

Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature

Timely Analysis of Immediate Health Policy Issues

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Summary

Since the enactment of the Patient Protection and Affordable Care Act (ACA) in March 2010, some have argued that health reform would erode employer-sponsored insurance (ESI) by providing incentives for employers to stop offering coverage. Others have claimed that most businesses would face increased costs as a result of reform, or even that the uncertainties surrounding the impact of health reform is hampering the economic recovery. This paper finds that the effects on employer coverage and employer health care spending would actually be small.

Using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM), we estimate how the Affordable Care Act would affect employer-sponsored insurance (ESI) and employer health care costs. To investigate the effects of health reform on ESI, we simulate the ACA as if fully implemented in 2010 and contrast the results with the pre-reform HIPSM baseline results for 2010. We also present HIPSM estimates on how ESI coverage would have changed over time without health reform, given changes in economic conditions and long-term health care cost growth. We divide employers into three groups: small firms with 100 or fewer workers, medium firms with 101 to 1,000 workers, and large firms with more than 1,000 workers.

We estimate that

- Overall ESI coverage under the ACA would not differ significantly from what coverage would be without reform. Small- and medium-firm ESI coverage would be almost unchanged, and large-firm ESI coverage would increase by just over 2 percentage points. Large-firm ESI policies cover more people than small- and medium-firm policies combined.
- Total employer spending on premium contributions, assessments, and vouchers would be 0.6 percent lower under ACA than without reform. Total spending by small firms would be 8.7 percent lower, mainly due to cost savings from the new ESI (SHOP) exchanges. The smallest firms would also be eligible for tax credits. Total spending by medium firms would increase by 11.8 percent, largely due to new assessments required of employers with workers independently buying subsidized insurance through the nongroup exchanges. Significant assessments could occur for firms not offering ESI and those who offer

a plan their low-income workers cannot afford. Spending by large firms would not change significantly.

- The average employer contribution per person covered by ESI would decrease by 7.9 percent for small firms, 1.1 percent for medium firms, and 3.1 percent for large firms. For small firms, the decline is due mainly to the introduction of more cost-effective coverage through SHOP exchanges. The much smaller declines for medium and large firms are due to improvements in the ESI risk pools. In particular, those currently not enrolled who would enroll due to the individual mandate have lower costs on average than current enrollees. Total ESI premiums and premium dollars paid by workers would both see similar decreases.
- In the absence of health reform, ESI coverage would fall by 2.6 percentage points in five years in our best-case scenario with 5 percent annual growth in private premiums. With 8 percent annual growth in premiums, the decline would be 7.6 percentage points in five years. Health costs have grown faster than inflation for many years, leading some employers, particularly small employers, to stop offering ESI to their workers. Our analysis suggests that trend would continue in the absence of health reform.

Some observers will likely conflate the trend of falling ESI coverage with the effects of specific provisions in the ACA. Analysts will need to account for how ESI coverage would have changed in the absence of reform when evaluating the future effects of the ACA. Ultimately, only effective cost control measures can address the current trend. Beyond cost control, the ACA can slow the current trend via subsidies to small employers, by cost savings generated by the exchanges (particularly administrative costs), through penalties on employers that do not offer coverage, and by increasing demand for ESI through the individual mandate.

Our findings of little overall effect of the ACA on ESI coverage are similar to the findings of the Congressional Budget Office (CBO) and run counter to some arguments predicting a major decline in ESI. We discuss those arguments and provide reasons why we believe claims that the ACA would cause major declines in ESI coverage are exaggerated.



Introduction

Since the enactment of the Patient Protection and Affordable Care Act in March 2010, many people, particularly in the business media and advocacy groups opposed to the ACA, have argued that health reform would erode employer-sponsored insurance by providing incentives for many employers to stop offering coverage. Using the Urban Institute's Health Insurance Policy Simulation Model, we estimate how the Affordable Care Act would affect employer-sponsored insurance and employer health care costs. We separate the effects on businesses of different sizes. Small businesses are defined here as those employing 100 or fewer workers. These employers would be eligible for new employer-sponsored insurance exchanges (or SHOP exchanges) under the ACA. Medium businesses are those employing 101 to 1,000 workers, and large businesses are those employing more than 1,000 workers.

To investigate the effects of health reform on ESI, we simulate the ACA as if it were fully implemented in 2010 and contrast the results with the prereform HIPSM baseline results for 2010. We also present HIPSM estimates on how ESI coverage would have changed over time without health reform, given changes in economic conditions and long-term health care cost growth.

Some have claimed that the ACA will greatly increase health care costs for employers and that many employers would drop ESI coverage as a result. Our results show the opposite—the ACA has little effect on overall ESI coverage and overall employer spending on health care would be slightly lower under the ACA. We discuss the arguments for why some employers might stop offering ESI after reform and provide reasons why we believe claims that ACA would cause major declines in ESI coverage are exaggerated.

