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THE CASE AGAINST MANDATED EMPLOYER-PROVIDED EMPLOYEE HEALTH INSURANCE:

A Practical Small Business Perspective

Mandated employer-provided health insurance comes in three principal flavors:

* a pure mandate, requiring an employer to provide and pay a fixed percentage of an employee's health insurance premium;

* a mandate requiring an employer to provide and pay a fixed percentage of payroll for employee health insurance (with some mechanism to transform unequal per capita premium payments into equal per capita policy benefits); and

* a mandate requiring an employer to provide employee health insurance or pay a tax, the so-called "pay-or-play" option.

The three are essentially the same in their effects on employers and employees as are the arguments against them, allowing discussion of only the first as representative of three, given it is the simplest and cleanest.

The Basics

The reader must appreciate a few basic numbers about the uninsured and health insurance costs before a discussion can begin: the Bureau of the Census reports that 45.5 million people or roughly 15 percent of the American population did not have health insurance in March 2007.[1] Of that number, 39 percent lived in family units or by themselves on incomes of less than $25,000; 30 percent on incomes between $25,000 and $49,999; 15 percent between $50,000 and $74,999; and 16 percent $75,000 or more [24]. Think of the median uninsured unit as having $35,000 of annual income.

Meanwhile, the average premium for a family health insurance plan in the United States in 2007 was $12,680; the average cost of an individual plan was $4,704 [8]. Assume for the moment that the minimum benefit package in a mandated health insurance plan costs 80 percent of the average, an arbitrary but commonly discussed level, meaning the minimum required premium cost is $10,144 and $3,763 respectively. Most discussion incorporates some employer-employee cost sharing arrangement with 70 percent – 30 percent common. The result is a mandated employer-provided health insurance program requiring a small employer to purchase a minimum policy costing $7,101 per full-time employee needing a family plan and $2,634 per

[1] The number is questionable and doesn't consider period of time without health insurance. Only a fraction of those without insurance at any point in time, went an entire year without it. See [5].

full-time employee needing an individual plan. The employer can deduct the premium as a business expense. For purposes of calculation, the author assumes the employer has a 30 percent marginal income tax rate (federal and state combined), though that is likely high given that those not providing health insurance earn the least income from their businesses [7]. The result is a minimum direct out-of-pocket cost of $4,971 per family policy and $1,844 per individual policy. (The calculations appear on Table 1.) The required employee's share is $3,043 per family policy and $1,844 per individual policy, whether paid directly by the employee or through a public subsidy.

Those are the key figures today; tomorrow they will be higher; the day after that, they will be still higher. But for now, the required employer-paid premium effectively increases a currently uninsured $25,000 a year employee's compensation by 20 percent needing a family plan or 7 percent for an employee needing an individual plan. If an employee earns $50,000 instead, compensation increases are 10 percent and 4 percent respectively. Despite these small business owner increased costs, in all cases the employee experiences lower take-home (prior to any subsidy and likely even then).

A small business perspective on these figures may help: a currently uninsured six-employee firm with three employees requiring a family plan and three requiring an individual plan will experience an annual immediate payroll cost increase of $20,445. An uninsured 10-employee firm with seven employees requiring a family plan and three employees requiring an individual plan will experience an annual immediate payroll cost increase of $40,329. That expense recurs every year and actually increases in real terms, rising faster than inflation and/or wages because health care costs rise faster than either.

Table 1
Calculation of Minimum Health Insurance Premium Cost for Employers and Employees under Mandated Employer-Provided Health Insurance

	Family Plan	Single Plan
Average Policy Cost	$12, 680	$4,704
Minimum Policy (80% of average)	$10,144	$3,763
Employer's Share (70% of minimum)	$7,101	$2,634
Tax Deductible (30%)	$2,130	$790
Total Employer Cost	$4,971	$1,844
Employee's Share (30% of minimum)	$3,043	$1,129

