

# What Would Health Care Reform Mean for Small Employers and Their Workers?

Timely Analysis of Immediate Health Policy Issues

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## Summary

Small employers face a unique set of challenges in providing insurance to their employees. High administrative costs and the limited ability to spread risk result in substantially higher premiums for the same benefits when compared to those available to their larger counterparts. These problems are further exacerbated by the fact that small firm employees typically earn lower wages than those in larger firms. These challenges result in offer rates for the smallest firms that are less than half the rates of large employers and lead to high rates of uninsurance among small firm workers.

Both the House of Representatives bill, the Affordable Health Care for America Act, and the Senate leadership bill, the Patient Protection and Affordable Care Act, contain a number of provisions that would have significant implications for small employers and their employees in their efforts to obtain affordable health insurance coverage. Each bill provides for the establishment of an organized health insurance marketplace, or exchange, in conjunction with a set of insurance market reforms. Subsidies for low-income individuals to purchase coverage in the exchange are included in both bills, as are tax credits providing temporary assistance to small employers offering coverage. New requirements on employers to contribute to the cost of coverage for their employees are proposed as well.

In this paper, we review the barriers to purchasing health insurance coverage for small employers and their workers and examine the implications of the proposed reforms. We highlight the differences between the House and Senate approaches, and discuss their potential for improving access and affordability for small employers. The health insurance exchanges, along with the associated insurance market reforms, can be expected to produce substantial improvements in the ability of small employers to obtain affordable coverage. Additional financial assistance in the form of subsidies to low-income individuals will further enhance affordability for small firm workers. Tax credits for employers purchasing coverage are temporary and thus likely to have modest effects.

Both bills would impose assessments on employers that do not contribute to employee coverage, but the two proposals differ in structure. To a significant extent, however, small employers are exempt from the requirements in both bills. The Senate bill explicitly exempts employers with fewer than 50 workers from a \$750 per full-time worker charge on firms not offering coverage. The House bill includes an 8 percent payroll assessment on firms not offering coverage to their workers, but no assessment would apply to firms with annual payrolls up to \$500,000, an exemption that would apply to most firms in the country. Reduced assessment rates would apply to firms with \$500,000 to \$750,000 in payroll, further protecting small employers. In addition, we highlight estimates from The Urban Institute-Brookings Institution Tax Policy Center showing that, at implementation, the House bill's income surtax would affect fewer than 1 percent of tax units with business income and that the Senate bill's hospital insurance tax increase would affect less than 4 percent of tax units with business income. As a result, neither bill imposes substantial new financial burdens on small businesses.

## Introduction

Small employers are at a significant disadvantage as purchasers of health insurance relative to large employers. The consequences are clear and

consistent over time: small employers are much less likely to offer health insurance coverage to their workers, and workers in small firms are more likely to be

uninsured. The barriers that small employers face in insurance purchasing come on multiple fronts and, as premiums continue to grow faster than wages, the declines in

small employer-based coverage outpace the declines among larger employers. Without significant reforms to how small group health insurance markets function and to health insurance options that are available to those without employer offers of coverage, there should be no expectation that these negative trends will be reversed.

Both the Affordable Health Care for America Act (H.R. 3962, which passed the House on November 7, 2009, hereinafter referred to as the “House bill”) and the current Senate Leadership bill, the Patient Protection and Affordable Care Act (H.R. 3590, hereinafter referred to as the “Senate bill”) would enact reforms that would change the health care options and affordability of coverage available to small employers and their workers. The most important of these are the development of health insurance exchanges combined with significant

reforms to insurance market regulations and subsidies to make insurance coverage affordable for the modest income population.

## Current Insurance Status and Barriers to Coverage

**Rate of Employer Offers of Coverage.** As table 1 shows, the share of employers offering health insurance varies considerably by employer size. In 2008 (the most recent data available from the Medical Expenditure Panel Survey – Insurance Component, MEPS-IC), only 35.6 percent of employers with fewer than 10 workers offered insurance to their workers, compared with 98.9 percent of employers with 1,000 or more workers. In addition, declines in employer offers over time have been greatest among the small employers. Between 2000 and 2008, the share of employers with 100 or more workers offering coverage to their workers has remained

essentially steady, whereas the share of employers with fewer than 100 workers offering coverage has fallen, with the smallest employers experiencing the largest relative declines. Employers with fewer than 10 workers were 10.1 percent less likely to offer coverage in 2008 compared to 2000, and those with 10 to 99 workers were roughly 4 percent less likely to offer coverage in 2008 than they were in 2000. In contrast, employers with 100-999 workers were as likely to offer coverage in 2008 as they were in 2000.

