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Effects of Changes to the Health Insurance System on Labor Markets

In the United States, health insurance coverage is linked to employment in ways that can affect both wages and the demand for certain types of workers. That close linkage can also affect people's decisions to enter the labor force, to work fewer or more hours, to retire, and even to work in one particular job or another.

Changes to the health insurance system could affect labor markets by changing the cost of insurance offered through the workplace and by providing new options for obtaining coverage outside the workplace. For example:

- Requiring employers to offer health insurance—or pay a fee if they do not—is likely to reduce employment, although the effect would probably be small.
- Providing new subsidies for health insurance that decline in value as a person's income rises could discourage some people from working more hours.
- Increasing the availability of health insurance that is not related to employment could lead more people to retire before age 65 or choose not to work at younger ages. But it might also encourage other workers to take jobs that better match their skills, because they would not have to stay in less desirable jobs solely to maintain their health insurance.

The overall impact on labor markets, however, is difficult to predict. Although economic theory and experience provide some guidance as to the effect of specific provisions, large-scale changes to the health insurance system could have more extensive repercussions than have previously been observed and also may involve numerous factors that would interact—affecting labor markets in significant but potentially offsetting ways.

The Current Link Between Employment and Health Insurance

In 2009, at least 150 million people under the age of 65—or about three out of every five nonelderly Americans—are expected to have health insurance that is provided through an employer or other job-related arrangement, such as a plan offered through a labor union. That figure includes active workers, spouses and dependents covered by family policies, and retirees under the age of 65. The cost of that insurance is estimated to be, on average, $5,000 for a single plan and $13,000 for a family plan. For people whose income is at 300 percent of the federal poverty level (about $32,500 for a single person without children and $66,000 for a couple with two children), that cost represents between 15 percent and 20 percent of total income.

One reason employment-based plans are popular is that they are subsidized through the tax code—meaning that nearly all payments for employment-based insurance are excluded from taxable compensation and thus are not subject to income and payroll taxes. Another factor is the economies of scale that larger group purchasers have; such economies reduce the administrative costs embedded in policy premiums. Partly as a result, large employers are more likely than small ones to offer insurance to their workers.[1]

Another commonly cited reason for the popularity of employment-based insurance is that employers offering coverage usually pay a large share of the premiums. According to a survey of firms conducted in 2008, employers contributed 73 percent of the cost of a family

1. As a result of those economies of scale, the average share of the policy premiums that covers administrative costs varies considerably—from about 7 percent for employment-based plans with 1,000 or more enrollees to nearly 30 percent for policies purchased by very small firms (those with fewer than 25 employees) and by individuals.

policy for their workers and 84 percent of the cost of single coverage, on average.[2] Employers make those sizable contributions, in part, to encourage broad participation among their employees, so as to limit the potential for "adverse selection." Otherwise, employers' health plans might disproportionately attract enrollees whose health care costs are above average, causing average insurance premiums to rise to reflect the higher spending per enrollee.

Who Bears the Cost of Employment-Based Health Insurance?

Although employers directly pay most of the costs of their workers' health insurance, the available evidence indicates that active workers—as a group—ultimately bear those costs.[3] Employers' payments for health insurance are one form of compensation, along with wages, pension contributions, and other benefits. Firms decide how much labor to employ on the basis of the total cost of compensation and choose the composition of that compensation on the basis of what their workers generally prefer. Employers who offer to pay for health insurance thus pay less in wages and other forms of compensation than they otherwise would, keeping total compensation about the same.

That relationship between employers' contributions for health insurance and compensation can be difficult to observe. Firms offering health insurance actually tend to pay higher wages, on average, than firms that do not offer it. However, those differences in total compensation reflect such factors as disparities in the skill and productivity of workers, not the employers' failure to pass on the costs of providing insurance.[4]

Health Insurance and the Decision to Work

In the current system, employment-based health insurance offers a number of advantages (including the ones listed above as well as coverage of existing medical conditions) that may be difficult or impossible for workers to obtain by purchasing insurance individually. For that reason, its availability can play an important role in people's decisions to enter or remain in the workforce—especially those nearing retirement, who probably place a greater value on coverage of existing conditions than do their younger counterparts. People who are insured through their employer but are not offered health benefits after retirement have an additional incentive to remain employed until they qualify for Medicare at age 65.

