Employer Coolness Toward Clinton Plan Mandates

by Sylvester J. Schieber

Many analysts looking at the Clinton proposal focus on the employer mandates and how to ameliorate the related burdens. However, the coverage mandate in the president's package is actually an individual mandate—that is, individuals are required to sign up with accountable health plans. The mandate that applies to employers is a financing mandate—they are required to contribute to the financing of health benefits on the basis of firm size, average pay levels, and work-force characteristics. There is also an administrative mandate in the president's plan requiring that employers facilitate enrollment in health plans, provide a premium collection mechanism, and so forth. Looking at each of these three mandates separately helps to explain the employer community's coolness to the Clinton proposal.

The Coverage Mandate

Few employers are opposed to the coverage mandates that President Clinton proposes. Some employers are strongly opposed to a true employer mandate that would require that all employers, or at least those above a certain size, set up and run a benefit program that would cover all workers. But many of those employers would be willing to endorse an individual mandate of the sort that Sen. John Chafee (R-RI) has proposed. Apparently even more are willing to endorse the "access" mandate that Rep. Jim Cooper (D-TN) recommends. Under the Cooper bill, everyone is responsible for signing up with an accountable health plan; employers simply do not have to make premium contributions that would make the plan responsible for providing care.

Sylvester Schieber is vice-president of The Wyatt Company, a benefits consulting firm in Washington, D.C., and director of its Research and Information Center.

The Financing Mandate

The element of the Clinton proposal that would result in universal coverage is the financing mandate. Here some of the strongest opposition to the Clinton proposal arises, but this opposition is far from universal among employers. Also, it is not purely a large employer/small employer issue. Rather, it is an issue of cost redistribution, or wage redistribution if one assumes that the financing ultimately comes out of wages.

Our estimate, based on analysis and modeling that we have been doing at The Wyatt Company, is that 20–25 percent of large employers have substantial numbers of workers who are not now receiving health benefits. These tend to be firms with large numbers of part-time or low-wage workers, concentrated in the retail sector of the economy, business service firms (providing security, cleaning, and temporary contracting services), food service firms, and such. But as Frank McArdle points out, employers in other sectors of the economy, including some in the public sector, would incur significant new costs if subjected to a financing mandate.[1] Economists' conclusions that the cost of the mandate will ultimately be borne by workers is not particularly reassuring to these employers.

Small employers seem to be more generally opposed to financing mandates than large employers are, largely because small employers are less likely to be providing health insurance to their workers today. For small employers, however, government subsidies under the Clinton plan would cover slightly more than half the premium costs for employers with fewer than ten employees and almost one-quarter of the costs for employers with 10–100 employees.[2] Many small employers that are willing to provide coverage at prices significantly below current market prices probably are unaware of the generosity of the Clinton plan for them and their workers. Thus, there is a strong perception that small employers are vigorously op-

posed to President Clinton's financing mandate, although many might support it if they truly understood its financial implications.

A point raised by many of the economists in this volume of *Health Affairs* is that employer contributions for health benefits result in reduced cash wages or other benefits. If this economic truth were widely believed, it would make little difference whether the financing mandate were imposed on employers or workers. However, many employers, their workers, and other observers believe that the incidence of health benefit cost increases falls on employers in the form of reduced profits or on consumers in the form of higher prices. If the employer could pass the cost increases back to the worker or on to the buyer, controlling health benefit cost increases would be of less concern.

A 1990 Wyatt survey of some 1,800 senior executives of large U.S. corporations asked the respondents: "How does your company try to cover increases in the costs of employer-sponsored health benefit plans?"[3] A substantial majority (64 percent) believed that there is some sharing of the burden of health benefit cost increases. Among the respondents, 73 percent believed that at least some cost increases are passed on in the form of higher prices; 71 percent believed that they reduce profits; while only 49 percent believed that they reduce other forms of compensation. Only 11 percent thought that the full burden falls on workers through reductions in other elements of the compensation package. These perceptions are likely to motivate executives' reactions to health reform proposals.

In a short-term budget context, employers believe that rapid increases in health benefits cannot be quickly offset by reductions in other elements of the compensation package. This puts employers in a semi-perpetual state of negotiating credit for health cost increases that are automatically granted because of the defined nature of health benefit programs. While employers may ultimately negotiate compensation credit, the rapid inflationary costs of health benefit programs can cause other short-term adjustments. Employers often focus on short-term results, which may contribute to their sense that health benefits, or at least the increase in their costs, are disproportionately paid out of profits or through higher prices.

