5. POTENTIAL EFFECTS OF EMPLOYER MANDATES AND MEDICAID EXPANSIONS

Two types of proposals have been prominently advanced to reduce the number of uninsured. So-called "employer mandates" require that employers offer group health insurance policies and pay a significant amount of the premiums for all employees who work more than a specified number of hours per week. Proposals to expand Medicaid require that categorical eligibility requirements be relaxed and/or that income eligibility limits be increased (i.e., thereby requiring all States to make Medicaid available to all those eligible below certain income levels) (see CRS, 1988b for a discussion of illustrative options).

A number of factors determine the effects of an employer mandate. The types of employees and employers to be included in an employer mandate are especially important. How many hours per week must be worked? Does coverage begin on the first day of employment or after a waiting period? Are the self-employed included? Are employee dependents covered? Will small firms be exempt? What level of benefits must be provided? How much must the employer contribute to the premium?

Similarly, the effect of an expansion in Medicaid depends on a number of policy decisions. For example, what is the minimum eligibility income level? Are the changes in eligibility mandatory or optional for the States? Are two-parent families with workers eligible or must one parent be absent or unemployed?

The following presents preliminary estimates of the effects of an employer mandate, Medicaid expansion, and combinations of an employer mandate and Medicaid expansion. The analyses use preliminary data from the March 1988 CPS supplement.

Employer Mandates

The following assumptions are used in estimating the effect of an employer mandate on the number of uninsured adolescents:

- The self-employed are exempt. All other "permanent" employees who work more than the required number of hours per week are covered (i.e., with no exemptions for firm size or industrial classification).[1]
- Employees working 26 weeks or more in the preceding year are considered "permanent" workers and would be covered under the mandate.
- The effects of the mandate are estimated using three different assumptions about the number of hours of work at which workers are covered: 18 hours, 25 hours, and 30 hours.
- All unmarried adolescents age 18 or younger would be covered by the mandate if their parents were covered as well; however, it is assumed that adolescents who are not heads of household who do not live with their parents would not be covered as dependents under the mandate.[2]

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1 The currently available 1988 CPS data do not include firm size. As a result, it is difficult to do any analysis that excludes small business even though many proposed mandates exempt employees in small firms (often five or fewer employees). Other data sources and a set of imputation rules could be used to assign sane employees to firms of 5 (or 10) workers or less, but such a process was beyond the scope of this paper. Note also that uhen final 1988 CPS public use files are available, the smallest firmsize coded will be 1 to 25 employees thus prohibiting any analysis for firms with less than 25 employees.

2 Most mandate proposals cover some adolescents who do not live with their parents; however, because the CPS file does not report parent's work status for adolescents who do not live with their parents, this analysis takes the conservative approach and does not impute dependent coverage to these adolescents. Adolescents who are living on their own and are eligible for employer-based coverage are included as employees, not as dependents.

Table 16 summarizes the effects of an employer mandate on adolescents given the above assumptions. If employees who worked 30 hours or more per week were included, approximately 2.55 million uninsured adolescents, or 55 percent of all adolescents currently without health coverage would become insured. Although reducing the hourly work threshold does increase the number of uninsured who would become covered, its effect is relatively minimal (at least within the range of 18 to 30 hours per week). For example, if the hourly work threshold was reduced to 25 hours per week, an additional 60,000 adolescents **(1.3** percent of all those uninsured) would be covered. If the threshold was 18 hours per week, an additional 136,000 adolescents (or 3 percent of all uninsured adolescents) would be covered.

This projection of how many adolescents would be covered by an employer mandate is slightly lower than similar analyses of the adult uninsured because a sizable number of uninsured adolescents neither live with their parents nor work full-time. Of the 1.87 million adolescents who would not recovered by an 18-hour-per-week threshold, 716,000 live on their own. It is possible that many of them would, in fact, be covered as a dependent on a parent's policy, and that actual coverage under a mandate might be higher than estimated here. Also not covered by an 18-hour threshold are approximately 379,000 adolescents with self-employed parents; 456,000 who live with nonworking parents; and 267,000 who live with parents who worked less than 26 weeks during the preceding year.