Workers whose health insurance will cover them in retirement tend to retire earlier, on average, than those without such benefits.[5] That conclusion has been reached by a number of studies using different estimating techniques. For example, studies that examined the correlation between health benefits and the probability of retirement, controlling for other factors, found that having health benefits in retirement increased the probability of retirement before age 65 by 30 percent to 80 percent. Studies using other estimating techniques generally found smaller results, and a few found little or no effect.[6] However, the weight of the evidence indicates that retirees' health coverage probably leads to earlier retirement.

The availability of employment-based health insurance may also affect decisions by younger workers to enter or remain in the workforce. If primary earners are not offered family coverage through their employer, other members of their household may enter the workforce to obtain employment-based insurance. Some research indicates that spouses who are not covered under the primary earners' insurance are more likely to be employed than are spouses who are covered through such a plan.[7]

Health Insurance and Choice of Jobs

Some of the same advantages of employment-based health insurance that may keep more people in the labor force

2. Henry J. Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET), *Employer Health Benefits: 2008 Annual Survey* (Washington, D.C.: Kaiser/HRET, September 2008).

3. For a discussion of that evidence, see Jonathan Gruber, "Health Insurance and the Labor Market," in A.J. Culyer and J.P. Newhouse, eds., *Handbook of Health Economics,* vol. 1 (Amsterdam: North Holland, 2006), pp. 645–706.

4. For further discussion of the incidence of employment-based health insurance, see Congressional Budget Office, *Key Issues in Analyzing Major Health Insurance Proposals*, pp. 4–8.

5. See, for example, Jonathan Gruber and Brigitte C. Madrian, *Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature,* Working Paper No. 8817 (Cambridge, Mass.: National Bureau of Economic Research, March 2002).

6. One reason for the diversity of the results is the difficulty of controlling for other characteristics of workers; people choose their jobs partly on the basis of retirement benefits, and those who prefer early retirement may be more likely to choose a job that offers health coverage in retirement.

7. Gruber and Madrian, *Health Insurance, Labor Supply, and Job Mobility.*

can also cause people to decide to work (or stay) at firms that offer health insurance rather than take a job that better matches their skills and interests but does not offer health insurance. In addition, those who have medical problems (or have family members with medical problems) have an incentive to stay in a job that provides health insurance in order to cover those preexisting conditions, even if more productive opportunities exist elsewhere—a phenomenon known as "job lock." (Those opportunities could include working for a different employer or becoming an entrepreneur.) At the same time, people for whom health benefits have little value—such as those who receive insurance coverage through a spouse's employer—are more likely to take jobs that do not offer health insurance but that instead pay higher cash wages and salaries or provide other desired fringe benefits.

The evidence is mixed regarding the effects of employment-based health insurance on job turnover. Although some empirical studies conclude that workers are less likely to change jobs when faced with the potential loss of health insurance, others report little or no effect.[8] Much of that evidence is difficult to interpret, however, because jobs that provide health insurance generally have other attributes that discourage turnover.

Effects of Changes in the Health Insurance System on Labor Markets

Proposals to change the health insurance system may include many provisions that could affect outcomes in the labor market. Those provisions could impose new requirements on businesses, provide subsidies for individuals or small businesses, or affect the availability and cost of health insurance obtained through the individual market or through new purchasing pools (sometimes called exchanges, gateways, or connectors).

Imposing a Play-or-Pay Requirement on Employers

Some proposals would require employers to either play—that is, contribute toward their workers' cost of health insurance—or pay a fee to the government. Those proposals usually require employers to offer plans that meet certain standards; they also specify a minimum amount for employers' contributions toward those plans.[9] That fee could be a fixed dollar amount paid for each worker who was not offered health insurance; alternatively, it could be set at a percentage of earnings, so that the payment per worker would rise as his or her earnings increased—up to, perhaps, some threshold amount.[10]

