 2009, the annual average pre-tax cost to the employer[131] of providing single coverage was $3712, while the cost to cover the employee plus one other family member was $6690, and the cost for family coverage was $10,553. In contrast, if the employer fails to offer any coverage, the annual nondeductible penalty under PPACA is generally $2000 per worker, and if the employer offers coverage but it is unaffordable, the annual PPACA penalty is $3000 per employee for whom the coverage is "unaffordable."[132]

Perhaps not surprisingly, most employers either plan to or already have done modeling to determine the financial impact of health care reform on their organization.[133] For example, Caterpillar has determined that it could reduce its costs by 70% if it eliminated its health care coverage and paid the penalties, and AT&T has calculated that its $2.4 billion health care coverage costs would fall to just $600 million if it simply paid the penalties.[134] Indeed, the National Retail Federation created an online tool to help retailers and other businesses determine the penalties they might face under the new pay-or-play mandate.[135]

Looking at these figures, David Merritt, vice president and national policy director of the Center for Health Transformation, as-

130. *Id.* at 3.

131. Of course, economists would contend that the employee rather than the employer bears the cost through reduced wages. *See supra* note 20 (discussing standard economic theory).

132. *See also* Florence Olsen, *Uncertainty Surrounds Employer Response to Insurance Reforms, IFEBP Speakers Say*, 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), May 11, 2010, at 1103 (noting that, according to Paul Fronstin of the Employee Benefit Research Institute, "[t]he weighted-average employer contribution for health insurance coverage was $8,900 in 2009, which is more than four times the 'pay or play' penalty of $2,000 per full-time employee or equivalent that employers with more than 50 employees would be charged in 2014 for not offering health insurance under the health reform law").

133. *See* TOWERS WATSON, HEALTH CARE REFORM: LOOMING FEARS MASK UNPRECEDENTED EMPLOYER OPPORTUNITIES TO MITIGATE COSTS, RISKS AND RESET TOTAL REWARDS 3 (2010) (noting that according to a survey of more than 650 mid- to senior-level benefit professionals, "79% of employers plan to model the financial impact of health care reform on their organization"); *see also* MERCER, *supra* note 119, at 4 (noting that "all employers are asking how health care reform will affect their plans and costs").

134. *See, e.g.*, HOLTZ–EAKIN & SMITH, *supra* note 6, at 3; Hyman, *supra* note 11, at 16 & n.38; Letter from Senator Orrin Hatch to President Barack Obama (June 14, 2010), *available at* 2010 WLNR 12150669.

135. *Health Mandate Cost Calculator*, NAT'L RETAIL FED'N, http://www.nrf.com/modules.php?name=Pages&sp_id=1290 (last visited May 11, 2011); *see* Press Release, National Retail Federation, NFR Calculator Lets Employers Determine Potential Penalties Under New Health Care Reform Law (May 25, 2010), *available at* http://www.nrf.com/modules.php?name=news&op=viewlive&sp_id=934.

serted that many companies might find eliminating health insurance an easy way to cut costs "knowing that employees will have the opportunity to go through a government insurance exchange, and perhaps with an insurance tax subsidy."[136] He even contended that there might be shareholder suits against companies that do not eliminate coverage for violating their fiduciary duty to the company; shareholders could contend that providing health insurance is not the wisest use of the company's funds.[137] Likewise, Representative Joe Barton said that "[f]rom a financial standpoint, from a purely economic standpoint, many companies would be better off discontinuing health care as a fringe benefit, paying the penalty and pocketing the savings."[138] Similarly, Leslie Norwalk, then-acting administrator for the Centers for Medicare and Medicaid Services under President George W. Bush, wondered "whether or not employers will keep their current employees and dependents on insurance coverage when the penalty is so much less than the coverage itself."[139]

Of course, determining whether an employer would be better off retaining coverage or dropping it and paying the penalty is much more complicated than simply comparing the cost of premiums with the cost of the penalty.[140] First, the employer may deduct the cost of premiums, but the penalties are nondeductible. Second, health care coverage is a form of nontaxable compensation to employees, and employees may demand higher wages if employers elect to eliminate coverage.[141]

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136. *Companies, Individuals May Find It Cheaper to Pay Fines Under Health Law, Speaker Says*, 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), May 25, 2010, at 1201.

137. *Id.*

138. Robert Pear, *Inquiry Says Health Care Charges Were Proper,* N.Y. TIMES, Apr. 26, 2010, http://www.nytimes.com/2010/04/27/business/27health.html?_r=1&scp=1&sq=%22Inquiry%20Says%20Health%22&st=cse.

139. Sara Hansard, *How Many Employers May Drop Coverage Under PPACA Isn't Clear, Lawyer Says*, 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), July 20, 2010, at 1556. Perhaps reflecting Caterpillar's calculations, Norwalk said, "Indications are that 70 to 75 percent of the cost of health care could typically be saved if employers decided to pay the $2,000 per employee penalty for not providing health insurance under [PPACA]." *Id.*

140. Moreover, offering or eliminating health care coverage are not the only options employers have. For example, they may continue to offer health insurance but lower their costs by increasing their employees' share of the premium. *See* Godofsky, *supra* note 121.