Methods

To estimate the effects of health reform, we use the Urban Institute's Health

Insurance Policy Simulation Model.¹ HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms.²

Within the model, workers are assigned to representative firms. Firms' decisions whether to offer coverage depend on their workers' demand for ESI. All else equal, firms with a higher share of younger and healthier workers, workers with other offers of ESI in the family, and workers with lower incomes who face lower tax rates and are eligible for Medicaid or subsidized coverage in the exchanges are less likely to offer health insurance. Firms with a higher share of workers who place a high value on health benefits and have fewer opportunities for subsidized coverage or coverage through a spouse are more likely to offer health insurance coverage.

Health insurance benefits are considered part of a total compensation package employers offer to their workers. There is empirical evidence that in a competitive labor market, reductions in benefits, such as health insurance, are offset by increases in wages, and vice versa, at least over time. Firms are limited in their ability to adjust wages worker by worker based on who takes up offered coverage.³ This means that if an employer stops offering ESI, the savings to be passed back to workers are distributed among all workers, not just those who were enrolled in ESI.

Changes in worker demand for ESI resulting from policy changes or premium changes, and taking wage offsets into account, lead to changes in the probabilities that firms offer health insurance. The sensitivity of firms' responses is calibrated to hit target elasticities from the empirical economics literature and reflects the

finding that small firms are more elastic than large firms.

We model the main coverage provisions of the Affordable Care Act. We simulate the ACA as if fully implemented in 2010 and compare it with the HIPSM baseline results for prereform 2010. This approach differs from that of the CBO and the actuaries at the Centers for Medicare and Medicaid Services (CMS) who by necessity provide 10-year estimates. Our approach permits more direct comparisons of reform with the prereform baseline. An earlier policy brief summarized the most important coverage provisions of the ACA and how they were reflected in the modeling.⁴ The provisions directly affecting employers are as follows:

- New state-based health insurance exchanges (the exchanges) offer plans constructed to meet actuarial value standards of 60, 70, and 80 percent.⁵ Exchange plans are guaranteed issue, as are all plans in the small group and nongroup markets. Premiums may be rated by age and tobacco use, with age bands of up to 3:1 and tobacco use bands of up to 1.5:1.⁶ Exchange-based insurance coverage is available to individuals and families purchasing nongroup coverage independent of an employer and to employer groups with 100 or fewer employees.⁷ Undocumented immigrants are barred from the exchange.
- Employees of firms that offer coverage will be ineligible for subsidized coverage in the exchange unless the employee's share of the premium exceeds 9.5 percent of income or if the actuarial value of the employer plan is less than 60 percent.
- Employee choice vouchers are available to workers whose employers offer health insurance coverage through the workplace, whose incomes are below 400 percent of the federal poverty level (FPL), and whose share of the lowest offered employer-sponsored insurance (ESI) premium is between 8 and 9.8 percent of income. Qualified workers can receive a voucher for the amount that their

employer would have contributed to their insurance premium if they had enrolled in the employer's plan. They can then apply this voucher to help pay for insurance through an exchange.⁸

- A small-group tax credit is available to firms that offer health insurance, have 25 or fewer employees, and have workers with an average pay of less than \$50,000.
- New assessments may apply to employers with more than 50 employees. If such a firm does not offer coverage and has at least one full-time employee who receives a subsidy in the exchange, a fee of \$2,000 per full-time employee is assessed, excluding the first 30 employees. Employers that do offer coverage but have at least one full-time employee who receives a subsidy are assessed the lesser of \$3,000 for each employee getting subsidies or \$2,000 per full-time employee.
- There is risk adjustment in the small-group ESI and nongroup markets between plans both inside and outside the exchange.
- Most health insurance market reforms apply to all small-group (up to 100 workers) ESI policies issued inside

or outside the exchange, except for grandfathered plans.⁹

The methodology used for the estimates of ESI coverage over time without health reform is described in a prior report.¹⁰

Results

We present three types of results: changes in coverage and costs of employer-sponsored insurance, ESI offer rates for small firms, and ESI premium trends due to the ACA.

ESI Coverage and Costs

In Table 1, we summarize ESI coverage and employer costs under the ACA and without health reform. Without health reform, 151.6 million nonelderly people would have health insurance coverage through their employer; 30.5 million of these would be covered under plans issued by small employers (those with 100 or fewer employees), 30.1 million by medium employers (those with 101 to 1,000 employees), and 67.3 million by large employers (more than 1,000 employees). There are also 23.7 million people who report ESI coverage on the Current Population Survey for whom there is no policyholder in the household or who report being ESI policyholders while not being in

the workforce (these individuals are reported separately at the bottom of the table).