A second perspective of mandated employer-provided health insurance premiums compares the required employer health insurance payment to FICA, Social Security's 7.65 percent tax that employers must pay on employee wages up to the $97,500 (2007) wage base. The comparison is apt because FICA is also a tax on labor. The employer's share of FICA on a $25,000 a year employee is $1,339 (including the 30 percent tax deductible); the share of health insurance premiums for the same employee is $4,971 (Table 1). The employer's share of FICA on a $50,000 a year employee is $2,678; the share of health premiums is $4,971. The employer's share of FICA on a $75,000 a year employee is $4,017; the share of health premiums is $4,971. The two are not equivalent until $93,000 of income, nearly to the FICA wage base. To the extent that policy analysts worry about FICA's adverse affects on labor markets, the impact of a mandated health premium dwarfs FICA's impact on low-income employees.

The Three Basic Arguments

There are three primary arguments against the imposition of mandated employer-paid health insurance: the policy is highly regressive as the uninsured, typically though not always low-income, eventually pay for their own health insurance through job loss, depressed wages and erosion of other benefits; the policy is inefficient because it is too blunt to distinguish between those needing and those not needing assistance to purchase health insurance; and, it is unfair to small employers and employees because the policy fails to address the real problems of the insurance market for small businesses, while retaining rigidities that injure both, and substituting a hefty, direct penalty on them, i.e., a tax, in large part because they are small and lack market power. Other arguments, such as driving off-budget massive public expenditures by laundering them through the private sector, are also valid, if more abstract, and less interesting to the daily concerns of small employers.

Taxing the Poor to Pay for Their Benefits - How It Works

Employers pay employees wages and benefits which, in combination, are termed compensation. The employer distributes compensation among its two components, principally as a means to attract employees rather than any personal preference for wages over benefits, benefits over wages, or one type of benefit over others [13]. There are exceptions: small employers, for example, will periodically display a noblesse oblige motive (for the employee's own good) to offer benefits when employees may prefer wages [10, 17]. The calculation may also change somewhat if the owner's family participates in the plan. But, employers typically consider one dollar spent on wages the same as one dollar spent on benefits.

An employer mandate to provide health insurance typically requires an employee to set aside a certain amount to pay his or her share of the premium. Given the median income of an uninsured family is about $35,000 and the median cost of a family policy is about $12,500 [8, from Exhibit 1.7], employees should expect to pay 9 percent of their gross income in premiums[2] plus any deductibles or co-pays even with the employer subsidy. Lower-income families would be liable for an even larger percentage as a share of income. Since few of these families pay any income tax, the tax exclusion does most of them no good. The employee's share is therefore highly regressive, though expected public subsidies would reduce its degree. But premiums are only the start.

With mandated health insurance, the employer must make adjustments for the required compensation increases. The adjustments will depend on the competitive situation the employer faces, including the immediacy or adjustment period. One adjustment most employers will make is to raise compensation for *selected* employees by the required premium amount, occasionally even going to the extreme and, if not holding employees totally harmless for their premium share, will at least substantially replace the pre-tax disposable income losses incurred. For those fortunate employees (don't ask about the timing of their next wage increase), the mandate achieves its social objective. It provides the employee insurance, when heretofore he or she had none, and perhaps even limits employee take-home losses.

a. *Making Employment Adjustments*

But the increased compensation cost for these fortunate employees must be borne elsewhere and decreases in other compensation costs are the prime target, particularly over the longer term.

[2] Assumed to be $12,680 average family premium X 0.8 (minimum policy) X 0.3 (employee's share).

Small employers have several possible employment-related adjustments available which they can impose individually or in combination with others. The most prominent is that one or more jobs will be eliminated. It is not even necessary to lay off anyone to reduce employment levels; attrition will accomplish the task and virtually no one but the Bureau of Labor Statistics will notice. Machines become a more attractive alternative under a mandate. Think computers to replace graphic designers or voice answering machines to replace receptionists. Or, products and services produced outside the United States substituting for domestically-produced ones. Think overseas backroom telephone operations replacing domestic backroom telephone operations, or in the case of smaller businesses, think the purchase and importation of customized computer applications rather than applications locally produced. Or, services could be dropped. Older people remember filling station attendants and theatre ushers, occupations which generally no longer exist. Other services could be eliminated or consolidated. Think delivery of dry cleaning, building supplies or even pizza. Since compensation is a fixed cost not dependent on hours worked, another option, if necessary, is simply to increase the hours of those already working to fill any vacuum left by eliminated positions [4].