Supporters of such play-or-pay requirements generally justify those provisions as a way to ensure that employers pay a portion of their employees' health care costs, referring to those requirements in some cases as "employer responsibility payments." However, if employers who did not offer insurance were required to pay a fee, employees' wages and other forms of compensation would generally decline by the amount of that fee from what they would otherwise have been—just as wages are generally lower (all else being equal) to offset employers' contributions toward health insurance.[11]

Play-or-pay requirements may have another rationale. They may encourage firms that currently offer health insurance plans to retain those plans in the future, despite the incentives created by other aspects of legislative proposals to drop such coverage; as a result, such provisions could reduce the budgetary costs of new subsidy programs. In June 2009, the Congressional Budget Office (CBO) analyzed title 1 of a draft of the Affordable Health Choices Act. That proposal contained generous subsidies for health insurance for families with income up to

8. For a discussion of those studies, see Brigitte C. Madrian, *The U.S. Health Care System and Labor Markets,* Working Paper No. 11980 (Cambridge, Mass.: National Bureau of Economic Research, January 2006), p. 19.

9. In Massachusetts, for example, employers with more than 10 full-time employees must make a "fair and reasonable" contribution to a qualifying health plan or pay an annual fee of up to $295 per full-time worker (roughly 15 cents an hour). The Senate Committee on Health, Education, Labor, and Pensions is considering legislation (the Affordable Health Choices Act) that would require firms to contribute at least 60 percent of the premiums for a qualifying plan or to pay $750 a year (or about 38 cents an hour) for each full-time worker. Different requirements would apply to part-time workers.

10. The House Tri-Committee Health Reform Discussion Draft includes a play-or-pay requirement for firms to contribute at least 72.5 percent toward a worker's premium (65 percent for family coverage) or pay a fee amounting to 8 percent of wages for each worker. For minimum-wage workers, that payroll tax would be roughly equal to 58 cents an hour. The requirements would be prorated for part-time workers.

11. The impact of the fee would be similar to that of employers' contributions for payroll taxes. Most analysts agree that wages and benefits would fall by the amount of an increase in those contributions.

500 percent of the federal poverty level but did not impose any play-or-pay requirements on employers. CBO concluded that the absence of such a play-or-pay requirement or other requirements for employers would have contributed to a noticeable decline in the number of people offered an employment-based plan.[12] A subsequent version of that bill—containing a play-or-pay requirement and a smaller subsidy program—led to a much smaller estimated impact on the amount of coverage provided through employment-based plans.[13]

Although play-or-pay requirements may prevent the erosion of employment-based plans, they are likely to affect the labor market. Because employees largely bear the cost of health insurance or play-or-pay fees in the form of lower wages, the effects of those provisions on employment and hours worked is likely to be relatively minor. However, a play-or-pay requirement could affect the amount of work available for certain categories of workers. In particular, a play-or-pay provision could reduce the hiring of low-wage workers, whose wages could not fall by the full cost of health insurance or a substantial play-or-pay fee if they were close to the minimum wage.[14]

The effect on employment would depend on the specifications of a play-or-pay requirement. Larger play-or-pay fees would tend to have a greater effect on employment; as the fees increased, more workers would be affected because their wages could not easily adjust without bumping into the minimum wage. The structure of the play-or-pay requirement would also matter. In some proposals, for example, the fees imposed on employers would apply only to full-time workers who were not offered health insurance; in others, the fees would apply to all workers but would be lower for part-time or temporary workers. Such limitations would increase incentives for firms to replace full-time employees with more part-time or temporary workers.

The effect of play-or-pay requirements on employment would also depend on the sensitivity of hiring decisions to changes in the minimum levels of compensation (including the minimum wage and the required levels of benefits). The impact of play-or-pay requirements on the employment of low-wage workers would be similar to the effects of raising the minimum wage—and the latter has been studied extensively. Although findings from those studies vary greatly, the weight of the evidence suggests that raising the minimum wage has a negative but small effect on the employment of low-wage workers.[15]

Several studies have used the findings from research on the minimum wage to estimate the effects of play-or-pay requirements on employment. One study estimated that 224,000 workers (or about 0.2 percent of all private-sector full-time workers between the ages of 22 and 65) could become unemployed if firms were required to provide health insurance costing, on average, $2 per hour worked (or roughly $4,000 a year per employee).[16] A second study found a larger effect—a potential loss of 750,000 jobs—from a higher play-or-pay assessment ($3 an hour, or $6,000 a year), but that estimate also included the effect of increasing the minimum wage from $5.15 (the minimum wage in 2004, the year of the study) to $7.25.[17] That study also assumed that play-or-pay requirements applied to part-time workers as well as full-time workers and that hiring decisions were somewhat more sensitive to changes in the minimum wage. Play-or-pay proposals that imposed less hefty assessments would have a smaller effect on employment.