141. *See* HOLTZ–EAKIN & SMITH, *supra* note 6, at 3 ("Health insurance is only one portion of the overall compensation package employees receive as a result of competitive pressures. And the evidence suggests that if one portion of that package is reduced or eliminated—health insurance—another aspect—wages—will ultimately be increased as a competitive necessity to retain and attract valuable labor."); MERCER, *supra* note 119, at 4. Specifically, Mercer found:

> The "savings" to an employer are not simply the difference between current cost and the penalty. Employees will expect some compensation adjustment to help them buy coverage in the individual market, and

How much additional compensation employees would likely demand depends, in part, on whether they would be eligible for subsidized coverage under PPACA[142] and their relative bargaining position in light of the state of the economy.[143] Moreover, employers offer health insurance for a variety of reasons,[144] such as to recruit and retain a highly-qualified workforce,[145] and should take these reasons into account when determining whether to continue offering health care coverage.[146]

Recent surveys suggest that most employers intend to continue offering health insurance. For example, according to a Towers Watson

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> employers must ask if they can afford the compensation boost sufficient to pay for high-cost individual marketed insurance.

Id.

142. According to Gary B. Kushner:

> While low- and middle-income employees would receive a subsidy to purchase coverage, the subsidy phases out as income rises, and it disappears completely after $88,000 in family income. Thus, an employee and spouse each earning $50,000, for example, might have to pay about $15,000 to purchase coverage through an exchange. Presumably, there would be significant pressure on employers not offering health benefits to increase employees' direct compensation to pay for that coverage. If paid as direct compensation, it is subject to payroll taxes and workers' compensation costs. In addition, any other benefit predicated on compensation, such as retirement plan contributions, life insurance or disability coverage, would proportionately increase. And after all of that, the employer still has to pay the $2,000 penalty.

Gary B. Kushner, *Now It's Employers' Turn: The Health Care Reform Law Will Reshape Your Benefits Agenda, Starting This Year*, HR MAG., June 1, 2010, at 34.

Taking into account the availability of subsidized coverage for workers with family income at or below 400% of the poverty level, Douglas Holtz–Eakin and Cameron Smith calculated that, with respect to about 43 million workers, it would make economic sense for the employer to drop coverage if the health plan costs the employer $11,941. HOLTZ–EAKIN & SMITH, *supra* note 6, at 3–4.

143. *See* Olsen, *supra* note 132, at 1103 (noting that, according to Paul Fronstin of the Employee Benefit Research Institute, "[i]f unemployment is near 10 percent in 2014 and if state health care exchanges are viable alternatives under [PPACA], employers might have little competitive reason to continue offering group health care coverage"); *cf.* Kushner, *supra* note 142, at 36, 39 (noting that employers should reconsider the role health insurance plays in the overall compensation strategy "if unemployment levels begin to decline to historically normal levels of 6 percent and employees begin feeling more comfortable leaving a job").

144. *See* Godofsky, *supra* note 121 ("Many employers prefer their employees to have health insurance, for a variety of reasons, including positive effects on morale and absenteeism, community reputation, goodwill, and moral reasons.").

145. *See supra* section II.D (discussing effect of employment-based health insurance on labor force).

146. *See, e.g.*, Bill Mooney, *Finding the Right Balance: Pain or Gain?*, 86 MERCER BUS. (Mercer Reg'l Chamber of Commerce, Trenton, N.J.), July 1, 2010, *available at* 2010 WLNR 14542859 (theorizing that "many employers, in particular large 'name-brand' companies, will continue to offer health insurance because of the so-called moral imperative and because in the end it is good business"). *See generally* Kushner, *supra* note 142 (discussing the importance of considering the role of health benefits in the total rewards strategy).

survey of more than 650 mid- to senior-level benefit professionals, almost half of surveyed employers (46%) said they would *definitely* continue to offer health insurance, and another 42% of employers said they were *likely* to continue to offer health insurance.[147] Only 3% of employers responded that they were likely to pay the excise tax rather than offer health insurance.[148] Similarly, approximately 87% of the 1021 individuals responding to an International Foundation of Employee Benefit Plans' survey of single employer plans reported that their organization would "continue to offer health care benefits because they are critical to employee recruitment and retention and remaining competitive."[149] Indeed, Tracy Watts, a health care specialist with Mercer, reported that Mercer has done "quite a bit of modeling for clients over the past several months," and "[t]here have only been a few circumstances where it actually turns out being financially a better deal for the employer to say, you know what, we're not going to do this any more, we're just going to pay the penalty."[150]

Employers' responses to the pay-or-play mandates in Massachusetts and San Francisco also suggest that employers may continue to offer employment-based health insurance despite the relatively low PPACA penalty. Early evidence shows that in both Massachusetts and San Francisco employers are choosing to provide health insurance rather than pay a penalty.[151] Of course, the pay-or-play mandates in Massachusetts and San Francisco are distinguishable from the PPACA pay-or-play mandate in a number of ways. For example, the Massachusetts penalty is much lower than the PPACA penalty,[152] while the San Francisco penalty is arguably higher and more strin-

147. TOWERS WATSON, *supra* note 133, at 4.

148. *Id.*

149. IFEBP, *supra* note 50, at 33.

150. Sara Hansard, *Few Companies Will Find Advantage In Dropping Health Coverage, Mercer Says*, 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), July 6, 2010, at 1530; *see also* Godofsky, *supra* note 121 (showing how an employer that currently offers no insurance could be financially better off offering insurance with a low subsidy than not offering insurance at all).

151. *See* Sharon K. Long & Paul B. Masi, *How Have Employers Responded To Health Reform In Massachusetts? Employees' Views At The End of One Year*, 27 HEALTH AFFAIRS w576 (2008) (finding "no evidence that concerns about employers' dropping or scaling back coverage under health reform have been realized"); Carrie Hoverman Colla et al., *How Do Employers React to a Pay-or-Play Mandate? Early Evidence from San Francisco* 24 (Nat'l Bureau of Econ. Research, Working Paper No. 16179, 2010) ("There is little evidence at this time of crowd-out due to the mandate, such as stopping offering insurance or restricting the generosity of benefits for some workers.").

