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100 Edgewood Avenue, Suite 1040, Atlanta, Georgia 30303 • ph: 404-420-1324 • fax: 404-420-1329 • www.gbpi.org

Contact: Alan Essig, aessig@gbpi.org

Reforming Healthcare Brief #2:

Pay-or-Play Laws Seek to Increase Employer-Sponsored Insurance

By Timothy Sweeney and Janna Sayer

Increases in the costs of health insurance are often difficult for employers to absorb. Not surprisingly, while health insurance premiums have increased significantly in recent years (double-digit increases in 4 of the last 6 years), the percent of employers sponsoring coverage has declined from 69% of firms in 2000 to 60% in 2005.¹ At the same time, the number of Americans without health insurance continues to rise. In 2004, approximately 45.5 million non-elderly Americans, including nearly 1.5 million Georgians, went without health insurance. These figures represent approximately 18% of all Americans under 65 and nearly 19% of non-elderly Georgians.²

This paper is the second in a series examining the recent increases in healthcare costs, corresponding declines in employer-sponsored insurance and increases in the uninsured population, and policies the federal, state, and local governments are currently examining and pursuing to address these problems. In the first paper, this series examined the growing popularity of Health Savings Accounts and the preferred federal tax-status these accounts currently enjoy. This brief will examine “pay-or-play” laws that several states and localities have proposed and enacted in an effort to halt the decline in employer-sponsored insurance. Future papers will examine Medicaid/SCHIP/State-only coverage expansions, small business pools and buy-in to state employee health plans, single-payer universal health insurance, and non-traditional healthcare arrangements some employers are considering in their attempt to reduce healthcare spending. This series will provide background on what these policies seek to accomplish, how they can or cannot be implemented, and to which populations they provide the most or least benefits.

While employer-sponsored health plans are still the most prominent health insurance products in the U.S., the rates at which employers offer their employees coverage is declining. In response to these declines, states and localities across the country have passed or considered laws that seek to either incentivize or require employers to provide insurance for their employees. One recent mechanism states are pursuing is referred to as “pay-or-play.”

What is “Pay-or-Play?”

Pay-or-play laws attempt to pressure employers into providing health insurance or healthcare services to employees. In order to do so, these laws impose financial penalties against employers who fail to provide a certain level of healthcare to employees.

These laws can vary greatly, specifically targeting only very large employers, for example, or more broadly targeting all employers. Some laws even target only a specific group or type of employers. Pay-or-play laws have been enacted on a statewide basis (Maryland) and have also been enacted at the local level (New York City). The laws can be structured in many different ways, such as requiring employers to provide a minimum level of health coverage to all full-time employees or simply requiring employers to spend a certain amount of money on employee healthcare, with little or no direction in how the dollars are spent.

In addition to structuring the requirements in a variety of ways, these laws may contain various enforcement mechanisms. A law requiring an employer to spend a certain percent of payroll on healthcare, for example, could force non-compliant employers to contribute a fee or tax in order to reach the mandated threshold. A law requiring a minimum level of insurance, on the other hand, could require employers to buy into a specific program if they choose not to offer their own insurance.

Why Seek Pay-or-Play Laws?

The U.S. is unique in its reliance on privately funded, voluntary, employer-sponsored health insurance.[†] From 2000 to 2005, however, the percent of Americans with health insurance through an employer-sponsored plan decreased from 66% to 61%.³ While small

[†] While most, if not all, other 1st-world nations provide some form of universal (or near-universal) health coverage, the system structures vary. Some nations rely in part on mandatory employer based coverage for large employers, for example; however, the U.S. is unique to rely on voluntary employer coverage for the bulk of health insurance.

employers (those with less than 50 employees) may feel the healthcare cost increases more acutely, even large employers may have difficulty dealing with the rapidly increasing cost of employee coverage.⁴ In general, these declining coverage rates may have a significant impact on the health insurance landscape.

Public programs are often available to fill the gap for low-income children, but working poor adults have fewer health insurance options. In Georgia, non-elderly parents are only Medicaid-eligible with incomes up to 33% of the Federal Poverty Limit (FPL), (approximately \$6,600 per year for a family of 4 or \$5,500 per year for a family of 3); childless adults are ineligible regardless of income. Low-income adults above these levels, but without insurance through an employer, may have children on Medicaid or PeachCare, but have a very difficult time affording private health insurance premiums. Therefore, while Medicaid and SCHIP increases have absorbed some of those families who lose employer-sponsored insurance, private insurance participation has not seen significant increases in recent years. As a result, the percent of working adults without insurance continues to increase.