The elimination of jobs is not the only option available in response to compensation increases caused by mandated employee health benefits. Employers can change jobs. Reducing employee hours is possible. For example, reducing a $10 per hour sales clerk's hours from 40 to 37½ a week offsets some of the employer's increased compensation cost, but also reduces the employee's pre-tax wages by $25 a week or almost 10 percent, and cuts government tax revenues. A variant is to transform as many full-time jobs as possible into part-time jobs to escape the mandate. (Mandating health insurance for part-time employees creates a series of other problems as well. See, Efficient Policy below.) The hourly take-home of employees becomes relatively greater for part-time work than full-time work under the mandate and less costly for the employer, increasing the option's attractiveness for both. The incentive to hire illegal immigrants also rises. While responsible people do not advocate that course, it would be unrealistic to ignore it.

Another possible, if not likely, adjustment is freezing or capping compensation increases for the foreseeable future and, as applicable, cutting other benefits, such as paid vacations or employer contributions to 401(k)s. The ability to pursue this course of action is constrained by competition for employees and by the reservation wage.[3] But there is an off-setting effect because the new health insurance benefit will cause additional people to enter the labor force, thereby increasing the relative amount of labor. The increased supply of labor pushes down the level of compensation [9, 23], and since benefits by law must increase, wages must suffer. Erosion of real take-home pay is therefore inevitable both because employers must find offsets beyond the elimination of jobs for the increased costs in the benefits side of compensation, and because more people will be applying for fewer jobs. The exceptions are those at or near the minimum wage. Their wages cannot be lowered by law, but that only increases pressures to adopt other courses, such as the cut-back in hours.

The United States presumably wants to foster job creation and retention as a public policy priority. More attractive jobs are preferable to less attractive ones. But since the world is not Lake Woebegone where all jobs, like children, are above average, less attractive jobs are generally preferable to no jobs. Yet, mandated employer-provided health insurance is effectively a significant tax on employment, particularly lower paid employment, raising its cost and making

[3] The "reservation wage" is the compensation level at which people would rather remain idle than work.

its creation and retention less attractive for those who do it. Larry Summers, a former Secretary of the Treasury, Obama economic Advisor and a well-known economist in his own right, put it this way, "… a payroll tax on employers directed at financing health insurance benefits would have exactly the same employment displacement effects as a mandated health insurance program." [23, p. 181]

Uninsured employees will effectively pay the entire cost of mandatory premiums through job loss, shifts in the terms and conditions of employment, and lower take-home [15]. That will not occur overnight, but it will occur because compensation, regardless of its distribution between wages and benefits, is reasonably stable over time and increases in real terms only as productivity increases.[4] In the interim, the measures employers take will zig and zag to meet immediate personal obligations and competitive needs.

b. *Some Numbers*

Models of mandated employer-paid employee health insurance show job loss,[5] and the overwhelming proportion of those occur in the lowest income categories. CONSAD Research Corporation found in its modeling of the Health Income Security Act, the Clinton proposal with its employer mandate and subsidies, that 750,000 full-time jobs (and 100,000 part-time jobs) would be destroyed[6] and another 23 million people would be adversely affected by other job-related impacts [6]. Of the full-time jobs lost, 66 percent were jobs with their occupants earning less than $10,000 (remember, this is the early 1990s); 26 percent in jobs earning $10,000 - $19,999; 8 percent in jobs earning $20,000 - $29,999; and, 1 percent in jobs earning $30,000 - $39,999. A negligible number of those earning $40,000 or more lose theirs. O'Neill and O'Neill [21] who estimated a much larger job loss than CONSAD, and Klerman and Goldman [12] who estimated a smaller one, and CONSAD, agreed on two essential points: job losses would occur and impacts would be most severe on the low-income. More contemporary research shows a similar pattern with job cuts at the bottom [1] and program benefits at the top [2].