Under health reform, the number covered by ESI would decline very slightly to 151.2 million. Coverage under small-firm and medium-firm ESI policies would each change by less than 1 percent, while coverage under large-firm ESI policies would increase by 1.5 million or 2.2 percent. This increase is due primarily to increased participation (take-up) in employer-offered plans that will result from the individual requirement to obtain health insurance (i.e., the individual mandate). As the small scale of the changes in ESI enrollment suggests, overall employer offer rates are largely unchanged. Various provisions of the ACA will affect different firms differently. Some would drop ESI and others would start offering it; these would largely cancel out.

Without health reform, premium contributions are the only health care-related employer expenses simulated by HIPSM.¹¹ Total expenses would be \$114.6 billion for small employers, \$98.9 billion for medium employers, and \$228.0 billion for large ones (Table 2).¹² Under the ACA, premium contributions would be by

Table 1. Changes in Employer-Sponsored Insurance Coverage Due to the ACA

	Total			Small Firms (<100 Employees)			Medium Firms (100–1,000 Employees)			Large Firms (1,000+ Employees)		
	Without reform	ACA	% Diff	Without reform	ACA ¹	% Diff	Without reform	ACA	% Diff	Without reform	ACA	% Diff
Total ESI												
Persons covered	151.6	151.2	-0.3%									
ESI policyholders and coverage (in millions)												
Single policyholders	44.4	46.5	4.9%	11.8	12.1	2.8%	10.4	10.7	3.3%	22.2	23.7	6.8%
Family policyholders	27.5	27.5	-0.2%	6.2	6.1	-1.2%	6.5	6.5	0.1%	14.9	14.9	0.1%
Persons covered	127.9	129.5	1.2%	30.5	30.4	-0.4%	30.1	30.3	0.7%	67.3	68.8	2.2%
Coverage where no policyholder is identifiable² (in millions)												
Persons covered	23.7	21.7	-8.5%									

Source: Urban Institute analysis, HIPSM 2010.

¹ We simulate the provisions of the Affordable Care Act fully implemented in 2010.

² Persons in the CPS reporting ESI coverage when no policyholder is present in the household.

Table 2. Changes in Employer Spending Due to the ACA

	Total			Small Firms (<100 Employees)			Medium Firms (100–1,000 Employees)			Large Firms (1,000+ Employees)		
	Without reform	ACA	% Diff	Without reform	ACA ¹	% Diff	Without reform	ACA	% Diff	Without reform	ACA	% Diff
Total ESI												
Employer premium contributions	513.3	494.1	-3.7%									
Employer costs	513.3	510.2	-0.6%									
Employer costs (in billions \$)												
Premium contributions	441.6	429.4	-2.8%	114.6	105.3	-8.19%	98.9	98.5	-0.46%	228.0	225.6	-1.0%
Employer subsidies	0.0	-4.5		0.0	-4.5		0.0	0.0		0.0	0.0	
Assessments	0.0	17.6		0.0	2.0		0.0	11.8		0.0	3.8	
Vouchers	0.0	3.0		0.0	1.9		0.0	0.2		0.0	0.9	
Total contributions	441.6	445.7	0.9%	114.6	104.6	-8.72%	99.0	110.6	11.80%	228.0	230.3	1.0%
Premium contributions where no policyholder is identifiable² (in billions \$)												
Premium contributions	71.8	64.7	-9.8%									

Source: Urban Institute analysis, HIPS M 2010.

¹ We simulate the provisions of the Affordable Care Act fully implemented in 2010.

² Persons in the CPS reporting ESI coverage when no policyholder is present in the household.

far the largest component of employer expenses, but would no longer be the only one. Total premium contributions for small employers would be \$105.3 billion after reform, a decline of 8.2 percent. This decrease is largely due to the introduction of health insurance exchanges for employers (SHOP exchanges). These small employers would receive \$4.5 billion in employer subsidies while paying \$2 billion in assessments and \$1.9 billion in employee choice vouchers. The result would be a decline in total spending of 8.7 percent.

Medium employers would see a decrease of less than 1 percent in premium contributions. However, they would pay \$11.8 billion in assessments and \$0.2 billion in employee choice vouchers. Medium employers are hit much harder by the assessment formula than large employers because they employ more subsidy-eligible workers and have somewhat lower ESI offer rates. The result is an 11.8 percent increase in spending in aggregate. Firms that offer ESI coverage that their low-income workers prefer to the exchange would not see large assessments. Firms may be able to reduce their assessments by changing their

Table 3. Changes Due to ACA in Average Employer Contributions per Person Covered

	Without reform	ACA ¹	% Diff
Small firms (<100 employees)	\$3,755	\$3,460	-7.86%
Medium firms (100–1,000 employees)	\$3,290	\$3,252	-1.14%
Large firms (1,000+ employees)	\$3,386	\$3,280	-3.1%
Total	\$3,451	\$3,316	-3.9%

Source: Urban Institute analysis, HIPS M 2010.

¹ We simulate the provisions of the Affordable Care Act fully implemented in 2010.

contribution rate or the structure of the policies they offer; however, we do not simulate such behavior.