The growing population of individuals without health insurance brings with it several concerns. First of all, individuals without health insurance are less likely to have a regular source of care. Because these individuals often lack access to preventive medicine, they are more likely to seek care in emergency rooms when care is needed. As more individuals go without health insurance, the amount of uncompensated care administered by Georgia hospitals and other providers increases. Though some federal and state funding is available to offset uncompensated costs, Georgia safety-net providers also end up passing these costs onto other healthcare consumers. These costs are felt by employers and individuals in the form of higher monthly insurance premiums.

One recent study estimates that over 7% of health insurance premiums paid by Georgians go to offset the healthcare costs of uninsured individuals.⁵ This amounts to approximately \$275 per year for individuals and \$746 per year for Georgia families. These costs are also felt by Georgia employers, and the increasing costs of health insurance often make it difficult for employers to continue to offer insurance to employees.

While the growth in public programs has helped to limit the increases in the uninsured population, this growth has also put significant pressure on state budgets. Once thought of as health insurance for families on cash assistance, even Medicaid is heavily populated

with children from “working-poor” families. When large, recognizable employers in particular have significant numbers of employees (or their children) receiving public health insurance, many policymakers become concerned. For example, studies in several states have shown that Wal-Mart employees (and their children) make up significant portions of Medicaid and SCHIP enrollees. In Georgia, a state survey in September 2002 found that over 10,000 PeachCare children (out of total enrollment of approximately 166,000), had parents working for Wal-Mart; the next largest employer had less than 800 children of employees enrolled in PeachCare.⁶

While pay-or-play laws seek to address several problems, one of the specific motivations is to address the growing uninsured population. By requiring employers to increase spending on healthcare for their employees, these laws may increase the number of low-income working individuals with insurance. At the same time, greater private sector health coverage may reduce growth in public insurance programs, easing pressure on state budgets. This could allow the state to invest additional resources in programs to assist individuals and employers in purchasing of insurance.

Barriers and Concerns

While several states and localities are examining pay-or-play laws, they must consider some of the barriers these laws may face. One particular issue that states seeking pay-or-play laws need to be aware of is in the interaction of their proposed law with the federal Employee Retirement Income Security Act (ERISA) of 1974. This law governs employer and employee pension and healthcare plans and effectively limits states’ abilities to force employers to sponsor health insurance plans. States retain the ability to regulate health insurance companies, but their ability is more limited for self-insured employer plans and for other aspects relating to employer-sponsored health insurance. Generally, ERISA is a complicated law; therefore, there is no “litmus test” to determine whether a specific state “pay-or-play” proposal would withstand a legal challenge on the basis of ERISA.

In addition to legal barriers, pay-or-play laws also face political opposition, often from the business community. While many acknowledge the role that declining employer-sponsored insurance rates have played on the overall increase in the number of uninsured Americans, some do not believe that laws requiring employers to provide coverage are a solution. Chambers of Commerce and other employer organizations have been particularly outspoken in opposition to such laws for being an added burden and cost to employers. Some employers who currently

provide insurance have been in favor of these efforts, as these businesses face higher costs than competitors who choose not to sponsor health insurance coverage.

ERISA at a Glance

The federal ERISA law contains two specific provisions that policymakers developing pay-or-play laws need to consider: the “preemption clause” and the “savings clause.”

The preemption clause states that “the provision of ERISA shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” This statement has been interpreted to void most state laws specifically referring to employer-sponsored health plans, and the U.S. Supreme Court has specifically ruled that ERISA preempts laws with a substantial financial or administrative burden on employer-sponsored plans or laws that attempt to directly regulate employer-sponsored plans. In general, ERISA’s preemption clause has been interpreted to say that states cannot require employers to sponsor health insurance, dictate the terms of an ERISA plan or employer’s premium contribution, or tax employer-sponsored health plans.

On the other hand, ERISA’s “savings clause” allows states to regulate the terms and conditions of health insurance, meaning that states can regulate health insurers, though “self-insured” employer health plans are not subject to state health insurance regulation. (Prior to the enactment of the ERISA law, states already had the authority to regulate “the business of insurance.”)

Overall, while ERISA prevents states from regulating the employers directly (and whether they provide health insurance), states have regulatory ability over the health insurance industry itself. Furthermore, while many cases have been decided by the Supreme Court determining the scope of ERISA, there is no clear indication whether current pay-or-play legislation will withstand legal challenges based on ERISA’s broad preemptive powers. Less prescriptive pay-or-play laws that do not seek to establish rules on the specific insurance coverage employers must provide, many contend, may be less likely to run afoul of ERISA as compared to more rigid laws that mandate specific coverage and contributions. Due to the broad preemptive power of ERISA, however, definitive statements about the legality of pay-or-play laws in general can not be made.

State and Local Efforts Nationwide

In recent years, several states and localities have either implemented or passed pay-or-play laws and many more are looking at such laws. Two of the most prominent laws have been passed in Maryland and New York City.