Remember, job loss is not the only job-related effect of mandated employer paid health insurance. CONSAD estimated that 23 million jobs would experience them [6]. Those job-related impacts were not as heavily skewed to the bottom of the income scale as job loss. Yet, lower-income people, not those at the bottom because they often lost their jobs, but near the bottom, remained the big losers. For example, only 3 percent of those impacted earned $10,000 or less, but 35 percent earned $10,000 - $19,999 and 25 percent $20,000 - $29,999.

Small Employer Options in the Short Term

Adjusting to mandated employer-paid health employee premiums is more difficult in the short term [19]. Unless jobs can be eliminated or other means found to escape the mandate, it is not always practical to make abrupt adjustments in business operations. This is particularly true when affected employees are near the legal minimum or, in more urban areas, the reservation wage.

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[4] The question is not whether employers shift, but whether they can fully shift and how long the shift takes. Opinion exists that some costs cannot be shifted due to certain institutional impediments [20, p. 4]. The small business impacts are a bit different due to the general absence of labor contracts and retiree health benefits, i.e., institutional impediments. The time required to shift all that will be shifted is an open question.

[5] A recent simulation of an employer mandate requiring a 50 percent employer premium contribution yielded a 1.6 million job loss, 55 percent of which came from those fewer than 100 people [3].

[6] The total expected job loss without the employer subsidies from the Clinton proposal was over 3 million, but only 19 million would be otherwise affected.

Unless the employer eliminates jobs to compensate for the added costs placed on him by the health insurance mandate, his alternatives are limited, highly undesirable, and potentially threatening to the survival of the business. The preferred route is to raise selling prices. Pursuing that course depends on competitors facing similar cost increases or not, and customers accepting higher prices for the firm's product/service or not. If one's primary competitors also face higher compensation costs (presumably due to the mandate), the employer has a greater opportunity to raise prices; if one's primary competitors do not face higher compensation, higher prices are virtually impossible. Considering almost three in four small businesses compete primarily against large organizations, most of which offer insurance, or a combination of large and small organizations [20], the number who can pursue the price-increases option is limited. Consumer resistance to price hikes generally increases as the economy slows, but even more for non-essential goods and services. Small firms compete in both types of markets, for essentials and non-essentials, meaning a substantial number will also be constrained by customer resistance.

A second short-term adjustment is to postpone or cancel business investment. The effect of postponed or delayed investment is to reduce productivity increases, which are the basis for generating new wealth. As a stop-gap, emergency measure to guarantee business survival or a sharp decline in income, deferral of investment is usually possible even as the business's competitive position deteriorates. But, it cannot continue or the business cannot survive. Moreover, failing to fix the roof or to purchase a more fuel-efficient machine may eventually make investments more costly and they cannot be postponed forever.

Another possible adjustment is to reduce business earnings or profits, or in the case of a small business owner, owner income. Assume for the moment a small employer chose the income reduction option and assume he also owned the six-employee firm with the $20,445 required health insurance premium in the example above. Cutting $20,445 from his income creates a big problem. Imagine cutting $20,445 from your pre-tax income! The median household income of a small employer is about $100,000, making the new pre-tax household income $79,555 [16].[7]

Unfortunately, there is a hitch here, too. Employers who earn relatively little from their businesses typically do not offer employee health insurance; in contrast, wealthier employers tend to offer employee health insurance (and pensions and higher wages) [7]. The median household income of small employers not offering employee health insurance is therefore likely to be lower than $100,000, much lower. And, what if you are one of the 14 percent of small employers whose household income is $50,000 or less? How does that work? And, how irksome if you are required to subsidize an employee whose household income is more than your own.