Other researchers have examined Hawaii's experience with an employer mandate. Since 1975, employers in that state have been required to offer health insurance to their full-time workers or pay a penalty.[18] One study of that mandate found that the rate of employment grew faster in

12. Congressional Budget Office, "Preliminary Analysis of Major Provisions Related to Health Insurance Coverage Under the Affordable Health Choices Act," letter to the Honorable Edward M. Kennedy (June 15, 2009).

13. Congressional Budget Office, "Affordable Health Choices Act," letter to the Honorable Edward M. Kennedy (July 2, 2009).

14. The minimum wage is scheduled to increase from $6.55 to $7.25 on July 24, 2009.

15. For a review of that literature, see David Neumark and William L. Wascher, "Minimum Wages and Employment," *Foundations and Trends in Microeconomics*, vol. 3, no. 1-2 (2007), pp. 1–182.

16. Katherine Baicker and Helen Levy, *Employer Health Insurance Mandates and the Risk of Unemployment,* Working Paper No. 13528 (Cambridge, Mass.: National Bureau of Economic Research, October 2007).

17. Richard Burkhauser and Kosali Simon, *Who Gets What from Employer Pay or Play Mandates?* Working Paper No. 13578 (Cambridge, Mass.: National Bureau of Economic Research, 2007).

18. The penalty paid for each day the firm does not offer health insurance to its full-time employees is the greater of $25 or $1 per employee not offered coverage. A firm that fails to provide coverage for more than 30 days may be shut down by the state.

Hawaii than in the rest of the United States after the mandate was instituted, although that result may have been due to factors other than the mandate.[19] Another study did not find any relationship between the mandate and employment levels in Hawaii but observed an increase in the employment of part-time workers—one of the categories of workers who were exempted from the mandate.[20]

Imposing a Surcharge on Employers Whose Workers Receive Health Care Subsidies

Some proposals have considered imposing surcharges on employers whose workers use health care that is subsidized by the government. In Massachusetts, employers can be required to pay a surcharge if employees and their dependents who are not offered a plan use, in total, more than $50,000 worth of care a year from a state-funded pool that was established to finance care for the uninsured. Other variants of surcharge proposals would require employers—even those that offer insurance to their employees—to pay all or a portion of certain health insurance subsidies that their workers received from the government. Supporters of such surcharges often refer to them as "free-rider" penalties. Although the surcharges would be imposed on the firms, workers in those firms would ultimately bear the burden of those fees, just as they would with play-or-pay requirements or premiums for employment-based health insurance.

The differences between the effects of play-or-pay requirements and employer surcharge provisions illustrate some of the trade-offs concerning the size and characteristics of the affected population. Relative to the broader-based play-or-pay requirements, employer surcharges tend to be more targeted, applying only to workers who are not enrolled in their employers' plans and receive government subsidies for insurance obtained elsewhere. Many of those workers, however, are more likely to have earnings at or near the minimum wage, and the size of such surcharges—if based on the actual costs imposed on government programs—could be larger per affected worker than the assessments being considered in many play-or-pay requirements. As a result, the effects of an employer surcharge could be concentrated among workers whose wages could not easily adjust to absorb its full cost; such targeted provisions could therefore have a much larger impact on employment than a substantially smaller play-or-pay fee affecting a broader base of workers. Moreover, the employment loss would be concentrated disproportionately among low-income workers who employers expected would be more likely to obtain subsidies from the government (for example, unmarried individuals who do not receive family coverage through a spouse's job).

At the same time, employer surcharge provisions, which would require government agencies to track subsidies to individuals and then identify which employers to bill, could be more difficult to implement than play-or-pay requirements, and those administrative hurdles might temper the effects of such provisions on employment. Employer surcharge provisions might also create greater uncertainty for firms because their liability would depend on whether workers chose a government-subsidized plan, obtained other coverage, or became uninsured.