Maryland:

In January 2006 the Maryland Legislature overrode the Governor's 2005 veto of the **Maryland Fair Share Health Care Fund Act**.⁷ This legislation creates several requirements that will take effect January 1, 2007, including:

- All employers with more than 10,000 employees will be required to report on total healthcare spending for workers, dependants, and retirees.
- Private employers with more than 10,000 employees will be required to spend at least 8% of payroll on health expenditures (requirement is 6% for non-profit employers meeting threshold).

- Employers spending less than the required amount must pay the difference into a state fund (or increase health expenditures to meet requirement).

Three private employers in Maryland currently employ more than 10,000 employees: Giant Foods, Wal-Mart, and Johns Hopkins University. Of these three employers, only Wal-Mart currently spends less than 8% of their payroll on health expenditures.

New York City:

In 2005, the New York City Council successfully overrode a Mayoral veto to pass the **Health Care Security Act**, which takes effect July 1, 2006.⁸ The

Beyond Pay-or-play: Healthcare Reform in Massachusetts Expands on Pay-or-play Concepts

By an overwhelming, bipartisan majority, the Massachusetts Legislature recently passed Healthcare reform legislation that includes a small pay-or-play requirement as part of a package of broader reforms including Medicaid coverage expansions, an "individual mandate" to obtain health insurance, and the creation/expansion of other programs to assist employers and employees with employer-sponsored insurance. Massachusetts Governor Romney signed the bill in April 2006, but also vetoed several provisions including assessments on businesses that do not provide insurance. At the time of this writing, the Massachusetts House of Representatives has successfully voted to override the Governor's vetoes; the Massachusetts Senate is expected to follow and restore all of the vetoed provisions, including the "pay-or-play" provisions.

While the legislation requires most residents to obtain health insurance by July 1, 2007, it also includes several provisions to assist individuals in meeting this requirement, including the following:

- Medicaid and SCHIP are expanded to cover children up to 300% of the Federal Poverty Level (\$60,000 for a family of 4);
- Creating the Commonwealth Care Health Insurance Program, which will offer zero-deductible insurance to individuals with incomes up to 100% FPL at no cost, and provide sliding scale subsidies to individuals with income below 300% FPL;
- Expand the existing Insurance Partnership Program for employees up to 300% FPL (currently 200% FPL). This program provides some financial assistance to employers and employees in small businesses if the employer pays at least 50% of health insurance costs for their employees;
- Private insurance changes including merging non-group and small group markets, allowing young adults to remain on their parents' coverage longer, and allowing the industry to develop insurance plans for the 19-26 age group.

In addition to assisting individuals with obtaining insurance, the Massachusetts plan as enacted by the Legislature also includes penalties for employers who do not offer, and individuals who do not purchase, health insurance:

- Beginning in tax year 2007, individuals who have affordable insurance available to them but do not purchase it will lose their personal exemption on their income taxes (worth about \$150). In subsequent years the assessment could increase to up to 50% of the monthly cost of insurance for each month the person is without insurance;
- Employers with more than 10 workers (full time equivalent) who do not offer health insurance will be assessed an annual fee of \$295 per uninsured worker;
- Employers with uninsured workers may also be assessed a "free rider" surcharge if their employees access a certain amount of free care in a year (3 for an individual employee or 5 for all employees). (Some believe this surcharge will not likely be paid, as employers must only offer to arrange for, not necessarily provide, coverage.)

While some issues and concerns remain regarding the definition of "affordable insurance" relating to the enforcement of the individual mandate, whether adequate state and federal funding will be available in the coming years, and surrounding the effects of the new (some fear scaled-back) health insurance products this legislation allows, the Massachusetts health care reform package is nonetheless unique in its comprehensiveness. By affecting all aspects of the healthcare system, supporters anticipate that this plan will address 90-95% of the current uninsured population in Massachusetts, and that by FY 2009 these changes will increase the number of covered lives (or insured population) by approximately 515,000 people.

City Council again overrode a Mayoral veto to amend the original law. As amended, the New York City law requires “grocery employers” with at least 50 full-time employees or 12,500 square feet of retail space to make health care expenditures on behalf of their employees at the prevailing level in the industry. According to supporters, this would result in employer contributions of about \$2.50 to \$3.00 for each hour an employee works. Like the Maryland law, health care expenditures are defined very widely and include, but are not limited to, health insurance premiums, direct payments for healthcare services, or even contributions to health savings accounts. Employers who do not comply with the new law will be fined.

Conclusions

As previously mentioned, the last 6 years have seen the percent of Americans receiving health insurance through an employer-sponsored plan drop from 66% to 61%. At the same time, the number of individuals either without health insurance or enrolled in public health insurance programs such as Medicaid has increased. In response to these trends, policy makers around the country are examining ways to strengthen, incentivize, and possibly even mandate employers to continue to provide insurance to employees. One such possibility is to implement pay-or-play laws.

