adequate gauge for impairment. Among patients whose sleep needs are satisfied with the use of the lower doses, unnecessary risk can be avoided, and as the labels point out, patients whose symptoms do not respond to the lower doses can be given the higher doses. The sex-specific labeling revisions reflect an evidence-based approach to risk management and dose individualization.

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The Unanticipated Consequences of Postponing the Employer Mandate

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The Obama administration's decision to postpone implementation of the employer mandate is the latest in a series of delays and alterations of the Affordable Care Act (ACA). But postponing the mandate — which requires larger employers to offer lower-income workers health insurance coverage similar to that available in the new insurance exchanges, on equal and affordable financial terms — may create large ripple effects. The good news is that as compared with instituting the mandate as planned, postponing it should barely increase the number of uninsured Americans after ACA implementation. But it affects other provisions, particularly the individual subsidies for purchasing insurance, and creates distorted incentives that may leave the government paying significantly more than planned.

More than 90% of Americans who obtain private health insurance today receive it through employers, but the centerpiece of the ACA's effort to make coverage more attractive to the uninsured focuses on insurance exchanges for individuals purchasing coverage directly. However, because both consumers and employers can in principle finance or obtain private health insurance in either setting, ACA provisions had to be compatible with both coverage channels. Moreover, the legislation created tax-financed subsidies for buying insurance only through the exchanges while relying largely on regulations and mandates to deal with employment-based coverage. Inevitably, this grafting of a new institutional and subsidy structure onto an already-complex system raises problems of potentially incompatible and inequitable incentives.

Fortunately, postponing the mandate will probably not vastly increase the number of people who remain uninsured, because most large employers already provide health benefits. Most would therefore face little burden in complying, even though the proximate cause of postponement is apparently the challenge of drafting reporting requirements. The 95% of firms that offer coverage, however, don't offer it to every worker at low explicit premiums, often excluding part-time, new, temporary, and low-wage workers. About 10% of uninsured Americans (5.5 million people) live in households with a worker affected by the large-employer mandate (see table). The $10 billion in revenues expected from the mandate's penalty (5 million uninsured workers × $2,000) is a small fraction of the eventual cost of the exchange subsidies. (The Congressional Budget Office estimates that in 2023, with full implementation, the annual subsidy cost will be $153 billion.[1]) So although the mandate would have reduced the coverage gap and raised some revenue, the effects of delaying it will be modest.

Meanwhile, the ACA's individual mandate remains in place. To the extent that this mandate causes people to seek or retain coverage, workers may still prefer their qualified coverage to be furnished through work rather than exchanges — especially if they are uninsured or incompletely insured but have income high enough that the tax exemption for employment-based coverage is worth more than their ex-

Estimated Numbers of Americans Younger Than 65 Years of Age, According to Insurance Status, Income, and Employer Size, 2011.*

Insurance Status	Income 138–400% of the Federal Poverty Level	Income 138–350% of the Federal Poverty Level
	no. in millions	
Any	100.4	86.3
Public insurance only	9.8	9.2
In firms with ≥50 employees	1.6	1.4
Private insurance only	68.4	56.7
Employer-sponsored insurance	62.3	51.4
In firms with ≥50 employees	49.1	40.1
Individual market	6.0	5.3
In firms with ≥50 employees	2.0	1.8
Private and public insurance	5.7	5.0
Employer-sponsored insurance	4.8	4.2
In firms with ≥50 employees	3.6	3.1
Individual market	0.9	0.8
In firms with ≥50 employees	0.3	0.2
Uninsured	16.5	15.3
In firms with ≥50 employees	5.5	5.1

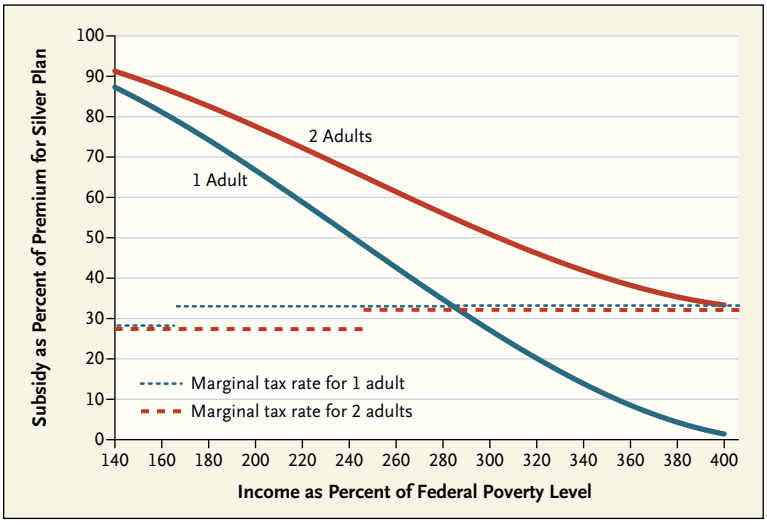
* Persons with incomes of 138 to 400% of the federal poverty level are eligible for subsidies to purchase insurance through the exchanges; for persons with incomes of 138 to 350% of the federal poverty level, the value of the exchange subsidy roughly equals the value of the tax exemption for employer-sponsored insurance. Data are from an analysis of the Current Population Survey, 2012 Annual Social and Economic Supplement.

change subsidy. The stimulus for this middle-class minority to obtain employer-sponsored insurance will be effective only if the individual mandate is aggressively enforced — and it's difficult to tax workers who owe little income tax and see coverage as unaffordable.