Going out of business is the last resort, but it is a viable option because small employers have relatively high levels of human capital, meaning they have employment options that most others do not. Over half of small employers have a college diploma, 20 percent of all small employers possessing either an advanced or a professional degree. More than half without an undergraduate degree have attended college and/or graduated from a vocational program. They

[7] The median income derived from a business, in contrast to a household with business income, is about $75,000. The mandated premiums in this case reduce income to $54,555.

are experienced people, have management know-how, and industry-specific skills. In other words, they are highly employable, even in a slow economy. Should mandated employee health benefits depress income below acceptable levels for any period, they have opportunities when others do not. And, they typically will not be forced to make their decision abruptly; they can weigh their options and when the opportunity is ripe, just leave for paid employment elsewhere. The overwhelming numbers of small firms that go out of business simply close; few leave debts, except to their savings accounts; even fewer file for bankruptcy.

A short social note should be incorporated at this point. Minority-owned small businesses are smaller than white-owned businesses and average lower payrolls per firm [26]. They also have a lower ratio of employing to non-employing firms than do white-owned enterprises. That means minority-owned businesses are less likely to currently provide employee health insurance and less able to absorb an increase in the fixed employment cost of graduating to an employing business. Hence, minorities are the most likely group of small business owners to be adversely affected by an employer mandate.

Inefficient Policy

Mandated employer-paid employee health insurance is at best a blunt policy instrument used to address the problem of a specific group, one that affects a multi-dimensional 15 percent of the population, all with their personal preferences, individual needs and aspirations. The result is an inefficient policy, a policy unable to match appropriate means and ends, to distinguish between those who need help and those who do not, and to minimize the inherent inequities in any redistribution scheme.

Employer mandates subsidize some who have no reason to be subsidized, from the public let alone an employer, and provide every uninsured employee the same employer-paid subsidy regardless of their financial condition. Over 30 percent of the subsidized have $50,000 or more of household income, approximately 2½ times the poverty rate; 16 percent have more than $75,000 or more, almost four times the poverty rate. Not only do these higher-income employees obtain a large, mandatory subsidy from their employers through a mandate, but they receive the same subsidy as employees earning $25,000 or less. And, they receive the subsidy, in part, from the 34 percent of small employers who themselves have a household income of $75,000 or less. An efficient social policy would provide greater subsidies to those at the bottom of the income distribution and none to those at the top. The employer mandate does not allow that to happen; it's all or nothing, every uninsured person, regardless of circumstance, gets the same employer subsidy. But, it is *not* likely every uninsured person will get the same government-provided subsidy to pay the employee's share of the premium – a notable double standard.

The inefficiency compounds because at any point in time half of the uninsured are not employed. And, then there are those who are temporarily uninsured. The number uninsured for any period in the year is double those without it for the year [3]. Many of those are COBRA eligible, but COBRA requires the employee to pay the entire premium which makes interim coverage thorny for low-income transitioners. The uninsured population is constantly changing, not an immobile target. If part of the solution is forcibly tying health insurance to the workplace, what is the policy for others? And, if there is a policy for others, why not have one rather than two? The blunt policy instrument of employer mandates cannot adequately substitute for the needed policy scalpel.

Health insurance is a lump-sum benefit; the covered employee obtains a fixed benefit regardless of hours worked. The lump-sum nature of health insurance leads to another efficiency problem with mandated employer-provided health insurance, part-time employees. If part-time employees are not covered by the mandate, a huge incentive arises for employers to hire part-timers because two part-timers will be $4,971 a year cheaper than one full-timer. Employees have similar incentives because insurance mandates do not raise (effectively, do not reduce) their take-home pay.

"The low insurance coverage among the poorest families stems partly from the fact that most uninsured work part-time and thus are not covered by most employer mandates" [14, p.15]. There is also evidence that excluding part-timers from mandates artificially increases the proportion of part-timers in the work force [22]. 'Then, cover part-timers!' is the response. Unfortunately, if the mandate covers part-timers, the employer's health insurance cost on an hourly basis doubles, raising the employer's share of a family plan for one job (filled by two part-time people) to almost $10,000 a year, $2,688 for an individual plan, effectively making this type of employment prohibitively expensive. Of the 32.5 million part-time jobs, 28 million are held by people who want part-time work, the most common reasons being that they are also in school or in training, and personal or family obligations [25]. So, instead of addressing the part-time problem head-on, the employer mandate ignores it or bludgeons it.