While opposition to these laws can be significant, recent bi-partisan, comprehensive healthcare reform efforts in Massachusetts show that pay-or-play concepts can be part of efforts to solve these serious issues. Though opponents argue against these laws because they would increase costs to businesses, many businesses who already sponsor health coverage for employees may embrace efforts to incentivize other employers to do the same. Proponents also point out that the added costs are currently being passed on to taxpayers, in order to pay for programs such as Medicaid, and to other healthcare payers in the form of higher insurance premiums.

Because the U.S. is unique in its reliance on privately financed, voluntary, employer-sponsored health coverage, any failure of businesses to provide insurance to employees affects the entire healthcare system. While nations that require employers to cover their workers can avoid significant coverage drops in difficult economic times, the U.S. system results in a sizable population without insurance. Furthermore,

though public programs and safety-net providers are sometimes available to fill in the gaps created by declining employer coverage, state budgets often have difficulty absorbing the additional costs. Costs not absorbed by public programs and funds are shifted to other healthcare consumers.

In general, because costs borne as a result of the uninsured population are felt across the healthcare spectrum, the U.S. system leads to significant cost shifting. Uncompensated costs realized by healthcare providers are passed on to other payers through higher monthly insurance premiums, meaning that all healthcare consumers pay higher costs as a result of the large uninsured population. As a result, employers and employees with insurance subsidize those without insurance. Also, taxpayers end up subsidizing healthcare costs of some employers who have large numbers of workers and/or their children enrolled in public health insurance programs (such as Medicaid or Georgia’s SCHIP program, PeachCare).

The problems of the growing number of uninsured individuals – increasing costs of private health insurance, decreasing offer-rates on behalf of private employers and even increasing Medicaid spending – permeate the healthcare system. The growing numbers of uninsured Americans creates large scale, system-wide issues, which will not be solved by singular, simple approaches. Because it only addresses specific aspects of our healthcare system, pay-or-play is not a solution to these problems by itself.

Depending on the structure of the laws, however, pay-or-play can be part of larger solutions to these problems, as demonstrated by the efforts in Massachusetts and elsewhere. Coupled with additional proposals that positively incentivize employers to sponsor health insurance and that ease the burden on employers who do so, pay-or-play laws may help address the recent drop in employer-sponsored insurance without being overly burdensome on employers. Together, significant healthcare reforms that result in increased employers sponsored coverage and fewer individuals without insurance may help eliminate some of the cost shifting in the current system, making the state’s healthcare system more efficient. Georgia policymakers should examine these proposals closely, as they may provide important lessons in developing a solution or plan that fits the needs of Georgia.

The Georgia Budget and Policy Institute (GBPI) is an independent, nonprofit, non-partisan organization engaged in research and education on the fiscal and economic health of the state of Georgia. The GBPI provides reliable, accessible and timely analyses to promote greater state government fiscal accountability as a way to improve services to Georgians in need and to promote quality of life for all Georgians.

¹ Employer Health Benefit 2005 Annual Survey. Kaiser Family Foundation and the Health Research and Educational Trust. <http://www.kff.org/insurance/7315/index.cfm>. Annual insurance premium increases ranged from 8.2% to 13.9% in the last 6 years.

² National and Georgia specific data from Census Bureau's March 2004 and 2005 Current Population Survey, compiled by Statehealthfacts.org. <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=profile&area=Georgia&category=Health+Coverage+%26+Uninsured&subcategory=Health+Insurance+Status>

³ “The Uninsured: A Primer.” Kaiser Commission on Medicaid and the Uninsured, January 2006. <http://www.kff.org/uninsured/upload/7451.pdf>.

⁴ Even very large employers such as General Motors have difficulty dealing with rising healthcare costs. <http://www.washingtonpost.com/wp-dyn/articles/A15828-2005Feb10.html>; <http://www.medicalnewstoday.com/medicalnews.php?newsid=23213>;

⁵ “Paying a Premium: The added cost of care for the uninsured.” Families USA, June 2005. www.familiesusa.org

⁶ “Wal-Mart stands out on rolls of PeachCare, Sign-up ratio far exceeds other firms’.” Article by Andy Miller, Atlanta Journal-Constitution, Feb. 27, 2004.

⁷ For more information on the Maryland Fair Share Health Care Fund Act see the Maryland Legislature’s page on the bill: <http://mlis.state.md.us/2005rs/billfile/sb0790.htm>;

⁸ For more information on the New York City Health Care Security Act see the following websites: <http://nyhealthcaresecurity.org/facts.html>; http://www.nyccouncil.info/issues/bill_details.cfm?ID=Int%200468-2004&TYPE=all&YEAR=2004&SPONSORS=YES&REPORTS=YES&HISTORY=YES