152. The Massachusetts' penalty is $295 per employee per year, which is estimated to be less than 10% of the actual cost of providing coverage. *See* Jon R. Gabel et al., *Report From Massachusetts: Employers Largely Support Health Care Reform, and Few Signs of Crowd-Out Appear*, 27 HEALTH AFFAIRS w13–w14 (2008).

gent than the PPACA penalty.[153] Nevertheless, early evidence in both Massachusetts and San Francisco show that employers are choosing to "play" rather than "pay," and thus these examples provide some evidence that employers may continue to provide health insurance rather than pay PPACA's relatively low penalty.

On the other hand, comments made by smaller employers subject to the PPACA pay-or-play mandate suggest that employers that do not already offer health insurance may elect to pay the penalty rather than offer health insurance. On July 26, 2010, the U.S. Chamber of Commerce, the National Federation of Independent Business, and the American Action Network held a forum entitled, "Behind the Curtain: The Health Care Law's Impact on Small Business."[154] At the forum, Scott Womack, president of Womack Restaurants, which owns eleven International House of Pancakes restaurants in Indiana and Ohio, declared, "We'll absolutely be paying the penalty . . . ."[155] He noted that average profits per employee in the restaurant industry are only about $2600 per employee and contended that the $2000 PPACA penalty[156] will "devastate" the industry.[157] Erik Oppenheim, vice-president of a company that owns twenty Burger King franchises in the District of Columbia and Maryland, said, "We would most definitely pay the penalty as opposed to offering the insurance to all of our qualified employees. It would definitely be much more cost-effective . . . ."[158]

Thus, based on survey data and employers' responses to the Massachusetts and San Francisco pay-or-play mandate, it appears likely that, at least in the short run, most employers that currently offer health insurance will continue to offer it rather than pay the PPACA

153. In 2008, the San Francisco ordinance required employers with 20–99 employees to spend $1.17 per hour for health care for each employee, and employers with 100 or more employees were required to spend $1.76 per hour for each employee. *See* Colla et al., *supra* note 151, at 6. In 2009, the amounts were increased to $1.23 per hour for employers with 20–99 employees and $1.85 per hour for employers with 100 or more employees. *Id.* Thus, each year, employers with 20–99 employees are required to spend about $2415 per employee for health care and employers with 100 or more employees are required to spend about $3633 per employee. *Id.* at 11. Employers who do not meet the health care spending requirement are required to pay the same amount directly to the city. Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits,* 37 J.L. MED. & ETHICS 88, 94 (2009). The city then uses the money to fund the Health Access Program, which is designed to provide medical care to the uninsured in San Francisco. *Id.* at 100.

154. Sara Hansard, *Small-Business Owners Vow to Pay Fines Rather Than Buy Employee Health Insurance*, 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), Aug. 3, 2010, at 1679.

155. *Id.*

156. Womack asserted that the $2000 penalty would total about $2800 per employee because it is not tax deductible. *Id.*

157. *Id.*

158. *Id.*

penalty.[159] On the other hand, employers that do not currently offer health insurance may elect to pay the penalty rather than offer insurance.[160] Moreover, if unemployment rates are high and some employers begin to drop coverage in favor of paying the penalty, other employers that currently offer coverage may decide to pay the penalty in lieu of offering insurance,[161] and PPACA could lead to an unraveling of employment-based health insurance.[162]

B. Tax Credit for Small Employers

While PPACA uses a "stick" approach to encourage large employers to offer health care coverage to their employees, it also employs a "carrot" method to encourage small employers with low- and moderate-income employees to provide their employees with health care coverage. Specifically, PPACA creates a small employer tax credit[163] that was "designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have."[164]

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159. The Centers for Medicare and Medicaid Services estimate employers will pay a total of $87 billion in pay-or-play penalties between 2014 and 2019. RICHARD S. FOSTER, CTRS. FOR MEDICARE & MEDICAID SERVS., ESTIMATED FINANCIAL EFFECTS OF THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT," AS AMENDED tbl.1 (2010). The CBO estimates that together uninsured individuals and employers will pay a total of $65 billion in penalties between 2014 and 2019. Letter from Congressional Budget Office to Nancy Pelosi tbl.2 (March 20, 2010), *available at* http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf [hereinafter CBO].

160. A Rand Corporation study projects that the enactment of PPACA will cause the percentage of firms with 51–100 employees that offer health insurance to increase from 90% to 98%, and the percentage of firms with more than 100 employees to increase from 93% to 98%. *See generally* RAND CORP., HOW WILL THE AFFORDABLE CARE ACT AFFECT EMPLOYEE HEALTH COVERAGE AT SMALL BUSINESSES? 1 (2010), *available at* http://www.rand.org/content/dam/rand/pubs/research_briefs/2010/RAND_RB9557.pdf. The Rand study, however, does not attribute that increase to PPACA's employer pay-or-play penalty. *See id.* Instead, it attributes the increase to PPACA's mandate that individuals purchase health insurance or pay a penalty. *Id.*

161. Mooney, *supra* note 146 (noting that at an investor's conference in New York, "Caterpillar basically said we are prepared to drop our employee health coverage, but we don't want to do it, and we don't intend to be first, but we will be quick second").

162. *See id.* ("'I think the reason most of the physicians were against [the PPACA] is that they look at it as slippery slope,' Cinotti said. 'That the exchanges are going to fail because the big employers are going to get out and then we're going to end up with a single-payer national system. And that's the real fear we have.'").

