

State Employer Health Insurance Mandates: A Brief History

March 2004

Background

Employer mandates are a central feature of many major plans to expand health insurance coverage. They were an important component of the last two efforts to establish universal health insurance throughout the United States, during the Nixon Administration in the early 1970s, and during the Clinton Administration in the early 1990s. Employer mandates have been incorporated into major reforms undertaken in Hawaii, Massachusetts, Oregon, Washington, and California. Both the adoption and implementation of employer mandates are contentious, and they are vulnerable to shifts in economic and political conditions. Employer mandates in Massachusetts and Washington were repealed primarily due to declining support within the state. The employer mandate included in the original Oregon Health Plan expired without ever being implemented due to the failure of Congress to approve an exemption from the requirements of the 1974 Employee Retirement and Income Security Act (ERISA). All of these reforms were significantly curtailed in the wake of the defeat of the Clinton Administration's proposal for national health reform and the election of Republican majorities in both houses of Congress in 1994.

Comparison of California's Health Insurance Act of 2003 to Prior Employer Mandates

Key Mandate Features

Massachusetts, Oregon, and Washington enacted employer mandates as part of comprehensive health care reforms that included significant subsidies for employers and low-income individuals, stronger regulation of insurance plans (e.g., guaranteed issue and renewal, standard benefit packages, and limits on the variation in premiums), and various methods of cost containment. The 2003 California law is much narrower in scope; it recommends the creation of subsidies for smaller firms and establishes but does not fund a commission to develop plans for containing the costs of the mandated coverage. The comparatively narrow scope of the California law means that its implementation is not dependent on new state revenues; indeed, it may reduce the state's health care budget modestly by shifting some low-wage workers from public insurance programs into employer-sponsored plans. On the other hand, the heavy reliance on private financing and lack of cost containment measures means that the plan will face persistent opposition from business interests.

The ERISA Challenge

California's Health Insurance Act of 2003 adopts a "pay or play" mandate under which employers subject to the law must pay the state a fee if they do not offer a qualified health insurance plan to their workers and contribute at least 80 percent toward the costs of coverage. The fees collected from employers will be used to provide uninsured workers and dependents with insurance coverage from a new state-sponsored purchasing pool. This type of employer mandate has not been subjected previously to a legal challenge. It most closely resembles the approach taken in Massachusetts' 1988 Health Security Act, which was never implemented and was ultimately repealed before it could be tested in the courts. Since the California law does not regulate the coverage provided through employer-sponsored health plans directly, some believe it would withstand a legal challenge based on ERISA. (See fact sheet ERISA Implications of SB 2 at www.chcf.org/topics/sb2/index.cfm?itemID=21740.)

Political Conditions

Apart from legal challenges, the political conditions under which California's Health Insurance Act of 2003 will be implemented also closely resemble conditions in Massachusetts after the enactment of its Health Security Act of 1988. California is still in the midst of a serious budget crisis and the governor who signed the 2003 legislation has been replaced by one who is likely to be less supportive of business regulation. The Massachusetts "pay or play" program was never implemented because of a severe economic downturn and because the program's most important political sponsor, Democratic governor Michael Dukakis, left office before the employer mandate was to take effect. His successor, Republican William Weld, announced his opposition to the program and the state legislature postponed implementation and eventually repealed the mandate. The repeal of an employer mandate in Washington State in 1995 also occurred following the departure of key legislators and the governor who championed the 1993 Health Services Act. A potentially significant difference in California today is that the employer mandate is now a top priority for the state labor federation and for national labor unions as well.

States Attempting to Use Employer Mandates to Expand Coverage (in chronological order)