But the demise of the employer mandate has a potentially more important side effect: it removes incentives for employers to offer coverage to lower-income workers at low enough explicit premiums that they would choose job-based coverage over exchange coverage. The ACA sought high "target efficiency" — aiming subsidies only at lower-income uninsured people without a large-group insurance option and avoiding having subsidies claimed by people at the same income level who already have large-group insurance. This goal was buttressed politically by the view that employers should pay their "fair share" of the cost of coverage out of their profits (despite strong economic arguments that workers ultimately pay for mandated benefits through lower wages or job loss[2,3]). To restrain lower-income workers from swapping employer insurance for exchange insurance, the regulations required employers with at least 50 employees to offer coverage with low enough explicit premiums to keep the group alternative more attractive.

With that threat gone, it may make sense for employers and lower-wage workers to implicitly agree to a deal whereby such workers buy insurance through exchanges using government-financed subsidies and are "made whole" through higher wages. Higher-income workers could still choose group insurance, taking advantage of their larger tax break. The graph illustrates the value of the exchange subsidy relative to the tax exemption for employer-sponsored coverage according to income. Of course, separating employees in this way is complex, but many firms already provide different benefits to different classes of workers, who often have different wage levels; for example, some restaurants offer low-premium coverage to management and key workers but not to waitstaff. Paradoxically, the postponement does not reduce a "burden" on employers as much as it creates an opportunity for them to work with their employees to take maximum advantage of exchange subsidies.

Crowding out of fully paid private insurance by more generously subsidized coverage has previously been documented with Medicaid,[4] but the threat it poses to the government budget for financing the ACA is much more substantial. Under the old rules, enrollment among people with incomes below 400% of the federal poverty level (the cutoff for subsidies) was projected to total 19 million by 2016, with modest growth thereafter.[1] But, as the table shows, more than 100 million Americans live in households with a worker whose income falls between the Medicaid threshold and the exchange-subsidy cutoff. Thus, penalty-free crowd-out runs the risk of dramatically boosting federal outlays for subsidies. According to our analysis of the Current Population Survey, an estimated 53 million Americans who are either employed by firms with more than 50 employees or are such workers' dependents would be eli-



Size of Exchange Subsidies for Families with One Adult and Families with Two Adults, According to Income Level.

Both single adults and married adults filing taxes jointly have positive taxable income, in the 10% income tax bracket, at 138% of the federal poverty level when taking the standard deduction and exemptions. If they must pay full taxes for Social Security (12.4%) and Medicare (2.9%), their marginal tax rate is 25.3% until their income is high enough to put them into the next income tax bracket. In 2013, single adults reach the 15% marginal income tax bracket at $8,925 in taxable income, which corresponds to about 165% of the federal poverty level for total household income, and married adults filing jointly reach it at $17,850 in taxable income, or about 243% of the federal poverty level for total household income. A silver plan is an insurance policy that covers 70% of insurable spending, on average, for an average person buying private insurance. Data are from the Kaiser Family Foundation Subsidy Calculator.

gible for subsidized exchange coverage. If they moved to exchanges, the annual subsidy bill could nearly triple.

Of course, paying a much larger subsidy to lower-income households without employer-sponsored insurance than to those with it was always going to cause instability. For example, employers already threatened to cut low-wage workers' hours below the law's 30-hour-per-week cutoff to avoid paying for their insurance. But potential (and now legal) employer responses to those nonneutral payments will exacerbate the instability. Dropping the employer mandate may boost enrollment in the exchanges, leading to such high expenditures on subsidies that taxpayer and political support for the ACA is weakened. Even unions have now reversed their earlier support for the legislation by demanding that their members who are covered by multiemployer plans ("Taft-Hartley plans") receive exchange subsidies, too.

Such changes may have other implications. Current employer-paid coverage is most generous in terms of physician and hospital reimbursement. Considerable evidence suggests that plans must be frugal in their provider payments to qualify for many states' exchanges and to constitute economical options for consumers. Both lower reimbursement rates and stricter managed-care rules may limit treatment of patients who formerly had more permissive insurance.

Our large, employment-based insurance system has historically been propped up by tax subsidies that make it cheaper than directly purchasing individual insurance. For the lower-middle-income population, the ACA reverses this distortion, potentially shifting the inequity in the opposite direction. Group coverage has some merits: when managed by a well-run, attentive benefits department, it can be less administratively costly than individual insurance, better tailored to workers' needs, and less prone to adverse selection. Economically, it would be ideal to offer equal subsidies regardless of how a person obtains qualified coverage, creating efficient choices between individual and group coverage. Perhaps the current threat to the employer mandate and target efficiency will induce us to confront the full fiscal cost of fair subsidies. Making subsidies available on a uniform basis at each income level would ideally lead to better choices of insurance products, less heated political rhetoric, and an opportunity to focus on other pressing problems in our health care system.

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