163. I.R.C. § 45R (added by Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, § 1421(a), 124 Stat. 119, 237 (2010), and amended by PPACA § 10105(e)(1)–(2), 124 Stat. at 906).

164. IRS News Release IR-2010-63 (May 17, 2010).

This section begins by describing the small employer tax credit. It then analyzes the credit's likely effect on small employers' willingness to offer health insurance.

1. Overview of Tax Credit

In order to qualify for the tax credit, small employers must satisfy three requirements.[165] First, the employer must have fewer than twenty-five full-time equivalent employees (FTE) for the taxable year.[166] Second, the average annual wages of the employees for the year must be less than $50,000 per FTE.[167] Third, the employer must maintain a "qualifying arrangement" under which the employer pays a uniform percentage of at least 50% of the premium cost of the health coverage for each employee covered under the employer-provided insurance.[168] Beginning in 2014, the small tax credit is only available if the insurance is provided through a state-sponsored insurance exchange.[169]

For tax years 2010 through 2013, small employers are eligible for a tax credit of up to 35% (25% for tax-exempt employers).[170] Beginning in 2014, the full credit will increase to 50% (35% for tax-exempt employers),[171] but employers will only be eligible for the credit for two years.[172] Employers with ten or fewer FTEs with average taxable wages of $25,000 or less are eligible for the full credit. The credit is

165. For guidance on the small employer tax credit, see IRS Notice 2010-44, I.R.B. 2010-22 (June 1, 2010).

166. I.R.C. § 45R(d)(1)(A) (added by PPACA § 1421(a), 124 Stat. at 238). The number of FTEs is determined by dividing the total number of hours of service for which wages were paid by the employer to employees during the tax year by 2080. I.R.C. § 45R(d)(2)(A) (added by PPACA § 1421(a), 124 Stat. at 238). Generally, self-employed individuals—including partners and sole proprietors, 2% shareholders of S corporations, and 5% owners of the employer—are not treated as employees. *See* I.R.C. § 45R(e)(1)(A) (added by PPACA § 1421(a), 124 Stat. at 240). In addition, the number of hours worked by seasonal employees who do not work more 120 days per year are not taken into account in determining FTEs. I.R.C. § 45R(d)(5)(A) (added by PPACA § 1421(a), 124 Stat. at 239).

167. I.R.C. § 45R(d)(1)(B), (d)(3)(B) (added by PPACA § 1421(a), 124 Stat. at 237, and amended by PPACA, § 10105(e)(1), 124 Stat. at 906). Beginning in 2014, the $50,000 income limit will be adjusted for inflation. *See* I.R.C. § 45R(d)(3)(B) (added by PPACA § 1421(a), 124 Stat. at 239, and amended by PPACA § 10105(e)(1), 124 Stat. at 906).

168. I.R.C. § 45R(d)(1)(C), (d)(4) (added by PPACA § 1421(a), 124 Stat. at 238–39).

169. *Cf.* I.R.C. § 45R(g)(3) (added by PPACA § 1421(a), 124 Stat. at 241, and amended by PPACA § 10105(e)(2), 124 Stat. at 906) (providing that for calendar years 2010 through 2013, arrangement will not fail to meet the requirements of § 45R(d)(4) solely because the insurance is provided outside of an Exchange).

170. I.R.C. § 45R(g)(2)(A) (added by PPACA § 1421(a), 124 Stat. at 241, and amended by PPACA § 10105(e)(2), 124 Stat. at 906).

171. I.R.C. § 45R(b) (added by PPACA § 1421(a), 124 Stat. at 238).

172. I.R.C. § 45R(a), (e)(2) (added by PPACA § 1421(a), 124 Stat. at 238, 240).

phased out as the number of FTEs increases from 10 to 25,[173] and annual average compensation increases from $25,000 to $50,000.[174] In addition, the credit is limited to the applicable percentage of "the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage."[175] Thus, if an employer purchases insurance with higher than average premiums, the employer will not receive a credit with respect to premiums that exceed the average.

Eligible small employers may take the credit in the form of a general business credit[176] and must reduce their income tax deduction for the premiums they pay by the amount of the credit.[177]

2. *Likely Effect*

The PPACA tax credit for small businesses appears to be well-targeted. While small employers are generally less likely to offer health insurance than are larger employers, very small employers are the least likely to offer health insurance. For example, in 2010, more than 95% of employers with fifty or more employees offered health insurance to their employees, while 76% of those with ten to twenty-four employees did, and only 59% of businesses with three to nine employees offered health insurance to their employees.[178]

How many employers will take advantage of the tax credit is not clear. Gary Kushner of Kushner & Company has lauded the tax credit as a strong incentive to eligible small employers to begin or continue to offer health care coverage to employees.[179] Kushner, however, does not offer an estimate of how many small employers are likely to take advantage of the credit. Similarly, Paula A. Calimafde, chair of the Small Business Council of America, asserted that "providing a tax incentive for small businesses to begin to offer or continue to offer health coverage will enable many to now purchase coverage for their employees."[180] Nevertheless, she noted that "[w]hether it will be enough of

173. I.R.C. § 45R(c)(1) (added by PPACA § 1421(a), 124 Stat. at 238).
174. I.R.C. § 45R(c)(2) (added by PPACA § 1421(a), 124 Stat. at 238). The wage limitations will be adjusted for inflation. *See* I.R.C. § 45R(d)(3)(B)(ii) (added by PPACA § 1421(a), 124 Stat. at 239, and amended by PPACA § 10105(e)(1), 124 Stat. at 906).
175. I.R.C. § 45R(b)(2) (added by PPACA § 1421(a), 124 Stat. at 238).
176. *See* I.R.C. § 38(b)(36) (added by PPACA § 1421(b), 124 Stat. at 241).
177. I.R.C. § 280C(h) (added by PPACA § 1421(d), 124 Stat. at 242).
178. KAISER 2010 SURVEY, *supra* note 2, at 38 ex. 2.2. The percentage of employers with three to nine employees that offered health insurance increased from 46% in 2009 to 59% in 2010. *Id.*
179. *Health Care Reform: Small Employer Tax Credit*, GARY KUSHNER'S BENEFITS BLOG (May 9, 2010), http://www.kushnerco.com/blog/wordpress/?p=137.
180. *See* Kushner, *supra* note 142, at 37.