While assuring that most workers and their dependents have health insurance benefits, an employer mandate may have other labor market effects (see Monheit and Short, 1988; Phelps, 1980; CRS, 1988b). For example, if employers are required to pay for health benefits for employees who were previously uninsured, they may respond by either raising prices, absorbing reduced profits, reducing cash wages (or other fringe benefits) or reducing staff.

It is likely that many employers would limit the rate of growth of cash wages so that total employee compensation (i.e., cash plus health benefits) remains the same. For uninsured, middle-income workers, this might be a desirable tradeoff; that is, they would receive less cash compensation than before, but would gain access to group health insurance and reap the benefits of tax-free employer contributions. However, lower-income employees may evaluate the tradeoff differently; they might prefer the cash to the health benefits. Therefore, in designing a mandate that includes these workers, it would be important to consider the feasibility of subsidizing employer contributions for the required health benefits.

It is also important to consider workers who earn at or near the minimum wage. Employers of such workers maybe prohibited by minimum wage laws from lowering wages, despite a mandated obligation to provide health coverage. Consequently, in response to a mandate, employers of minimum-wage workers may be less likely to make new jobs available.

Medicaid Expansions

Proposals to expand Medicaid may mandate or simply give States the option to broaden Medicaid eligibility. Currently, States have the flexibility, within limits, to set their own eligibility levels for the Aid to Families with Dependent Children (AFDC) and Medicaid programs. Some States have relatively broad eligibility policies while others are much more restrictive. However, with few exceptions, adolescents are eligible for Medicaid only if they are in a family with a so-called "deprivation factor;" that is, a family with an absent parent or one whose principal breadwinner is unemployed (see CRS, 1988c for an excellent summary of eligibility rules).[3]

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3 This is unchanged by the passage of the Family Support Act of 1988 (Public Law 100-485).

Table 16--- Potential Effect of Various Employer Mandates on Uninsured Adolescents by Living Arrangement and Parent's Work Status (in thousands)

Living arrangement/ parent's work status	Number covered by mandate on 30 hours per week employees	Additional number covered by lowering mandate to 25 hours per week[a]	Additional number covered by lowering mandate to 18 hours per week[a]	Number not covered by 18 hours per week mandate	Totals
Living without parents	75	2	22	716	815
Parent is self-employed	14	6	4	379	403
Parent is not working	10	2	4	456	472
Parent working fewer than 26 weeks	9	0	6	267	282
Parent working 26 weeks or more	2,440	51	101	49	2,641
Total	2,549 (55.3%)	60 (1.3%)	136 (3.0%)	1,868 (40.5%)	4,613 (100.0%)

[a]Entries refer to the number of uninsured adolescents (in 1,000s) who would be covered by the employer mandate.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1988 Current Population Survey.

If the current categorical requirement of a "deprivation factor" is maintained, the potential for an expansion in Medicaid to cover significant portions of uninsured adolescents is severely limited. As can be seen in table 17, if all adolescents in single-parent households with incomes below 100 percent of poverty were covered by Medicaid, approximately 707,000 of the 4.6 million uninsured adolescents would be covered. However, even if States were required to extend eligibility standards to all such adolescents, it is doubtful that all would enroll. In fact, many of the 8 percent of *uninsured* adolescents who were in single-parent households in 1987, with incomes below 50 percent of poverty, were already eligible to receive Medicaid benefits.

If categorical requirements were dropped, and all adolescents with family income below a specified standard were eligible for Medicaid, then significant portions of the currently uninsured could be covered by a Medicaid expansion. Over 40 percent of uninsured adolescents in 1987 lived in households with family income below 100 percent of poverty, and an additional 19 percent were in households with income between 100 and 149 percent of poverty (table 17).