The employer size differences in the likelihood of offering coverage are even more dramatic when examining employers with a low-wage workforce separately from those with a higher-wage workforce. Among employers for which at least half of their workers were low wage,<sup>1</sup> only 18.4 percent of the smallest

**Table 1. Percent of Private-Sector Establishments that Offer Health Insurance by Firm Size and Wage: 2000-2008**

	Total	Fewer than 10	10-24 Employees	25-99 Employees	100-999 Employees	1000+ Employees
<b>All Firms</b>						
2000	59.3%	39.6%	69.3%	84.5%	95.0%	99.2%
2008	56.4%	35.6%	66.1%	81.3%	95.4%	98.9%
Percentage Change:	-4.9%	-10.1%	-4.6%	-3.8%	0.4%	-0.3%
<b>Firms in Which 50% or More of Employees Are Low Wage</b>						
2000	42.5%	25.4%	46.3%	73.5%	94.2%	96.4%
2008	41.8%	18.4%	36.6%	60.1%	91.4%	98.0%
Percentage Change:	-1.6%	-27.6%	-21.0%	-18.2%	-3.0%	1.7%
<b>Firms in Which Fewer than 50% of Employees Are Low Wage</b>						
2000	64.7%	50.2%	83.4%	92.4%	96.9%	99.4%
2008	63.8%	44.0%	79.3%	91.8%	97.6%	99.4%
Percentage Change:	-1.4%	-12.4%	-4.9%	-0.6%	0.7%	0.0%
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2000 and 2008 Medical Expenditure Panel Survey-Insurance Component.						

employers offered health insurance coverage in 2008, compared with 98.0 percent of the largest low-wage employers according to the MEPS-IC. Between 2000 and 2008, the share of low-wage employers offering coverage to their workers fell almost 28 percent for employers with fewer than 10 workers, and 21 percent for employers with 10 to 24 workers, but held steady for the largest employers. Those small employers for whom a majority of workers were not low wage experienced significant declines over this time as well, but the declines were not as large as for low-wage employers (12.4 percent for the employers of fewer than 10 workers, 5 percent for those with 10 to 24 workers). So the differential in offer rates between small and large employers is large and growing even larger, and the situation for low-wage firms and their workers is particularly severe.

**Rate of Take-Up of Employer Coverage, Given an Offer.** Workers in the smallest firms are also less likely than their large-firm counterparts to take up employer offers when they have one, although some of these workers receive coverage through a spouse employed by a larger firm (data not shown).<sup>2</sup>

**Rate of Uninsurance.** These differences in employer offer rates and take-up translate directly into differences in insurance coverage rates for workers employed by small versus large firms. According to the Census Bureau’s March Supplement to the Current Population Survey (the Annual Social and Economic Supplement)<sup>3</sup> fully one-third of workers employed in firms of fewer than 25 workers were uninsured in 2008, compared with 13.5 percent of those employed by firms of 1,000 or more workers (see table 2).

**Barriers to Small-Group Coverage.** The lower insurance offer rates among small employers are due, at least in part, to the fact that small employers must pay significantly more for the same health benefits than large employers. Smaller firms face much larger administrative costs per unit of benefit.<sup>4</sup> Administrative economies of scale occur because the costs of enrollment and other activities by plans and providers are largely fixed costs.<sup>5</sup> Insurers simply have fewer workers over which to spread these fixed costs in small firms. In addition, insurers charge higher premiums to small employers, because small employers experience greater year-to-year variability in medical expenses than do large firms<sup>6</sup> simply because there are fewer workers over which to spread risk.