Finally, mandated employer-paid employee health insurance does nothing to address the numerous and thorny inefficiencies facing small employers in the current health insurance market. Small employers still must pay relatively higher premiums for relatively fewer benefits [11, 27]; they still can provide employees only a single health insurance policy option; they still watch premiums rise inexorably, annually surpassing wage and price growth, often by multiples. And, since they would be required to pick-up a minimum premium regardless of what they purchase for their employees, they have less incentive than ever to shop for health insurance that provides the most benefits for the fewest dollars. The health insurance mandate simply ignores those issues and, by doing so, exacerbates them.

Fairness

A disingenuous argument in support of an employer mandate is that employers who do not provide employee health insurance compete unfairly; they transfer their employees' health care costs to those offering insurance because uncompensated care raises costs to all who pay for health care, insured or not; therefore, those who provide health insurance to their employees subsidize irresponsible employers who do not. The argument obfuscates wages and compensation, and simply ignores the fact that all small employers compensate their employees for work performed. Some compensate their employees entirely in wages, other than compulsory taxes, and some compensate them in various combinations of wages and benefits. Those not compensated in part through the offer of health insurance can choose to use the wages portion of their compensation to purchase health insurance or not. Their choice depends on the relative value they place on health insurance, discounted by the tax subsidy provided. But since the money is theirs, the choice is theirs.

On the other hand, it is reasonable to inquire about the fundamental fairness of small employers' inability to benefit from ERISA, or something similar. And, it is reasonable to inquire about the fundamental fairness of governments' and other large groups' ability to squeeze providers, leaving insured small groups and individual payers to subsidize the negotiated rates of the economically powerful. And, it is reasonable to inquire about the fundamental

fairness of a system that allows some people to choose from several health care options while condemning others to access a single plan.

Providing all with health insurance is a social objective. Social objectives are traditionally financed through the ability to pay or when appropriate some type of user fee. The employer mandate is effectively a tax levied without regard to either of the two aforementioned principles, making it unfair by definition. And, that injustice exists whether you believe that the beneficiary ultimately pays this tax in lower compensation, including fewer employment opportunities, or small employers, many of whom are often little better off than those whom they are taxed to subsidize, pay it directly.

Conclusion

If mandated employee benefits are so counter-productive, why do policymakers even consider them? Roger Feldman offers three reasons [9]: the "popular fiction" still holds that employers pay for mandated employee health insurance premiums, even though that fiction fails to appreciate that the small business owners, compelled to initially finance a large share of the program, do not have the deep pockets they assume of all employers; businesses using comparatively expensive labor find it to their competitive advantage to force their competitors to assume costs they have incurred, another example of individual businesses using government regulation to help them achieve a competitive advantage; and, the costs of an employee mandate do not appear on a government budget, allowing politicians to control more resources without forcing them to also raise revenues to pay for their policy preferences. A fourth reason, which blends and expands on the previous three, is that an employer health insurance mandate is a simple, easy to explain, minimally intrusive way to demonstrate political concern and action on an intricate, complex and pressing problem. That the poor will eventually pay for the benefits they receive is a bit of trivia that the public, including the poor, do not really need to know or understand. That it is inefficient in targeting the problem is an irrelevant diversion. That its foundation is an historic irrationality is academic.

But whatever the reasons, including expediency, mandated employer provided health insurance is poor policy in any of its variations.

REFERENCES

[1] Baicker, K and Levy H (2007). Employer Health Insurance Mandates and the Risk of Unemployment, NBER Working Paper No. 13528, Cambridge, MA., October.

[2] Burkhauser, RV and Simon, KI (2007). Who Gets What from Employer Pay or Play Mandates, NBER Working Paper No. 13578, Cambridge, MA., November.

[3] Chow, MJ and Phillips, BD (2009). Small Business Effects of a National Employer Health care Mandate. NFIB Research Foundation, Washington.

[4] Cutler, DM and Madrain, BC (1998). Labor Market Responses to Rising Health Insurance Costs: Evidence on Hours Worked, *The Rand Journal of Economics*, Vol. 29, No. 3, pp. 509-530.