Large employers would save 1 percent in premium contributions, but would pay \$3.8 billion in assessments and \$0.9 billion in vouchers. The net result would be a 1 percent increase in spending over this group.

In Table 3, we examine how the average employer premium contribution per person covered by ESI would change under the ACA. Employer premium contributions vary, but the employer pays on average 80 percent of the total ESI premium. The average contribution per person declines under the ACA for

small firms by 7.9 percent, from \$3,755 to \$3,460. Thus, it is significantly less expensive for small firms to provide insurance under the ACA than without health reform. We discuss the reasons why below. The average premium contribution decreases for medium firms by 1.1 percent and for large firms by 3.1 percent. Thus, ESI premiums decline for all firm sizes, though the difference is much smaller for medium and large firms. Overall, the average premium contribution would decline by 3.9 percent.

Finally, the individuals and families in HIPS M are based on the Current Population Survey. Some respondents report having ESI coverage from

someone outside the CPS household, others report ESI with no potential policyholder in the household, and still others report being an ESI policyholder without being in the work force. There is no way to identify the employer characteristics of the policyholders of these plans. Rather than allocate these cases across employers, we tabulate their coverage and costs separately. Many of these are children, so their average premium contributions are somewhat lower than the averages above.

ESI Offer Rates for Small Firms

In Table 4, we present ESI offer rates for firms with fewer than 50 employees. The offer rate would increase 4.3 percentage points overall for small firms. The smallest firms would see the biggest increase; the offer rate for firms with fewer than 10 employees

would increase by 5 percentage points. This is in part due to the premium tax credit and in part to the larger savings to the smallest employers by offering ESI through the SHOP exchanges. Administrative premium loads for ESI outside these exchanges are on average much higher for firms with fewer than 25 employees than the expected load in the exchanges. For firms of 25 to 49 employees, it is generally higher—depending on factors such as industry—but the difference is smaller.

Besides administrative costs savings in the SHOP exchanges and the premium tax credits, there are other important factors specific to the ACA that are considered in our simulation of ESI offer decisions. The individual mandate increases demand for insurance coverage. However, those eligible for subsidies in the nongroup exchanges

may prefer to take that coverage instead, reducing the demand for ESI. Employees eligible for vouchers may want to be offered ESI in order to take the voucher. On the other hand, if too many employees prefer taking vouchers instead of enrolling in ESI, the employer may decide not to offer. Thus, even within a single firm, there would be factors affecting offer decisions in both directions.

ESI without Health Reform over Time

In an earlier report, we simulated how health insurance coverage and costs would change over time if no health reform were enacted.¹³ Figure 1 shows how the share of nonelderly persons with ESI coverage would change over time under three scenarios. These scenarios vary in assumptions about economic factors, such as employment and how health care costs and premiums would grow over time. The estimated declines in ESI coverage over time are significant even under the best case scenario. Average annual rates of premium growth were 5, 7, and 8 percent in the best, intermediate, and worst case scenarios, respectively. Trends in premiums for 2010 suggest growth rates even higher than in our worst case scenario.¹⁴

As long as underlying health costs grow faster than inflation, there will be pressure on some firms to stop offering ESI. This should not be confused with the specific provisions in the ACA and can ultimately be addressed only by effective cost control measures. Besides cost control, the ACA is expected to slow this downward trend in ESI offer to some extent via cost savings generated by the new health insurance exchanges and by increasing demand for ESI through the individual mandate.

Discussion: Why ESI Won't Die

Our findings contrast with the predictions of some who argue that the ACA will substantially disrupt or reduce employer-sponsored insurance. A common argument is that employers will drop coverage because the costs

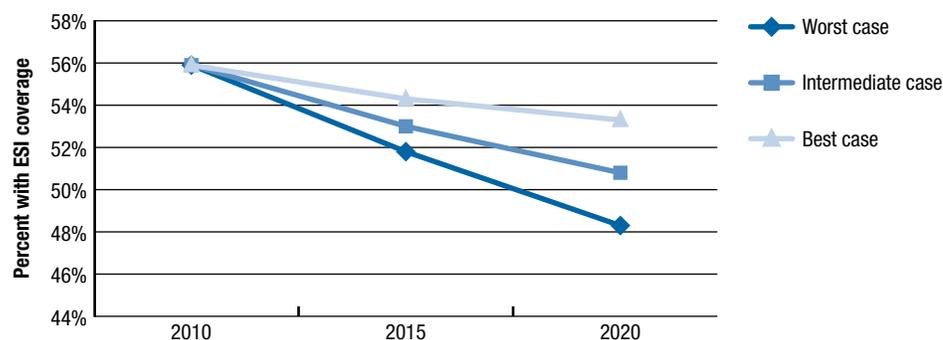
Table 4. Changes in ESI Offer Rates for Small Firms

	Without reform	ACA ¹	% Point difference	% Difference
< 10 Employees	35.3%	40.3%	5.0%	14.0%
10–24 Employees	64.3%	66.9%	2.6%	4.0%
25–49 Employees	77.5%	77.7%	0.2%	0.2%
Total	42.2%	46.5%	4.3%	10.2%

Source: Urban Institute analysis, HIPSIM 2010.