STATE	Key Employer Mandate Provisions	Employer Financial Contribution	Status
<p>1974 Hawaii Prepaid Health Care Act</p>	<ul style="list-style-type: none"> • Employers must provide health insurance for all employees working 20 or more hours a week. • Employees working fewer than 20 hours a week, government employees, sole proprietors with no employees, the unemployed, seasonal workers, and Medicaid beneficiaries are exempt and are supposed to be covered by a program established in 1989 known as the State Health Insurance Plan (SHIP). • Requires that all insurance plans have certain benefits such as inpatient hospital, emergency room care, maternity, medical, and surgical care. • Employers can offer Type A (comprehensive) or Type B (less comprehensive) plans. 	<ul style="list-style-type: none"> • Employer must pay at least 50 percent of the premium cost but can require the employee to contribute an amount up to 1.5 percent of wages. • If employer offers Type A plan, there is no contribution requirement toward dependent coverage. If employer offers Type B plan, a 50 percent contribution toward dependent coverage is required. 	<ul style="list-style-type: none"> • In effect. • Implemented January 1975. • Mandate successfully challenged in <i>Standard Oil vs. Agsalud</i> case, upheld by Supreme Court in 1981. • Congress granted the Prepaid Health Care Act an exemption from the provisions of ERISA in 1983 but specified that any substantive changes in the law would void the exemption.
<p>1988 Massachusetts Health Security Act</p>	<ul style="list-style-type: none"> • Employers with more than five employees must provide coverage to their employees (but not dependents) by January 1992 or pay new payroll tax as described in next column. • Certain part-time, seasonal, and temporary workers as well as those covered under Medicare or non-employer based private insurance were exempt from provisions of mandate. • The Department of Medical Security would determine the benefits package under directive that it should mirror the typical employer package and any managed care plan should be comprehensive. 	<ul style="list-style-type: none"> • Employers provide health insurance or pay 12 percent tax on first \$14,000 of annual wages per worker. 	<ul style="list-style-type: none"> • Implementation was to be effective 1992, but was postponed in 1991, 1994, and 1995. • First postponement agreed to by legislature in face of worst economic recession since 1930s and opposition to employer mandate by new Republican governor who took office in 1991. • Subsequent postponement was to gain time to develop an alternative plan. • Repealed in 1996 because no alternative plan could be identified for universal coverage and state instead pursued major expansion of Medicaid.
<p>1989 Oregon Health Plan</p>	<ul style="list-style-type: none"> • Required employers not currently offering coverage to provide coverage for “permanent” employees (working at least 17.5 hours per week) and their dependents or make contribution to new state fund to help pay for coverage of employees and their dependents. • Offered tax credits for small employers (3 to 25 employees) to voluntarily purchase insurance. If insufficient numbers of small employers provide coverage by 1995 then it would be mandatory in the workplace for all employers, including self-employed. If not providing insurance then must “pay” as described in next column. 	<ul style="list-style-type: none"> • Play option: Employer provides health insurance coverage to employees and dependents. There are no requirements regarding a minimum employer contribution or benefit level. • Pay option: Employer pays an amount equal to 75 percent of an employee’s premiums and 50 percent of the dependents’ premiums into a state fund that will provide coverage for the uninsured. 	<ul style="list-style-type: none"> • Implementation was to be effective in July 1995, but 1993 legislation delayed mandate until 1997 for firms with more than 25 employees and 1998 for firms with 25 or fewer employees. • A repeal of the employer mandate was passed by the legislature but vetoed by the governor in 1995. • The authority for the employer mandate expired because an ERISA exemption was not obtained from Congress by January 1996, as required by the legislation.