Expanding or Creating Individual Subsidies for Health Insurance

Subsidies for health insurance coverage can affect people's decisions about whether and how much to work. A subsidy can be provided through the transfer system (possibly as a voucher) or through the tax system (as an exclusion from income, a tax deduction, or a tax credit). A subsidy represents an increase in income, and some recipients may respond by working fewer hours (and thus offsetting part of the increase in subsidy income with a reduction in wage income).

To limit costs, subsidies are typically phased out as a beneficiary's income rises. Over the phase-out range, a worker receives less compensation for each additional hour worked, because each dollar earned reduces the subsidy. That effect, known as an "implicit tax," can lead people to work fewer hours than they otherwise would, in the same way that income and payroll tax rates do. Most empirical studies conclude that increases in marginal tax rates generally reduce the number of hours worked, particularly among secondary earners (typically, the spouse of the main earner in a family).[21] Higher tax rates also reduce people's incentive to raise their income in other ways,

19. Norman K. Thurston, "Labor Market Effects of Hawaii's Mandatory Employer-Provided Health Insurance," *Industrial and Labor Relations Review,* vol. 51, no. 1 (October 1997), pp. 117–135.

20. Thomas C. Buchmueller, John DiNardo, and Robert G. Valletta, *The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii,* Working Paper No. 2009-08 (San Francisco, Calif.: Federal Reserve Bank of San Francisco, April 2009).

21. See Congressional Budget Office, *Labor Supply and Taxes* (January 1996).

such as working harder in the hope of winning raises; accepting new positions or responsibilities with higher compensation; or investing in their future earning capacity through education, training, or other means.[22]

Policymakers face a trade-off in deciding how to phase out subsidies. If subsidies are large and are phased out quickly, the implicit tax rates, and thus the negative impact on work incentives, can be quite high. Implicit tax rates can be reduced by expanding the range over which the subsidy is phased out, but doing so increases the number of people subject to the implicit tax and boosts the total cost of the subsidy. In the extreme, the same subsidy can be granted to everyone, but doing so substantially increases budgetary costs, which might in turn be financed through higher explicit tax rates. Alternatively, a subsidy can be eliminated all at once at a certain income (creating a "cliff" in the relationship of subsidy to income), which eliminates the cost of phasing out the subsidy more gradually but, for people whose potential income is near the cliff, significantly increases the disincentives to work more. People whose income is just below the threshold can respond by not working more hours, and those whose income is just above the threshold may cut their hours of work in order to qualify for the subsidy.

One program that creates work disincentives for its recipients is Medicaid. That program is structured so that eligibility for benefits is completely eliminated at a specified income for most eligibility categories (a cliff).[23] For individuals whose income is close to that threshold, working more and earning a higher income can lead to the loss of Medicaid benefits, creating a disincentive to work more. Proposals that would simply extend Medicaid eligibility to families whose income was slightly higher than allowed under current law would effectively move the cliff—reducing disincentives to work for families at the current threshold but creating new disincentives for families whose income was somewhat higher. One study concluded that a series of increases in the income limit for Medicaid eligibility in the late 1980s and 1990s increased the labor force participation of working-age single mothers by a small but statistically significant amount.[24] Creating new subsidies for health insurance for families above the eligibility thresholds for Medicaid would effectively reduce the size of current cliffs because people would become eligible for the new subsidies at the same time they became ineligible for Medicaid.

New subsidies might be created to cover the costs of private health insurance, and they could be gradually reduced over a specified income range in a variety of ways—with different implications for marginal tax rates and work incentives. Those subsidies could be gradually reduced at a uniform rate, causing implicit marginal tax rates to rise by the same amount for all recipients in the phase-out range. For example, a proposal might provide families whose income was at the federal poverty level (roughly $23,000 for a family of four in 2013, the year in which many proposals would take effect) with fully subsidized health insurance valued at $15,000. That subsidy might be gradually reduced as income increased, and families whose income was above 400 percent of the poverty level ($92,000) might be ineligible for any subsidy. In that case, marginal tax rates would go up by about 22 percentage points for all families whose income was between 100 percent and 400 percent of the poverty level.