an incentive to get small businesses into the health care delivery system remains to be seen."[181] The IRS mailed about 4 million postcards to small employers that might be eligible for the tax credit.[182] The IRS does not, however, have an estimate of the number of businesses likely to take advantage of the credit.[183]

The Congressional Budget Office (CBO) projects that over the next ten years, about $40 billion in tax credits will be provided to small employers, with program expenditures reaching a maximum of $6 billion in 2013 and then stabilizing at $3 to $4 billion per year thereafter.[184] The Centers for Medicare & Medicaid Services (CMS) project similar, though somewhat lower, figures. Specifically, the CMS estimates that $31.4 billion in tax credits will be provided to small employers between 2010 and 2019, with credits totaling $3.3 billion in 2010, $4.6 billion in 2011, $4.9 billion in 2012, $5.2 billion in 2013, $5.7 billion in 2014, $6.2 billion in 2015, $1.6 billion in 2016, and no credits being provided after 2016.[185]

In July 2010, Families USA and Small Business Majority issued a report lauding the tax credit for small businesses.[186] It asserted that more than 4 million (4,015,300) small businesses would be eligible to receive the tax credit in 2010, and it noted that this figure represented almost 84% of all small businesses in the nation.[187] In addition, it pointed out that more than 90% of the small businesses in eleven states would be eligible to receive the tax credit in 2010.[188] On July 28, 2010, Senator Chuck Grassley, Ranking Member of the Senate Committee on Finance, issued a press release entitled, "Health Care Tax Credit for Small Businesses Has Been Oversold."[189] The press release did not acknowledge the fact that the IRS mailed out postcards to about 4 million businesses that might be eligible for the credit. Instead, it challenged the study for failing to factor in the requirement that the employer pay at least one half of the premium in order to be eligible for the credit. "When that's considered, the Congressional

181. *Id.*
182. IRS News Release IR-2010-48 (April 19, 2010). An image of the postcard notice is available at http://www.irs.gov/pub/irs-pdf/n1397.pdf.
183. *See* Lauren Gardner, *IRS Releases Guidance on Determining Eligibility for Small-Firm Health Care Credit*, 37 BNA PENSION & BENEFITS REP. (Bureau for Nat'l Affairs, Arlington, Va.), May 25, 2010, at 1202.
184. CBO, *supra* note 159, at tbl.4.
185. FOSTER, *supra* note 159, at tbl.1.
186. *See generally* FAMILIES USA & SMALL BUSINESS MAJORITY, A HELPING HAND FOR SMALL BUSINESSES: HEALTH INSURANCE TAX CREDITS (2010), *available at* http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf [hereinafter FAMILIES USA].
187. *Id.* at 2.
188. *Id.*
189. Press Release, Chuck Grassley, Ranking Member of U.S. Senate Comm. on Fin., Health Care Tax Credit for Small Businesses Has Been Oversold (July 28, 2010).

Budget Office estimates that only 3 million small business employees nationwide would benefit from this tax credit in 2016."[190] The Families USA study does, however, expressly state: "To qualify for the tax credits, businesses must cover at least 50 percent of each employee's health insurance premiums."[191] It simply does not estimate the number of employers that will choose to provide health insurance to workers and claim the credit.

Like Senator Grassley, the National Federation of Independent Business (NFIB) has criticized the Families USA study for overselling the tax.[192] The NFIB estimated that just under 2 million, or about 35% of, small businesses in the United States currently offer health insurance, pay more than one-half of the premium costs, and thus qualify for the tax.[193] The NFIB, however, did not estimate how many additional employers might choose to offer health insurance in light of the new tax credit. Instead, it simply claimed that the relevant statistic is how many employers currently qualify for the credit rather than are eligible for the credit.

A September 2010 Commonwealth Fund report provides estimates for the number of workers working for firms that will be eligible for the tax credits and the number of workers in firms that will take up the tax credit between 2010 and 2013.[194] Specifically, the report states that up to 16.6 million employees are estimated to be working for firms that will be eligible for the small employer tax credits, while about 3.4 million employees work in firms that will take up the tax credit between 2010 and 2013.[195] These estimates were provided by Jonathan Gruber and Ian Perry of the Massachusetts Institute of Technology using the Gruber Microsimulation Model for the Commonwealth Fund.[196]

In sum, it appears that around 4 million small businesses would be eligible for the tax credit in 2010. It is not entirely clear, however, how many will claim the credit. According to projections by the CBO, about 3 million employers are expected to claim the credit in 2016, while according to estimates by Jonathan Gruber and Ian Perry,

190. *Id.*

191. FAMILIES USA, *supra* note 186, at 2.

192. Press Release, Nat'l Fed'n of Indep. Bus., *Just the Facts: Small Business Healthcare Tax Credit* (July 20, 2010), *available at* http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099.

193. *Id.*

194. SARAH R. COLLINS ET AL., COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: SMALL BUSINESSES AND THE AFFORDABLE CARE ACT OF 2010, at 7 (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/Small%20Business/1437_Collins_realizing_hlt_reform_potential_small_business_ACA_ib.pdf.