¹ We simulate the provisions of the Affordable Care Act fully implemented in 2010.

Figure 1. Projected Percent of the Nonelderly Covered by ESI without Health Reform



of providing coverage outweigh the penalties for not offering it.¹⁵ Such a limited comparison provides little if any guidance on whether a firm would face an incentive to drop coverage. There are no penalties for not offering ESI now. Why would an employer currently offering coverage stop offering it due to the imposition of such a penalty?

Firms offer ESI as a form of compensation because workers value health benefits, and by obtaining coverage through the employer, the firm contribution and often the worker contribution as well are excluded from income and payroll taxes. A fundamental result in labor and health economics, supported by empirical evidence, is that workers bear the full cost of health insurance coverage on average and over time. If a firm were to stop offering ESI, a competitive labor market would require firms to compensate the workers for the lost value by some other means, such as higher wages. The estimates presented here make this assumption and reflect a new long-run equilibrium.

Even under a short-term view that could generate savings to a firm, labor market competition prevents firms from simply dropping health insurance coverage without compensating workers by an amount sufficient to allow them to obtain similar coverage elsewhere—at least if they want to keep their current workforces. These considerations, which are broadly accepted by economists, are generally viewed with skepticism by those who operate businesses. This is likely because the mechanisms by which wages are adjusted are not apparent. They operate at a market level rather than a firm level and they operate over time rather than being the result of any conscious business decision.

In a report released May 2010, Douglas Holtz-Eakin and Cameron Smith emphasize that the decision to offer insurance coverage is not simply a comparison between the direct costs of offering coverage and the penalty for not doing so.¹⁶ They present calculations for hypothetical workers and ESI plans that show that firms could drop benefits

for workers with incomes under 300 percent FPL (who would qualify for Medicaid or more generous subsidies in the nongroup exchanges), provide increased wages that offset the workers' premium cost net of subsidy, and save money overall. Their computations are not inconsistent with the *individual* preferences simulated by HIPSM—workers who would receive large subsidies are indeed more likely to prefer the exchanges.

In sizing up the magnitude of the incentive for firms to drop ESI due to the ACA, Holtz-Eakin and Smith roughly estimate the number of working Americans with incomes under 250 percent of the FPL and state, “This suggests that there are about 43 million workers for whom it makes sense to drop insurance if the health plan costs the employer \$11,941.” In our view, this relatively incomplete analysis greatly overstates the magnitude of firm incentives to drop ESI after reform. Our reasons include the following:

- Nondiscrimination rules require that firms that offer health benefits offer them to all workers, and firms employ a mix of workers at different income levels. Firms would have an incentive to drop ESI only if the savings on low-income workers outweigh the costs of compensating all workers for the lost benefits.
- As shown in Table 5, the large majority (79 percent) of workers with their own ESI coverage have incomes above 250 percent of the FPL. The share is higher (81 percent) in large firms. Firms would not have an incentive to drop coverage for these workers and would need to compensate them with higher wages if they did.
- Only 35 percent of ESI policyholders with incomes under 250 percent of the FPL select family coverage according to our estimates (Table 5). In 2014, a single policy would cost the employer around \$5,100—far less than \$11,941. This greatly reduces the savings firms would obtain from dropping ESI.
- The tax advantage of ESI is unchanged under the ACA. Holtz-Eakin and

Smith only consider federal income taxes, but employer premium contributions are excluded from payroll taxes and state income taxes (if applicable) as well. Many workers' contributions to premiums are excluded from these taxes under Section 125 plans. When all relevant taxes are taken into account, firms that dropped ESI coverage would have to compensate the higher-income workers even more.

- Higher-income workers tend to be older than lower-income workers. In large firms, half of workers with incomes more than 250 percent of the FPL are between the ages of 45 and 64 (Table 5). In compensation for the loss of benefits to higher-income workers, an employer dropping coverage would need to raise wages enough to allow the worker to buy unsubsidized, age-rated coverage in the exchange. Equivalent age-rated coverage in the nongroup market would very likely be more expensive than average premium costs under ESI. Again, this implies a higher cost of compensating workers for lost ESI benefits.
- The individual mandate raises demand for all types of coverage, including ESI coverage. There will be new demand for ESI coverage among currently uninsured workers who already have offers and those who do not. This acts as a counter-incentive to firms dropping coverage.
- The empirical findings of Gruber and Lettau (2004) suggest that the preferences of high-wage workers in a firm carry more weight than the preferences of low-wage workers. If applicable, this would temper incentives for an employer to drop ESI.¹⁷
- It may not be sufficient for a firm to boost the wages of workers who lose ESI coverage. Pay equity considerations could require that all workers, even those who did not participate in the employer's plan, receive wage increases. This would add to the cost of dropping coverage.
- In Massachusetts, which passed a landmark set of reforms in 2006

similar to those in the ASA, the rate of employer-sponsored coverage increased about 3 percent from fall 2006 to fall 2009, a period covering both the implementation of the state reforms and a 4.5 percentage point rise in the state unemployment rate.¹⁸ The Massachusetts experience suggests that the combination of individual and employer mandates can increase ESI coverage, even when subsidized alternatives to ESI are introduced.