An alternative approach would provide subsidies over the same income range but would link eligibility for those subsidies to an "affordability" standard that would limit the amount a family spent on health insurance premiums to a percentage of family income. For example, a family with income at the federal poverty level could be required to pay 1 percent of income but would receive a federal subsidy for the difference between the cost of their health insurance and the family's required contribution. That cap on premiums could be set to rise with income—for example, increasing to 10 percent of income as the family's income rose to 400 percent of the federal poverty level—and implicit marginal tax rates would also increase as income rose. An advantage of raising the cap is that

22. Martin Feldstein, "Effects of Taxes on Economic Behavior," *National Tax Journal*, vol. 61, no. 1 (March 2008), pp. 131–139.

23. Although eligibility for Medicaid varies by state, all states are required to cover pregnant women, children under age 6 whose family income is at or below 133 percent of the federal poverty level, and children who are at least age 6 but not yet 19 and whose family income is up to 100 percent of the federal poverty level. Some factors reduce the severity of the cliff: Eligibility for children can extend to higher income levels than eligibility for parents, so families do not lose all their benefits at once; and transitional medical assistance continues Medicaid eligibility temporarily for people whose earnings have risen to a level that would otherwise make them ineligible.

24. For estimates of the size of the effect on labor supply, see Aaron S. Yelowitz, "The Medicaid Notch, Labor Supply, and Welfare Participation: Evidence from Eligibility Expansions," *Quarterly Journal of Economics,* vol. 110, no. 4 (November 1995), pp. 909–939.

families with income below 200 percent of the poverty level—a group typically in the phase-out range for other income-related transfers and tax credits (such as the earned income tax credit)—would face smaller increases in marginal tax rates than under the approach that phased out subsidies uniformly over a broad income range. A disadvantage of that approach is that it could result in a cliff at the income level at which people were no longer eligible for a subsidy. Thus, a family whose income in 2013 was just over four times the federal poverty level and who paid $15,000 for insurance would pay 16 percent of income, compared with 10 percent if their income was slightly lower. That cliff, however, could be reduced or eliminated by either increasing the premium cap or extending the subsidy to families with slightly higher income.

Capping the Exclusion of Employment-Based Insurance

Some proposals would limit the current tax subsidy for health insurance by reducing the tax exclusion for employment-based health insurance—perhaps by capping the amount of payments that could be excluded from taxable income. Reducing that exclusion would make a larger share of compensation taxable. By itself, that change would reduce after-tax income, encouraging people to work more to make up for their lost earnings. Capping the exclusion would also affect the relative prices of goods: The effective price of health insurance would rise, making other goods relatively less expensive. For example, the price of leisure—a good that people "purchase" with forgone earnings by choosing to work less—would fall relative to the cost of health insurance. In the absence of other changes, an increase in the price of health insurance would tend to boost the consumption of other goods, including leisure. The net effect on labor supply of the reduction in income and the change in relative prices is uncertain and would depend on the details of the proposal.

Giving Preferential Treatment to Small Businesses

Many proposals to change the health insurance system would give small businesses subsidies or other types of preferential treatment. Subsidies based on a firm's size might be intended to help "level the playing field" between large and small firms, whose costs for providing health insurance differ, but they could also create a competitive advantage for small firms. Similarly, proposals that exempted small businesses from play-or-pay requirements, or lowered the assessments imposed on those firms, could favor employment in such firms.

The responses to such incentives could take several forms—some involving actions by workers, some involving actions by firms, and some involving actions by both parties. For example, workers might prefer to take jobs with smaller firms to take advantage of the new subsidies. Similarly, firms might take steps to become smaller (or avoid actions that might expand their workforces). For example, firms could outsource—that is, lay off employees and contract with other, smaller companies for the same services. Alternatively, they could divide themselves into subsidiaries with smaller workforces. One study examined the impact of state regulations governing health insurance plans offered by small groups and found a clustering of firms just under the statutory thresholds (for example, 25 employees) in states with rules that favored small firms, suggesting that some employers might have adjusted their size to take advantage of the preferential treatment of smaller firms.[25]

A firm seeking to reorganize in response to such incentives, however, could face high barriers to that process. It might find that keeping all of its workers within the same entity was more efficient. Employee benefit laws also limit the extent to which firms can treat employees differently across subsidiaries. Certain features of proposals—such as limiting subsidies only to the smallest firms or capping the average wages of workers in eligible firms—might make it more difficult for firms to reorganize or for workers to move to smaller firms. Administering subsidies for small businesses, however, might be challenging, because it would be difficult for government agencies to monitor the size of firms—providing opportunities for some firms to claim subsidies for which they were not eligible.