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<p>1989 Oregon Health Plan, cont.</p>	<ul style="list-style-type: none"> • Required employers subject to the mandate to provide coverage for basic benefits based on priority list developed by Oregon Health Services Commission and approved semi-annually by legislature (subject to federal exemption from ERISA). The law does not specify minimum benefits for employers currently offering coverage. • Required all insurers offering coverage to small businesses to offer as an option the basic benefit package developed by the Oregon Health Services Commission. • Required state to gain federal exemption from ERISA by January 1996 in order for employer mandate to take effect. 	<ul style="list-style-type: none"> • Tax credits provided to small employers (3 to 25 employees) who voluntarily provide insurance before July 1995. 													
<p>1992 California Affordable Basic Health Care Act</p>	<ul style="list-style-type: none"> • Would have required all employers to provide basic health care coverage to eligible employees and their dependents. Mandate was to be phased in over three years, beginning with firms of 25 employees or more in 1994 and including all employers in 1997. • Firms were not required to provide coverage to part-time employees, those who worked fewer than 25 hours per week (under the legislative version of the proposal, SB 248) and 17.5 hours per week (under the ballot initiative, Proposition 166). • New employers were exempt from the mandate for 27 months. • Required that insurers charge the same premium for the basic health coverage to all employers within the same geographic region, except for groups of 100 or fewer persons, which they could charge up to 30 percent more. • Outlawed medical underwriting and exclusions or waiting periods for preexisting conditions for the basic health coverage required under the mandate. • Created a Health Care Coverage Commission to set policies for cost containment, medical practices, and technology assessment. • SB 248 authorized an annual percentage limit on increases in insurance premiums for basic coverage; if increases exceeded the limit, a panel would have been empowered to set premiums, hospital rates, and professional fees. • Proposition 166 did not include cost containment provisions. 	<ul style="list-style-type: none"> • Employers required to pay at least 75 percent of the premium. 	<ul style="list-style-type: none"> • Proposed as SB 248 and ballot initiative as Proposition 166. • SB 248 passed Senate, stalled in Assembly primarily due to state budget crisis. • Proposition 166 failed by two-to-one margin. 												
<p>1993 Washington Health Services Act</p>	<ul style="list-style-type: none"> • Required large employers (more than 500) to cover employees by July 1995 and dependents by July 1996. • Smaller firms phased in so that all employees and their dependents were to be covered by July 1999. • Seasonal agricultural employees and employers were originally exempted from the mandate, then later included. 	<ul style="list-style-type: none"> • Employers provide health insurance or pay health security assessment if: <table border="1" data-bbox="1333 1193 1669 1388"> <thead> <tr> <th>Number of Employees</th> <th>Percentage of Gross Annual Payroll</th> </tr> </thead> <tbody> <tr> <td>< 20</td> <td>6%</td> </tr> <tr> <td>20–49</td> <td>7.5%</td> </tr> <tr> <td>50–499</td> <td>9.75%</td> </tr> <tr> <td>500–999</td> <td>11.5%</td> </tr> <tr> <td>≥ 1,000</td> <td>12%</td> </tr> </tbody> </table> 	Number of Employees	Percentage of Gross Annual Payroll	< 20	6%	20–49	7.5%	50–499	9.75%	500–999	11.5%	≥ 1,000	12%	<ul style="list-style-type: none"> • Employer mandate repealed in 1995 after governor and key legislative sponsors left office.
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STATE	Key Employer Mandate Provisions	Employer Financial Contribution	Status
<p>1993 Washington Health Services Act, cont.</p>	<ul style="list-style-type: none"> • All insurers must offer uniform benefit package based on the Basic Health Plan offered through the Washington Health Care Authority. It includes comprehensive benefits but with some substantial deductibles and coinsurance. Persons with employer-based coverage must be offered a choice of at least three certified health plans, one of which could be a self-insured plan for firms with more than 7,000 workers. 	<ul style="list-style-type: none"> • Employers who elect to provide insurance coverage must pay at least 50 percent of the cost of the least expensive plan in the region. • Employers contribute prorated amount for employees working fewer than 30 hours per week. • Called for establishment of \$150 million assistance fund in 1997 for firms with fewer than 25 employees. Such employers can apply for assistance from fund. • Called for tax credit system for firms with fewer than 500 employees. Credit could not exceed 40 percent of the employer's actual premium paid on behalf of the employees' dependents. 	
<p>2003 California Health Insurance Act of 2003 (SB 2)</p>	<ul style="list-style-type: none"> • By January 2006, firms with 200 or more employees must provide state-approved coverage for employees and their dependents or pay a fee to the state. By January 2007, firms with 20 to 199 employees must provide coverage for employees only. Firms with fewer than 20 employees are exempt. • The legislation exempts firms with 20 to 49 employees from the requirements unless the state provides a tax credit for those firms equal to 20 percent of the employer's net cost of the fee. • The Employment Development Department will collect the fee from firms that do not offer qualified coverage. To receive credit against the fee, employers must demonstrate coverage of their workers under: (1) health care service plans regulated by the Department of Managed Health Care; (2) group health insurance policies regulated by the Department of Insurance, with limits on out-of-pocket costs; (3) Taft-Hartley health and welfare funds or other collective bargaining agreements. • Self-insured employer-sponsored plans meeting ERISA requirements, multiple employer welfare arrangements regulated by the Department of Insurance, and coverage for public employees also qualify if they meet the benefits required under items 1 or 2 above. • The Managed Risk Medical Insurance Board (MRMIB) will administer a new State Health Purchasing Program, which will be responsible for negotiating coverage on behalf of employees and dependents who do not receive coverage through their employer. • For more information on SB 2, refer to the fact sheet at www.chcf.org/topics/sb2/index.cfm?itemID=21733. 	<ul style="list-style-type: none"> • Employer fee to be established by MRMIB based upon estimated coverage costs for all enrollees and dependents. • Employers providing health coverage receive credit against the fee. • Employers must contribute at least 80 percent of the cost of coverage. Employee out-of-pocket financial contributions cannot exceed 5 percent of wages for workers below 200 percent of the Federal Poverty Level. MRMIB will establish maximum levels of employee cost-sharing (premiums, deductibles, copayments). 	<ul style="list-style-type: none"> • Signed by governor in October 2003.

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