[5] Congressional Budget Office (2003). How Many People Lack Health Insurance and For How Long? A CBO Paper, Washington, May.

[6] CONSAD Research Corporation (1994). Employment and Related Economic Effects of Health Care Reform, Pittsburgh, PA, April.

[7] Dennis, WJ, Jr. (2000). Wages, Health Insurance and Pension Plans: The Relationship Between Employee Compensation and Small Business Owner Income, Small Business Economics, Vol. 15, No. 4, pp. 247-263, December.

[8] Employer Health Benefits, 2008 (2008). The Kaiser Family Foundation and Health Research & Educational Trust, Washington.

[9] Feldman, R (1993). Who Pays for Mandated Health Insurance Benefits? *Journal of Health Economics*, Vol. 11, pp. 341-348.

[10] Fronstin, P and Helman, R (2003). Findings From the 2002 Small Employer Health Benefits Survey, Employee Benefits Research Institute, Washington, January.

[11] Gabel, J, McDevitt, Gandolfo, L, et al. (2006). Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down. *Health Affairs*, 25, No. 3, pp. 832-843, May 1.

[12] Klerman, JA, and Goldman, DP (1994). Job Loss Due to Health Insurance Mandates, *JAMA*, Vol. 272 (17); pp. 552-556, August.

[13] Lee, DR, and Warren, RS, Jr. (1999). Mandated Health Insurance and the Low-Wage Labor Market, *Journal of Labor Research*, Vol. XX, No. 4; pp. 507-515.

[14] Meara, E, Rosenthal, MB, Sinaiko, AD, and Baicker, K (2007). State and Federal Approaches to Health Reform: What Works for the Working Poor? *Forum for Health Economics & Policy*, Vol. 10, Iss. 1, Article 5.

[15] Morrisey, MA (2005). Price Sensitivity in Health Care: Implications for Health Care Policy. NFIB Research Foundation, Washington, Chapter V.

[16] NFIB Research Foundation (2007). Finance Issues, *National Small Business Poll*, Vol. 7, Iss. 6, (ed.) WJ Dennis, Jr., Washington.

[17] _____ (2003). Health Insurance, *National Small Business Poll*, MA Morrisey, Vol. 3, Iss. 4, (ed.) WJ Dennis, Jr., Washington.

[18] _____ (2003). Competition, *National Small Business Poll*, Vol. 3, Iss. 8, (ed.) WJ Dennis, Jr., Washington.

[19] _____ (2001). Adjusting to Cost Increases, *National Small Business Poll*, Vol. 1, Iss. 4, (ed.) WJ Dennis, Jr., Washington.

[20] Nichols, LM, and Axeen, S (2008). Employer Health Costs in a Global Economy: *A Competitive Disadvantage for U.S. Firms.* New America Foundation, Washington, DC, May.

[21] O'Neill, JE and O'Neill, DM (1993). The Employment & Distributional Effects of Mandated Benefits, American Enterprise Institute, Washington.

[22] Sherstyuk, K, Wachsman, Y, and Russo, G (2007). Labor market effects of employer-provided health insurance, *Economic Inquiry*, Vol. 45, Iss. 3, pp. 538- 557.

[23] Summers, LH (1989). Some Simple Economics of Mandated Benefits, *The American Economic Review*, Vol. 79, Iss. 2; pp.177-183, May.

[24] U.S. Bureau of the Census (2008). Current Population Survey, 2008 Annual Social and Economic Supplements. Washington.

[25] U.S. Bureau of Labor Statistics (2008). Labor Force Statistics from the Current Population Survey, Full-Time and Part-Time Status, October 25, 2008, ftp://ftp.bls.gov/pub/special.requests/lf/aat20.txt

[26] U.S. Small Business Administration (2007). *Minorities in Business: A Demographic Review of Minority Business Ownership* (2007), prepared by Ying Lowery, Office of Advocacy, Washington, DC, April.

[27] _____ (2003). Study of the Administrative Costs and Actuarial Values of Small Health Plans, Actuarial Research Corporation. Office of Advocacy, contract no. SBAHQ-01-M-0811, Washington, January.