195. *Id.*

196. *Id.* at 7 & n.13.

about 3.4 million employees work for firms that will take up the credit between 2010 and 2013.

C. Excise Tax on "Cadillac" Plans

As discussed above, employment-based health insurance is accorded favorable tax treatment, principally under sections 105 and 106 of the Internal Revenue Code. Critics of this favorable tax treatment contend that, among other things, it leads to over-insurance which distorts the health services market, causes inefficient allocations of scarce resources, and inflates health care costs.[197] PPACA creates a nondeductible excise tax on so-called "Cadillac" health care plans,[198] effective in 2018, to address this problem.[199] This section begins by describing the Cadillac tax. It then discusses the likely effect of the tax on employers' willingness to offer Cadillac plans.

1. Overview of Cadillac Tax

The excise tax applies to any "excess benefit" provided under "applicable employer-sponsored coverage."[200] Generally, a health plan qualifies as "applicable employer-sponsored coverage" if the value of coverage is excludable from the employee's income under section 106 of the Internal Revenue Code.[201] An "excess benefit" arises if the annual cost of coverage exceeds $10,200, in the case of individual coverage, or $27,500, in the case of family coverage,[202] multiplied by a "health cost adjustment percentage."[203] The "health cost adjustment percentage" increases the dollar limits to the extent that the 2018 per-employee cost under the Blue Cross/Blue Shield standard option

197. *See supra* section III.A.
198. *See* I.R.C. § 4980I (2006) (added by Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, § 9001(a), 124 Stat. 119, 847 (2010), and amended by PPACA § 10901, 124 Stat at 1015, and Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. 111-152, § 1401, 124 Stat. 1029, 1059).
199. *See* Zelinsky, *supra* note 6, at 7-4 (stating that the Cadillac tax "originated in the broad consensus that the Code's current tax treatment of employer-provided medical care encourages overconsumption of medical services"); *see also* AM. ACADEMY OF ACTUARIES & SOC'Y OF ACTUARIES, FEDERAL HEALTH CARE REFORM: EXCISE TAX ON HIGH-COST EMPLOYER PLANS 9 (2010) ("One purpose of the excise tax outlined in the PPACA is to raise revenue from insurance companies and plan administrators. Another purpose of the tax is to reduce health spending by taxing a portion of the cost of comprehensive benefits, thereby making them a less attractive form of compensation.").
200. *See* I.R.C. § 4980I(a) (added by PPACA § 9001(a), 124 Stat. at 848).
201. I.R.C. § 4980I(d)(1)(A) (added by PPACA § 9001(a), 124 Stat. at 850).
202. Coverage under a collectively bargained multiemployer plan is deemed to be family coverage and thus always eligible for the higher limit. I.R.C. § 4980I(b)(3)(B)(ii) (added by PPACA § 9001(a), 124 Stat. at 848, and amended by HCERA § 1401(a)(1)(B), 124 Stat. at 1059).
203. I.R.C. § 4980I(b) (added by PPACA § 9001(a), 124 Stat. at 848, and amended by HCERA § 1401(a), 124 Stat. at 1059).

under the Federal Employees Health Benefits Plan exceeds the 2010 cost by more than 55%.[204] After 2018, the dollar limits will be adjusted for inflation.[205] The dollar limits are also adjusted for age and gender[206] and are increased for retirees and plans that primarily cover employees in high-risk professions[207] or employees who repair or install electrical or telecommunications lines.[208] The cost of coverage is to be determined under rules similar to those established under COBRA.[209]

The excise tax is imposed on the "coverage provider."[210] In the case of a group health plan, the coverage provider is the health insurance issuer.[211] In the case of health savings account (HSA)[212] and medical savings account (MSA)[213] contributions, the employer is the coverage provider.[214] In all other instances, the coverage provider is the person that administers the plan,[215] which will often be the employer.[216]

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204. *See* I.R.C. § 4980I(b)(3)(C)(ii) (added by PPACA § 9001(a), 124 Stat. at 848, and amended by HCERA § 1401(a), 124 Stat. at 1059).

205. I.R.C. § 4980I(b)(3)(C)(v) (added by PPACA § 9001(a), 124 Stat. at 848, and re-designated by HCERA § 1401(a)(2)(C), 124 Stat. at 1059). Initially, the limits will increase at 1% over increases in the CPI. After 2020, increases will be limited to increases in the CPI. *See* I.R.C. § 4980I(b)(3)(c)(v) (added by PPACA § 9001, 124 Stat. at 848, and amended and re-designated by HCERA § 1401(a)(2)(C), (E), 124 Stat. at 1059–60).

206. *See* I.R.C. § 4980I(b)(3)(C)(iii) (added by PPACA § 9001(a), 124 Stat. at 848, and amended by HCERA § 1401(a)(2)(C), 124 Stat. at 1059).

207. High-risk professions are defined broadly to include law enforcement, fire protection, longshoremen, emergency medical technicians, construction, mining, agriculture, forestry, and fishing industries. I.R.C. § 4980I(f)(3) (added by PPACA § 9001(a), 124 Stat. at 852, and amended by PPACA § 10901(a), 124 Stat. at 1015).

208. *See* I.R.C. § 4980I(b)(3)(C)(iv) (added by PPACA § 9001(a), 124 Stat. at 848, and re-designated by HCERA § 1401(a)(2)(C), 124 Stat. at 1059).

209. *See* I.R.C. § 4980I(d)(2) (added by PPACA § 9001(a), 124 Stat. at 851).

210. *See* I.R.C. § 4980I(c) (added by PPACA § 9001(a), 124 Stat. at 849).