One concern often raised about expanding Medicaid is that employers may respond by dropping private health coverage for low-wage workers who would be eligible for coverage under the expansion. Should this happen, the pool of eligibles could be much larger than those who are currently uninsured and living under the income thresholds In 1987, there were approximately 600,000 privately insured adolescents in families with incomes between 50 and 99 percent of poverty; some of these might "leak" from the private system to Medicaid if Medicaid was available to all families with incomes below 100 percent of poverty. However, the potential leakage would be much greater if Medicaid were available to all adolescents in family incomes below 150 percent of poverty; about 1.7 million additional privately insured adolescents are in families with incomes between 100 and 149 percent of poverty.

Combined Approach: Employer Mandate With a Medicaid Expansion

Table 18 shows the proportion of uninsured adolescents who would be covered by various combinations of an employer mandate and Medicaid expansion. The entry in the bottom right corner of the table shows that if employers were required to cover all workers who worked 18 hours or more and Medicaid was available to all adolescents in families with income below 200 percent of poverty, then only 7 percent of adolescents without health coverage would remain uninsured. An employer mandate that included employees of at least 30 hours per week combined with a Medicaid expansion that included all adolescents below 100 percent of poverty, would cover over 80 percent of uninsured adolescents (see the center of table 18).

Note that most of the adolescents left out by the combination of an employer mandate and Medicaid expansion are children of the self-employed. If the self-employed were included under a "combination" mandate, the vast majority of uninsured adolescents would become covered (even if the expansion included only those up to 100 percent of poverty).

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3 Section 89 of the Internal Revenue Code, the so-called "nondiscrimination" section, will make this more difficult than previously, but not impossible.

Table 17.--Potential Effect of a Medicaid Expansion on Uninsured Adolescents by Poverty Level and Living Arrangements (in thousands)

Medicaid eligibility level[a,b]	Estimated number (percent) of uninsured adolescents covered by the Medicaid expansion		
	Living arrangement		
	Living with one parent	Living with two parents or living alone	Total
Less than 50 percent of poverty	354 (8%)	523 (11%)	877 (19%)
50 to 99 percent of poverty	353 (8)	657 (14)	1,010 (22)
100 to 149 percent of poverty	288 (6)	582 (13)	870 (19)
150 to 199 percent of poverty	212 (5)	431 (9)	643 (14)
200 percent of poverty and above	275 (6)	938 (20)	1,214 (26)
Total number of uninsured adolescents covered under expansion	1,482	3,131	4,614
Overall proportion of uninsured adolescents covered by expansion	(33%)	(67%)	(loo%)

[a]Entries are the proportion of currently uninsured adolescents who would be insured under the indicated level of Medicaid expansions.
[b]The Medicaid expansions assume that all adolescents in families with income below the specified amount would be covered by Medicaid.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1988 Current Population Survey.

Table 18.--Potential Effects of Various Combinations of Employer Mandates and Expansions in Medicaid on Uninsured Adolescents, Age 10-18

Medicaid eligibility level[a,c]	No employer mandate	Employees included in the mandate[a,b] (no. of hours worked weekly)		
		30 hours	25 hours	18 hours
No expansion	0%	55%	57%	60%
Anyone below 50% of poverty	19	71	72	75
Anyone below 100% of poverty	41	81	82	84
Anyone below 150% of poverty	60	87	87	89
Anyone below 200% of poverty	74	92	93	93

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Proportion of uninsured adolescents who would become covered

[a]Entries are the proportion of currently uninsured adolescents who would be insured under the indicated combination of an employer mandate and Medicaid expansion.
[b]The employer mandates assume that all workers excluding the self-employed (and their dependents), who work more than the indicated number of hours for at least 26 weeks during the preceding year, would be covered.
[c]The Medicaid expansions assume that all adolescents in families with income below the specified amount would be covered by Medicaid.

SOURCE: Office of Technology Assessment, 1989, based on estimates from the March 1988 Current Population Survey.