Enhancing the Individual Insurance Market or Creating Exchanges

Proposals might increase the attractiveness of health insurance coverage that is not provided through employers, even though those proposals might still retain current tax subsidies for employment-based insurance. For example, some proposals would establish exchanges where people could shop for insurance. Insurance obtained through exchanges could provide some of the advantages of employment-based insurance, including lower administrative costs. Another common feature of many proposals

25. Kanika Kapur and others, *Do Small Group Health Insurance Regulations Influence Small Business Growth?* Working Paper No. WR-351-ICJ (Santa Monica, Calif.: Rand Institute for Civil Justice, May 2006).

is the provision of subsidies that would help cover the costs of health insurance purchased through exchanges. Other changes to the insurance market—prohibiting insurers from denying coverage to people because of their preexisting conditions or limiting how much insurers could vary prices with the age or health status of insured individuals—would also make insurance in the exchanges or individual market more affordable for less healthy or older individuals.

By making insurance obtained outside the workplace more attractive, those provisions could cause some people to retire early. In its 2008 report *Budget Options, Volume 1: Health Care*, CBO analyzed an option that would allow people between the ages of 62 and 64 to buy into Medicare coverage. Under that option, participants would pay premiums equal to the average cost of benefits for program participants plus a 5 percent administrative fee. CBO estimated that the number of retired individuals would increase by roughly 20,000 as a consequence. That option, however, did not include subsidies to cover the costs of Medicare premiums or restrictions on how much premiums could vary with the age of enrollees—two features that would increase the attractiveness of the "bridge" coverage.

Increasing the availability of health insurance from sources other than employers could also reduce the participation of some younger workers in the labor force, especially those for whom gaining employer-based insurance is a major motivation for working; however, that effect would probably not be large. The impact on participation would probably be greatest among secondary earners because they tend to be more responsive to changes in the marginal benefit of working than are primary earners. Proposals that increased the availability of health insurance from other sources could also reduce job lock and, potentially, lead to better matches of workers to jobs.

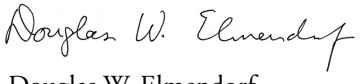
Effects of Changes to the Health Insurance System on International Competitiveness

Some analysts have argued that domestic firms offering health insurance to their workers face higher costs for compensation than do competitors based in countries where insurance is not related to employment and that fundamental changes to the health insurance system could reduce or eliminate that disadvantage. However, such a cost reduction is unlikely to occur, except in the short run, primarily because the costs of fringe benefits are largely borne by workers in the form of lower cash wages. Other economic factors (including tax rates and currency values) are likely to have a larger impact on a nation's competitiveness in the world market.

To be sure, workers' cash compensation might not increase immediately by the full amount of any reduction in employers' payments for health insurance. For that reason, firms that currently contribute toward the costs of their workers' health benefits could temporarily reap some savings in labor costs if changes to the health insurance system resulted in their workers receiving subsidized coverage in some other way. But those firms would experience no permanent change in their competitive status.

In at least one circumstance, firms might find it difficult to adjust wages as health care costs increased or declined. Some firms have commitments to cover the health care costs of their retirees, and those commitments may not be fully funded. Reducing those legacy costs could ease the financial strain on those firms. Stockholders could benefit, but whether lower costs would enhance the firms' competitiveness would depend on how firms used those additional savings. If those retiree benefits were the result of collective bargaining on behalf of both active workers and retirees, active workers might bear the costs of those benefits—but they might also capture any savings resulting from reductions in those costs.

This brief was prepared by Janet Holtzblatt and Benjamin Page. It and other CBO publications are available at the agency's Web site (www.cbo.gov).



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