211. *See* I.R.C. § 4980I(c)(2)(A) (added by PPACA § 9001(a), 124 Stat. at 849).

212. An HSA is a health savings account authorized by Section 223 of the Internal Revenue Code. I.R.C. § 223. For a brief overview of HSAs, see FROLIK & MOORE, *supra* note 61, at 123–24.

213. An MSA is an Archer medical savings account authorized by Section 220 of the Internal Revenue Code. Archer MSAs are functionally similar to HSAs but may only be established by self-employed individuals and small employers. *See* Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 799 & n.131 (2006)

214. *See* I.R.C. § 4980I(c)(2)(B) (added by PPACA § 9001, 124 Stat. at 849).

215. *See* I.R.C. § 4980I(c)(2)(C) (added by PPACA § 9001, 124 Stat. at 849).

216. *See* Zelinsky, *supra* note 6, at 7-5 (noting that the employer sponsoring the plan will often be the plan administrator).

2. Likely Effect

The CBO estimates that employers will pay Cadillac excise taxes of $12 billion in 2018 and $20 billion in 2019.[217] The CBO, however, does not estimate how many employers will change their plans in order to avoid the tax.[218]

According to a Mercer survey of about 800 employers, of all the elements of PPACA, employers are most concerned about the "Cadillac" tax.[219] Based on its extensive research and client experience, Towers Watson estimates that the excise tax could hit as many of 60% of employers if current trends continue.[220]

If the Cadillac tax goes into effect as scheduled, then it will likely cause many employers to change the terms of their plans. According to a survey by the International Foundation of Employee Benefit Plans, close to half of respondents are focusing on redesigning their health plans to avoid the excise tax for Cadillac plans.[221] Towers Watson has identified "[p]rogram design, including the use of CDHPs[222] and other strategies to drive continued improvement in workforce health [as] some of the tools employers are likely to use to keep costs at or below the medical cost component of the Consumer Price Index."[223] PricewaterhouseCoopers has suggested employers consider increasing cost sharing, reducing benefits, and moving to more tightly managed care as possible strategies to trim benefit costs in order to avoid the Cadillac tax.[224]

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217. CBO, *supra* note 159, at tbl.2.
218. Since the concept of the Cadillac tax is relatively new and there is limited data available to analyze its likely effect, perhaps this is not surprising. *Cf.* AM. ACADEMY OF ACTUARIES & SOC'Y OF ACTUARIES, *supra* note 199, at 4–7 (providing revenue estimates for the Cadillac tax as originally introduced but recognizing the tentative nature of estimates).
219. *See* MERCER, *supra* note 119, at 2 ("A recent Mercer survey of 791 employers found that the excise tax was their most significant concern, followed by changes to lifetime limits and dependent eligibility.").
220. TOWERS WATSON, *supra* note 133, at 5. Nevertheless, Towers Watson reports that 43% of employers with medical plans for active employees report believing they would be subject to the excise tax. *Id.*; *cf.* Kushner, *supra* note 142, at 39 (stating that it would seem that few employers would initially be impacted by the Cadillac tax because average health plan costs for most employers are significantly below the applicable thresholds today).
221. IFEBP, *supra* note 50, at 33.
222. CDHPs are consumer-driven health care plans. For an overview of CDHPs, see FROLIK & MOORE, *supra* note 61, at 122–24.
223. TOWERS WATSON, *supra* note 133, at 7.
224. PRICEWATERHOUSECOOPERS' HEALTH RESEARCH INST., BEHIND THE NUMBERS: MEDICAL COST TRENDS FOR 2011, at 19 (2010), *available at* http://www.areadevelopment.com/article_pdf/id36630_PwCHealthCosts.pdf. The American Academy of Actuaries and Society of Actuaries identified the following possible methods to reduce costs to avoid the tax: (1) enrollee cost-sharing increases, such as co-payments, deductibles, co-insurance, and benefit limits; (2) reduction in covered ben-

Shortly after the excise tax was first introduced in November 2009 (with an earlier effective date and lower thresholds),[225] Mercer surveyed 465 employer health plan sponsors about how they would likely respond to such a tax.[226] Nearly two-thirds (63%) of the respondents said they would reduce covered benefits to avoid paying the tax.[227] Of those who would reduce benefits, 75% said they would raise deductibles and co-pays, 40% said they would add an alternative low-cost plan to their benefit offerings, and 32% said they would replace their current plan with a low-cost option.[228] Many of the larger employers reported that they would seek to lower costs through more sophisticated strategies.[229] For example, 25% of employers with workforces of 5000 or more employees said "they would seek quality and cost-efficiency improvements through high-performance networks, medical homes, and health management incentives."[230] The largest employers were also the most likely to report that they would terminate employer contributions to flexible health spending, health reimbursement, and health spending accounts.[231]

Thus, based on survey data, it appears likely that many employers will change their health plans in order to avoid the Cadillac tax. Of course, it is quite possible that the Cadillac tax will be repealed before it ever goes into effect. The excise tax was initially scheduled to take effect in 2013.[232] The PPACA's sidecar reconciliation bill extended the effective date until 2018.[233] As Edward Zelinsky has noted, "four elections, including the congressional election of 2014 and the presidential election of 2016, will take place before this levy goes into effect."[234] The levy's long-delayed effective date[235] suggests that the Cadillac tax carries a "high[ ] level of political toxicity," and "[i]t is

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efits; or (3) elimination of high-cost plans. AM. ACADEMY OF ACTUARIES & SOC'Y OF ACTUARIES, *supra* note 199, at 13.