**Table 2. Health Insurance Coverage of Workers by Firm Size: 2008**

	Self-Employed	<25 Employees	25-99 Employees	100-499 Employees	500-999 Employees	1000+ Employees
<b>Employer Sponsored</b>	46.6%	50.9%	68.4%	75.2%	77.8%	77.2%
<b>Individually Purchased</b>	18.8%	7.7%	4.5%	3.1%	3.5%	3.5%
<b>Medicaid</b>	4.3%	6.8%	5.5%	5.1%	4.5%	4.8%
<b>Other</b>	2.3%	1.5%	1.1%	1.0%	0.8%	1.0%
<b>Uninsured</b>	27.9%	33.2%	20.4%	15.5%	13.3%	13.5%
	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: Kaiser Family Foundation. 2009. The Uninsured: A Primer. Supplemental Data Tables, available at: <http://www.kff.org/uninsured/7451.cfm>.

Small group health insurance regulations vary significantly across states. All but 9 states allow commercial insurers to adjust small employer premiums based on the health status of the workers in the group and the group's claims experience.<sup>7</sup> One high-cost enrollee in a small group can have a significant impact on the average expected health spending in a small group, whereas a large group can average their high-cost cases over many people. Almost all states allow significant variations in premium rates as a function of the age of the workers, and many also allow adjustments based on the industry of the employer. These rating practices create additional difficulties for many small employers to obtain affordable coverage for their workers.

Another barrier to small employers providing health insurance is that the typical worker in a small firm is paid significantly less than workers in large firms, as shown in table 3. The median wage for workers in firms with fewer than 10 workers is about \$10,000 less than in firms of 1,000 or

more workers. Empirical economic research has provided strong evidence that there is an implicit tradeoff between cash wages and health insurance benefits.<sup>8</sup> In other words, workers actually pay for the cost of their employers' contributions to their health insurance by receiving wages below what they would have received had no employer health insurance been offered. The lower wages of small-firm workers imply that they are far less able to pay for health insurance through wage reductions; consequently, their employers are less likely to offer them such benefits.

Small employers are also disadvantaged by being financially unable to devote significant resources to shopping for health insurance coverage for their workers. Doing so carefully can be an extremely time-consuming process. Small business owners do not usually have a benefits manager to take on this task and so are often left to do so themselves. Often this means relying upon an insurance broker to make choices on their behalf. Reports of "churning," or annual turnover of

health insurance policies by small groups, are very high.<sup>9</sup>

Workers in small firms that do not offer health insurance are often left with few options for health insurance coverage, and 70 percent of all uninsured workers have no access to an employer-based insurance plan (either their own or through a family member).<sup>10</sup> Those that do not have a spouse with an employer offer and who are not eligible for public insurance programs have the option of pursuing coverage in the private, individual insurance market. However, in the vast majority of states, there is no guarantee that an individual can purchase health insurance in this market at any price, premiums and benefits when offered may vary with the health status of the individual applicant, cost-sharing requirements are generally quite high, and administrative costs are highest in this market. As a consequence, affordable policies in this market may still pose significant medical service access limitations for modest-income workers.

**Table 3. Annualized Median Wage by Firm Size, 2008**

Firm Size	Median Wage
All Firm Sizes	\$33,000
Under 10	\$27,733
10-24	\$28,000
25-99	\$31,000
100-999	\$35,000
1000+	\$37,333

Source: Urban Institute tabulations of the 2009 Annual Social and Economic Supplement to the CPS.

The challenges to small employers in providing health insurance to their workers may introduce economic inefficiencies into labor markets. First, individuals may not be choosing the job options best suited to their skills and productivity as a consequence of their preferences for health insurance coverage. For example, a worker that prefers a job in a small firm compared to one in a large firm may not take the small firm job if they or their family members have a strong preference for health insurance coverage and do not have other sources (public or private) for obtaining coverage outside of the chosen workplace. Second, individuals wishing to start their own businesses may be hampered from doing so because of the difficulty and costs associated with obtaining insurance coverage as a small business owner. These circumstances are often referred to as “job lock.” Health insurance has been shown in the empirical economics literature to have significant impacts on job choice and job mobility.<sup>11</sup> The magnitude of the efficiency implications of job lock is less clear at this time, however.