For each of these reasons, most of which HIPSM accounts for, we believe the risk of widespread dropping of employer-sponsored coverage due to the ACA is far lower than some have suggested, particularly among large firms. Any economic incentives to drop employer-sponsored health insurance due to the ACA would not even begin to take effect until sometime after 2014, when the exchanges are up, running, and perceived as a viable alternative to ESI.

The extent of dropping due to the ACA could be larger than we predict, however, if workers and firms were to re-sort or reorganize into ones employing mainly low-income workers and others employing mainly high-income workers substantially more than is the case today. Because firms already face such incentives and because a diverse mix of skills is needed for most enterprises, we think the scope for ACA-induced restructuring of firms is limited and dominated by the other considerations we have described. It

is, however, an additional source of uncertainty in our estimates.

If there is more dropping of ESI than our estimates suggest, more workers will obtain coverage through Medicaid and the nongroup exchanges, driving up government costs of the reforms and reducing employer costs. Any savings employers obtain in total compensation costs in the short run will be largely dissipated over time as labor markets re-equilibrate. Reductions in the price of labor induced by health insurance subsidies will increase firms' demand for labor and lead to firms bidding wages higher.

As we have noted, the tax advantage that employer-sponsored insurance enjoys under current law is unchanged under the ACA. It has been argued that the excise tax on high-cost premiums would nullify this advantage over time.¹⁹ The value of the tax advantage has been estimated to be around 40 percent of the premium. While this is the rate of the excise tax, the tax will apply only to the value in excess of a specified threshold, not to the total value of coverage. Thus, the two will not be offsetting.

Many have argued that health care costs under reform would be much higher than without reform, adding to the reasons employers may drop coverage after reform. Health care costs have been increasing for many years; the trend of employers dropping coverage due to increasing health care costs is not new. It was, in fact, an important

motive for health reform. Our estimates show that trend would have continued or even accelerated without the ACA, leading to noticeable losses in employer-sponsored coverage. It should not be confused with the potential effect of provisions of the ACA.

The employer dropping that has occurred over the past decade has been concentrated heavily among small employers, while offer rates among the largest employers have been almost unchanged. For example, according to estimates from the Medical Expenditure Panel Survey-Insurance Component (MEPS-IC), the offer rate for firms with fewer than 10 employees declined from 46.6 percent in 2000 to 43.7 percent in 2008, while the offer rate for firms with 1,000 or more employees changed slightly—from 99.4 percent in 2000 to 98.9 percent in 2008.²⁰ Ultimately, this trend of declining ESI offer can be addressed only by effective cost control measures. Beyond cost control, the ACA can slow this trend in declining ESI offer via subsidies to small employers, by cost savings generated by the exchanges, and by increasing the demand for ESI through the individual mandate.

Claims that the ACA will greatly increase health care costs for businesses often focus exclusively on provisions that would increase costs, such as the tax on insurers or noting that many more people would have insurance coverage, while ignoring cost-savings provisions. Increases in total societal health care costs, such as the costs of health insurance for those currently

Table 5: Workers in Offering Firms with Own ESI Coverage

Firm Size Group	Worker's Income	N	% within Firm Size Group	% with Single Policy	% age 45 – 54	% age 55 – 64
100 or fewer Employees	Under 250% FPL	4,918,974	26.98%	65.33%	20.39%	11.47%
	Over 250% FPL	13,312,462	73.02%	66.89%	28.37%	20.70%
101 - 1000 Employees	Under 250% FPL	3,368,409	19.59%	62.83%	20.76%	12.42%
	Over 250% FPL	13,829,047	80.41%	62.25%	29.52%	18.48%
Over 1000 Employees	Under 250% FPL	7,404,683	19.20%	65.99%	20.96%	10.88%
	Over 250% FPL	31,163,249	80.80%	60.36%	30.10%	20.22%
All Firm Sizes	Under 250% FPL	15,692,066	21.21%	65.10%	20.74%	11.40%
	Over 250% FPL	58,304,758	78.79%	62.30%	29.56%	19.92%

uninsured, will not necessarily raise the costs individual businesses face. Since the individual mandate will increase demand for coverage, some employers currently offering ESI will face higher take-up rates, increasing their costs due to higher enrollment. Take-up rates are already high; the average across all firm sizes is nearly 80 percent.²¹ The largest increases in health care costs due to health reform will typically involve employers that do not offer insurance coverage today; these employers will either choose to start offering insurance or face the possibility of a penalty should their workers obtain subsidies through the health insurance exchanges. Such increases would not result in a decline in ESI coverage.