In a salary administration context, employers see individual workers getting benefit value under their health benefit plans based either on demographics or on extended social ties that bear no relation to worker productivity. The practical result of experience rating is that it is more expensive to provide health benefits to a fifty-five-year-old worker than to a twenty-five-year-old worker. This bears no relationship to their respective contributions to a firm's output. Similarly, it is more expensive to provide health benefits to a thirty-five-year-old worker with dependents than to one without dependents. Employers perceive either that they are providing a gratuity to some workers, or that they are acting as a taxing and redistribution agent among their workers. While the latter may be the case, many, if not most, employers find such a role abhorrent.

Many employers, both large and small, believe that they would be substantial financial winners under the Clinton proposal because the universal financing mandate would eliminate the cost shifting that is now going on among employers. Most employers who are now providing relatively generous benefits include working spouses and dependents of their employees, whose benefits would be financed by other employers under the Clinton proposal. The only way to eliminate this cost shift is through an employer-financing mandate or complete elimination of employer financing for any workers. An individual-financing mandate still would leave employers providing generous benefits with the prospect of funding benefits for working spouses of their own employees.

Administrative Mandates

Another interesting aspect of the business community's reaction to President Clinton's health reform proposal is the relatively cool reception it has received from even those firms that might financially

benefit. There are two reasons for this. The first relates to the historical role that U.S. employers have played in providing health benefits to workers. The second relates to the nature of the administrative mandates in the Clinton plan.

Employer role. In other developed countries it is fairly common for employers to participate in financing health insurance through premium or tax financing mechanisms, but those employers are not directly involved in defining the benefits covered or in administering the insurance systems. Clearly, there are some employers in the United States today who would like to wash their hands of the traditional role they have taken in providing health benefits to workers and their dependents. But many others want to maintain this unique role because they distrust the government's ability to control the cost of the system.

Technically, the Clinton plan would allow large employers (more than 5,000 employees) to continue to operate their own health plans outside the regional health alliances. However, the 1 percent payroll tax that corporate alliances would be subject to is such an onerous burden that these plans would not be financially viable. While 1 percent may seem a trivial amount, when measured against the guaranteed premium limit of 7.9 percent in the regional alliance, it implies a penalty of at least 12.7 percent for setting up a corporate alliance. In addition, the prospect that corporate alliances might have to subject their plans to alternative benefit mandates on a state-by-state basis makes administering the plans untenable.

Many employers would be willing to pay some share of the cost of providing community-rated benefits to higher-risk persons. However, they do not want to be forced into regional alliances to do it. They also want the burden of providing community-rated benefits to be broadly distributed. Ultimately, though, they want to continue to operate their own health plan because they think that their own economic motivations to control the costs will be stronger.

Administrative complexity. Any employer who has implemented a flexible benefit plan can attest to the complexity in communicating three or four benefit options, conducting enrollments, and so forth. This complexity would be compounded under the Clinton reform measure.

Based on early experiences in Florida and Washington State with regional alliances, it is likely that the entire United States could be divided into 300 or more regions. If the employer is going to act as the withholding agent for the collection of premiums for covered workers, it is likely that workers will look to the employer to provide information on the plan options during the enrollment period. But this would not be the largest hurdle that employers would face. If we assume that the regions are served by an average of five accredited health plans, each with its own rate for the basic benefit package, an employer with a broadly distributed work force could face well over a thousand withholding rates just to collect the monthly premiums. Not a payroll system in existence today could accommodate this requirement. Modifying or replacing these systems is not a trivial matter.

Conclusion

In the final analysis, it will be impossible for the Clinton proposal or any of the major alternatives to garner universal support from the employer community. Modifying the Clinton proposal to make corporate alliances more viable, limiting states' ability to mandate benefits and levies on them, and reducing the administrative complexity of the proposal would garner far more support than the plan is now receiving.

NOTES

1. See F.B. McArdle, "How Would Business React to an Employer Mandate?" *Health Affairs* (Spring II 1994): 69–83.
2. The Wyatt Company, *The Economics of Health Reform* (Washington: The Wyatt Company, 1994), 11.
3. The Wyatt Company, *Management USA: Leading a Changing Work Force* (Washington: The Wyatt Company, 1990).

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