### Implications of the House and Senate Bills for Small Firms and their Workers

A number of provisions in the House and Senate bills would make significant improvements in the ability of many small employers and their workers to purchase insurance coverage at affordable prices. The most important of these are the establishment of health insurance exchanges, reforms to insurance market rating rules, and the provision of subsidies to assist the low-income population purchase health insurance coverage through the exchange. In addition, both bills would place some

new requirements on employers to contribute to the cost of coverage for their workers and both would provide tax credits to assist certain small employers in the purchase of coverage. The financing provisions in each bill could also have some tax implications for small employers.

***The Health Insurance Exchanges and Insurance Market Rating Reforms.*** Under the House bill, a national health insurance exchange would be established, whereas under the Senate bill states would generally establish their own exchanges.<sup>12</sup> Each exchange, whether state or nationally based, would provide an organized marketplace for individuals and some employer groups, usually small employers, to purchase health insurance.<sup>13</sup> Under the House bill, the national exchange would include both individuals and employer groups; under the Senate bill, states could decide whether to keep the small employer groups in separate exchanges. Under the proposals, the exchange would contract with private health insurers and offer a public health insurance option to small employers and those purchasing coverage on their own.

In the first year, firms with 25 or fewer workers would be eligible to buy coverage in the House bill exchange; this would expand to firms with up to 50 workers in the second year and to at least 100 workers in year three, but could be expanded further in later years at the discretion of the Health Choices Commissioner. Under the Senate bill firms with up to 100 employees could purchase coverage through the exchanges. Beginning in year 4, states could allow larger businesses to purchase through the exchanges as well.

New insurance market regulations would prohibit preexisting condition exclusion periods, would limit age rating to a ratio of 2 to 1 (i.e., the oldest adult could not be charged more than twice the premium of the youngest adult for identical coverage) under the House proposal and 3 to 1 under the Senate proposal. Health status rating, gender rating, and rating based upon industry of employment would be prohibited.<sup>14</sup> In this way, the health care risks of workers in small firms would be spread more broadly than they are today in the vast majority of states, shared across all those enrolled in coverage through the insurance exchange in which it participated. Not only would workers in small firms have a choice of insurance plans—a situation extremely unusual for small groups today—but those that have been priced out of the market due to health issues or an older workforce in the past may have affordable access to coverage for the first time. In addition, all small groups purchasing coverage would see a significant decrease in the year-to-year variability in premiums with this broader-based sharing of health care risk.<sup>15</sup>

Small employers can also be expected to reap administrative savings from purchasing coverage through the health insurance exchange. Administrative costs are a significant component of group insurance premiums, with the Congressional Budget Office estimating that they range from 7 percent of premiums for the largest groups up to 30 percent of premiums for the smallest groups and individuals.<sup>16</sup> A significant component of administrative costs is attributable to marketing expenses. For example, insurers typically pay agent commissions of 10 percent of

the first year's premium in the small-group market; first year commissions are even higher in the nongroup market.<sup>17</sup> A more organized marketplace run through the exchange, which provides greater consumer protections and improved information, could reduce marketing costs significantly. For example, the Massachusetts Connector, the exchange developed under that state's health care reform initiative, currently pays agent commissions that range from 1.3 to 3.3 percent of premiums, significantly lower than prior to reform.<sup>18</sup>

In addition, all those enrolling in insurance coverage through the proposed national or state health insurance exchange would have the option of remaining in the exchange, even if they change employers or leave the workforce.<sup>19</sup> As a result of that consistent eligibility and the broad-based risk-pooling in the exchange, annual churning across insurance policies should be significantly reduced, which should also lead to administrative savings<sup>20</sup> as well as significantly reduced job-lock. The presence of the public plan option under both bills could also be expected to provide small employers and their workers with an especially low administrative-cost insurance option relative to what they have today.<sup>21</sup>

Under both the House and Senate bills, employers of any size currently offering insurance coverage to their workers are "grandfathered".<sup>22</sup> In other words, those providing insurance coverage to their workers prior to reform would be able to continue providing that same coverage to their workers after reform if they desired to do so.