Conclusion

Overall rates of ESI coverage would change little under the ACA.

Modeling the major coverage provisions of the ACA as if fully implemented in 2010, we estimate that the number of nonelderly adults covered by an employer-sponsored insurance plan would be very slightly lower under the ACA than without health reform (151.2 million v. 151.6 million). There would be a 2.2 percent increase in ESI enrollment through the plans of employers with more than 1,000 employees, while smaller employers would see little change in enrollment.

ESI premiums would fall noticeably for small firms and decline somewhat for others.

The average employer premium contribution per person covered by insurance sponsored by small firms would fall by 7.9 percent, a significant reduction in premiums. The average premium contribution would fall by 1.1 percent for medium firms and 3.1 percent for large firms. Overall, the average premium contribution would fall by 3.9 percent under the ACA.

Total spending by small firms would fall.

Health care spending by small firms (100 or fewer employees) would decline by 8.7 percent under the ACA. The change for small firms is due primarily to an 8.2 percent decline in spending on premium contributions. The average

employer premium contribution per person covered by ESI declines under the ACA for small firms by 7.9 percent. Thus, even after controlling for the decrease in enrollment, it is less expensive for small firms to provide insurance under the ACA than without health reform. This is due mainly to the introduction of ESI health insurance exchanges (SHOP exchanges) for small businesses. This is one of the most important provisions of the ACA for small businesses and has been strangely absent from most commentary on how health reform would affect employers. ESI exchanges would provide a new more cost-effective ESI option to small businesses.

Exchanges provide two main advantages. First, the administrative loads of ESI premiums vary greatly with firm size, and the smallest firms have the highest loads built into their premiums. Loads for the smallest firms are little different from typical administrative loads for nongroup insurance, and both are significantly higher than that likely to prevail in the new exchanges as a consequence of the ACA's market reforms (e.g., prohibition against medical underwriting, minimum loss ratios, more centralized marketing) and increased competition among plans.

The second advantage of these plans and the market reforms implemented with them is that there would be far more sharing of risk within the small-group and nongroup insurance markets. Under the ACA, purchasers in these markets could no longer be charged higher premiums as a consequence of the health status or claims experience of their enrollees, a practice common across the country today. Thus, increased sharing of risk would make the availability of affordable ESI coverage far more dependable for small firms with higher-than-average-cost workers. Today, high health costs incurred by a few enrollees can make coverage for an entire small firm unaffordable simply because there are not enough workers over which to spread these excess costs.

Total spending for medium-sized firms would increase. In contrast with the results for small firms, total premium contributions for medium

firms (101 to 1,000 employees) would be almost unchanged. However, these firms would pay \$11.8 billion in employer assessments. The smallest firms, those with fewer than 50 workers, are exempt from all employer assessments, so the average effect on employers of 100 or fewer is smaller than the effect on the medium-sized firm group. Also, the assessment formula for nonoffering employers disregards the first 30 workers obtaining subsidies in the exchanges, which would constitute an assessment discount of a third or more for employers of 50 to 100 workers. Premium assessments are higher for medium firms than for large firms because they have a higher proportion of low-income workers and lower ESI offer rates. Some employers may be able to reduce their assessments by reducing the workers' premium contribution rate, particularly for lower-wage workers, or by changing the structure of the plans they offer. For example, an employer could raise its premium contribution rate so that fewer low-income workers offered ESI could qualify for exchange subsidies, thus reducing its assessment. Any such optimization of contribution rates and benefit package structure would be highly specific to a given business and its workers. Thus, we do not simulate such behavior.

Total spending for large firms

would not change. Large firms would see a modest increase in ESI enrollment, but their total health care spending, including premium contributions, assessments, and vouchers, would increase by only 1 percent. This is important because large-firm ESI policies cover more people than small- and medium-firm ESI policies combined.

Total spending by employers of all sizes would decrease slightly.

When we take into account the ESI premium contributions for persons in our underlying survey data for whom employer characteristics of the policyholder cannot be identified, total health care spending by employers would be \$513.3 billion under the ACA

and \$510.2 billion without reform, a decrease of 0.6 percent.

Our estimates contrast with various claims of adverse effects of health reform on businesses for reasons we discuss. In particular, small businesses

will clearly benefit, enjoying lower overall costs and lower premiums. Some medium-sized businesses would see significant increases in spending due to assessments if they do not offer coverage or offer coverage that their low-income workers cannot afford.

These increases could mean lower wages for workers in those firms. Large firms would see little change. Thus, claims that the uncertainties surrounding the impact of health reform on businesses would hamper the economic recovery are not justified.