225. Initially, the excise tax was scheduled to take effect in 2013 and was designed to apply to employee-only coverage at or above $8500 and family coverage at or above $23,000. Press Release, Mercer, Majority of Employers Would Reduce Health Benefits to Avoid Proposed Excise Tax, Survey Finds (Dec. 3, 2009), *available at* http://www.mercer.com/press-releases/1365780.
226. *Id.*
227. *Id.*
228. *Id.*
229. *Id.*
230. *Id.*
231. Some 25% of employers with 5000 or more employers said they would terminate such contributions, compared to 19% of employers of all sizes. *Id.*
232. *See* Patient Protection and Affordable Care Act (PPACA), Pub. L. 111-148, § 9001(c), 124 Stat. 119, 853 (2010).
233. *See* Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. 111-152, § 1401(b), 124 Stat. 1029, 1060.
234. Zelinsky, *supra* note 6, at 7-24.
235. Many of the other provisions of PPACA have delayed effective dates. Yet, the Cadillac tax's effective date is delayed the longest. *See id.*

unlikely that officeholders running for re-election in 2018 will embrace a different political calculus than did their peers in 2010. Hence the prognosis for the tax on 'Cadillac' plans is at best uncertain."[236]

V. CONCLUSION

Health care in the United States has long been financed principally through employment-based health insurance. At least in the short run, the Patient Protection and Affordable Care Act is unlikely to disturb that balance.

PPACA's three incentives with respect to employment-based health insurance are unlikely to change significantly the number of employers who elect to offer employment-based health insurance. The penalty under the large employer pay-or-play mandate, though low relative to the cost of health insurance premiums, is unlikely to affect employers' willingness to offer health insurance, at least in the short run. The small employer tax credit may encourage some employers that do not already offer health insurance to offer health insurance. It is not clear, however, how many employers will elect to claim the credit. At most, only about 4 million small employers would be eligible to claim the small employer tax credit, and many—though certainly not all—of those small employers currently offer health insurance. Thus, the small employer tax credit may increase somewhat the number of small employers that offer health insurance, but it is unlikely to have significant impact on the total number of employers that offer health insurance. Of the three incentives, the Cadillac tax is likely to have the greatest impact on employers' behavior. Survey data suggests that many employers will likely change the terms of their plans in order to avoid the excise tax. Nevertheless, it is quite possible that the tax will be repealed before it ever goes into effect.

Projections by the Centers for Medicare & Medicaid Services (CMS) and the Congressional Budget Office (CBO) confirm that the number of individuals covered by employment-based health insurance is not expected to change significantly as a result of PPACA. The CMS estimates that the number of individuals enrolled in employer-sponsored health care plans will decline modestly, from 165.9 million in 2010 to 164.5 million in 2019, as a result of the enactment of PPACA.[237] The CBO projects that the number of individuals covered by employer-sponsored health plans will increase from 150 million in 2010 to 162 million in 2019 as a result of PPACA,[238] but it expects the

236. *Id.* at 7-25

237. FOSTER, *supra* note 159, at 3.

238. *See* CBO, *supra* note 159, at tbl.4.

total number covered in 2019 to be 3 million less than would have been covered had PPACA not gone into effect.[239]

Although these absolute numbers mask a fair bit of churning,[240] this churning is not attributable to PPACA's employer pay-or-play mandate, small employer tax credit, or Cadillac excise tax. Instead, it is due to other changes wrought by PPACA, such as the individual mandate and the requirement that dependent care coverage be extended to age twenty-six.[241] If PPACA ultimately does fundamentally reform employment-based health insurance in this country, it will be indirectly through its substantive regulation of health care, rather than directly through the specific incentives it creates in the form of the pay-or-play mandate, small employer tax credit, and Cadillac excise tax.

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239. *Id.* at 10 & tbl.4.

240. *See* Hyman, *supra* note 11, at 13 ("Although the estimated number of Americans receiving [employment-based health insurance] is projected by CMS to stay almost exactly the same, there is considerable churn underneath the picture of placid stasis."). Specifically, the CMS projects that by 2019, an additional 13 million workers and family members will become newly covered by employer-sponsored plans as a result of additional employers offering health coverage, a higher percentage of employees electing to enroll in employer-sponsored plans, and PPACA's mandate that employer-sponsored plans extend dependent coverage up to age twenty-six. FOSTER, *supra* note 159, at 7. Meanwhile, the CMS projects that 2 million workers currently covered by employer-sponsored plans will become eligible for Medicaid and another 12 million workers will replace employer-sponsored health insurance with subsidized coverage through the exchanges. *Id.* at 6–7. Similarly, the CBO projects that 6 to 7 million new people would be covered under PPACA, largely because the individual mandate would increase workers' demand for employment-based coverage. CBO, *supra* note 159, at 10. The CBO further projects that 8 to 9 million individuals who would be covered under current law would not be offered coverage under PPACA. *Id.* The CBO expects that the firms that would not offer coverage to be smaller employers and employers with predominantly low-paid workforces. *Id.* Finally, the CBO projects that between 1 million and 2 million people who would be covered under an employer-sponsored plan under current law would instead choose to obtain coverage through an exchange. *Id.*

241. The Rand Corporation's Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model predicts that PPACA will increase the number of workers offered employment-based health insurance coverage from 115.1 million to 136 million. Christine Eibner et al., *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1394 (2010). Like the CBO and CMS, Rand does not attribute this increase to PPACA's employer pay-or-play mandate, small employer tax credit, or Cadillac excise tax. *See id.* at 1394–95. Instead, it credits PPACA's individual mandate and the availability of new, often lower-cost insurance options for small businesses through the exchanges. *Id.*