Notes

- 1 For more about HIPSM and a list of recent research using the model, see “The Urban Institute’s Health Microsimulation Capabilities,” <http://www.urban.org/url.cfm?ID=412154>. A more technical description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas, “The Coverage and Cost Impacts of Expanding Medicaid” (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), <http://www.urban.org/url.cfm?ID=411905>.
- 2 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.
- 3 See, for example, Jonathan Gruber, “Health Insurance and the Labor Market,” in *Handbook of Health Economics*, vol. 1, edited by A. J. Culyer and J. P. Newhouse (645–706)(2000).
- 4 Matthew Buettgens, Bowen Garrett, and John Holahan, “America under the Affordable Care Act,” (Washington, DC: The Urban Institute, 2010). <http://www.urban.org/url.cfm?ID=412267>.
- 5 Actuarial value reflects the share of average covered benefits paid by the insurer, where the remaining amount is the responsibility of the enrollee. The ACA allows exchange plans to offer a 90 percent actuarial value plan as well. We do not model this in the exchange. Such a package would be significantly more comprehensive than a typical ESI plan now; even the 80 percent plan would be more comprehensive than many current ESI plans. We do not model the catastrophic-only plan available to some young adults and to those exempt from the individual mandate. We also do not model the option for a state basic health plan. A forthcoming policy brief will focus on this option.
- 6 This means, for example, that the premium charged to the oldest policyholders may be at most three times the premium charged to the youngest policyholders, and tobacco users can be charged 1.5 times as much as nonusers. Note that we do not model wellness provisions in the group market, which would allow additional premium variation on top of age and tobacco use.
- 7 We model a merged exchange providing coverage to both individual and small group purchasers. States can choose to have separate exchanges for these two markets. We have simulated the latter option and the results do not differ substantially from those presented here.
- 8 For more about vouchers, see Matthew Buettgens and Linda Blumberg, “Making Health Reform More Affordable for Working Families: The Effect of Employee Choice Vouchers” (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=412025>.
- 9 Certain market reforms do apply to large employers and grandfathered plans, for example, the prohibition against rescissions, and lifetime and annual benefit limits. For more detail, see Linda J. Blumberg, “How Will the Patient Protection and Affordable Care Act Affect Small, Medium, and Large Businesses?” (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=412180>. We do not simulate grandfathered plans. These will largely disappear over time, and our intent is to simulate the ACA in a steady state marketplace.
- 10 Bowen Garrett, Matthew Buettgens, Lan Doan, Irene Headen, and John Holahan, “The Cost of Failure to Enact Health Reform: 2010–2020” (Washington, DC: The Urban Institute, 2010).
- 11 In Table 1, we report only employer premium contributions and the costs or savings of specific provisions introduced under the ACA: employer subsidies, assessments, and vouchers. We do not report changes in wages or taxes.
- 12 Premium contributions where no policyholder is available are not included in this section of Table 2, since the appropriate firm sizes are unknown. They are included in the overall total.
- 13 Garrett et al., “The Cost of Failure,” 2010.
- 14 Matthew Buettgens, Bowen Garrett, and John Holahan, “The Effects of Large Premium Increases on Individuals, Families, and Small Businesses” (Washington, DC: The Urban Institute, 2010), <http://www.urban.org/url.cfm?ID=412079>.
- 15 See, for example, Shawn Tully, “Documents Reveal AT&T, Verizon, Others, Thought about Dropping Employer-Sponsored Benefits,” *Fortune*, May 6, 2010.
- 16 Douglas Holtz-Eakin and Cameron Smith, “Labor Markets and Health Care Reform: New Results” (Washington, DC: American Action Forum, 2010), <http://www.americanactionforum.org/>.
- 17 Jonathan Gruber and Michael Lettau, “How Elastic Is the Firm’s Demand for Health Insurance?” *Journal of Public Economics* 88 (2004): 1273–93.
- 18 Sharon K. Long and Karen Stockley, “Sustaining Health Reform in a Recession: An Update on Massachusetts as of Fall 2009,” *Health Affairs* 29, no. 6 (2010): 1234–41.
- 19 See, for example, Austin Frankt, “The Decline of Employer-Sponsored Coverage under Health Reform: Good, Bad, or Ugly?” *Kaiser Health News*, May 27, 2010.
- 20 Jessica Vistnes, Alice Zawacki, Kosali Simon, and Amy Taylor, “Declines in Employer Sponsored Insurance Coverage between 2000 and 2008: Offers, Take-Up, Premium Contributions, and Dependent Options,” Center for Economic Studies Discussion Paper 10-23 (Washington, DC: U.S. Census Bureau, 2010), <http://ideas.repec.org/p/cen/wpaper/10-23.html>.
- 21 Vistnes et al., “Declines in Employer Sponsored Insurance,” 2010.

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