***Subsidies for the Purchase of Insurance Coverage.*** Employers' decisions as to whether or not to offer health insurance coverage will affect how their workers fare under reform. The small-employer workforce tends to be significantly lower wage than that of larger employers. Thus, even in the presence of a national or state health insurance exchange and the insurance market reforms that would be implemented in conjunction with it, small employers can still be expected to be less likely to offer health insurance coverage to their workers than larger employers, and small-firm workers less likely to enroll. As a consequence, the financial assistance in purchasing exchange-based insurance coverage and the expansion of eligibility for the Medicaid program that both the House and Senate bills would provide are critical elements to expanding insurance coverage for these low-wage workers and their families. Fully 60 percent of all uninsured workers have family incomes below 200 percent of the federal poverty level,<sup>23</sup> the income group for which financial assistance provided through the bills is most generous. Almost 95 percent of all uninsured workers have family incomes below 400 percent of the federal poverty level, and all of these workers would be eligible for some financial help in purchasing coverage through the exchanges.

Under the House bill, eligibility for the Medicaid program would be expanded to all individuals with family income up to 150 percent of the federal poverty level. The Senate bill would expand Medicaid eligibility for all those up to 133 percent of the poverty level. Subsidies for the purchase of exchange based coverage would be

available under both proposals for those up to 400 percent of the poverty level. Subsidies in the bills are structured to limit the premium contributions of individual/family purchasers to a specified percentage of income, with the percentage of income cap increasing as income increases.<sup>24</sup> The percentage of income caps range from 1.5 percent to 12 percent under the House bill and from 2 percent to 9.8 percent under the Senate bill.

Both bills would also provide some financial assistance to the low-income to cover some of the cost-sharing associated with health insurance. Cost sharing subsidies would be available to those up to 350 percent of the poverty level under the House bill and for those up to 200 percent of the poverty level under the Senate bill.

No subsidies (other than Medicaid) would be available to those purchasing coverage outside of the health insurance exchanges under either bill, and the vast majority of subsidies would accrue to those purchasing insurance through the exchanges without contributions from employers. Those workers whose employers contribute to the cost of their coverage would only be eligible for premium and cost-sharing subsidies if the workers' portion of the premium exceeds 12 percent of income under the House bill or 9.8 percent of income under the Senate bill.

***Small Employer Tax Credits.*** Both bills would provide tax credits to assist small, low to average wage employers contributing to health insurance coverage for their employees. Both bills would restrict eligibility for subsidies to employers of 25 workers or less, with average

wages of less than \$40,000. The maximum credit under each bill would be 50 percent of the benchmark premium. The House bill limits tax credit availability to two years while the Senate bill provides for a reduced credit for the three years prior to the establishment of the exchange (2011-2013) and a two year limit for purchasing exchange-based coverage. Because these tax credits are temporary they are likely to have only modest effects.

**Financing Mechanisms.** Both bills also include a variety of financing mechanisms to pay for the reforms. These include savings from Medicare and Medicaid as well as some new taxes and fees. The House bill includes a new 5.4% surcharge on families with incomes over \$1,000,000 and individuals with incomes over \$500,000. Documentation provided by the office of Speaker Nancy Pelosi claims that this additional tax will only impact 1.2 percent of small business owners.<sup>25</sup> In the Senate bill, a 0.5 percent increase in the Medicare payroll tax is included on

earnings over \$200,000 for individuals and \$250,000 for married couples filing jointly.

According to analyses by the Urban Institute – Brookings Institution Tax Policy Center (TPC), just 0.2 percent of all tax units and 0.9 percent of tax units with business income would potentially be affected by the House proposed income surtax when implemented in 2011.<sup>26</sup> The TPC estimates that those figures would increase to 0.5 percent of all tax units and 1.6 percent of tax units with business income in 2019. Under the Senate proposal to increase the hospital insurance tax, the TPC estimates that 1.5 percent of all tax units and 3.4 percent of tax units with business income would be affected in 2013, the first year of implementation.<sup>27</sup> In 2019, 2.4 percent of all tax units and 5.1 percent of tax units with business income would be affected.

**Employer Responsibility.** Current law does not require employers to offer or contribute to the cost of insurance coverage for their workers.

Both the House and Senate bills would create some new requirements for employers to participate in health insurance coverage for their workers or pay an assessment. To a significant degree, however, small employers are exempt from these requirements. Under the Senate bill only employers of 50 or more workers would be required to pay a fee if one or more of their full time employees obtained a subsidy through a health insurance exchange.<sup>28</sup>

Under the House bill, the basic requirement is for employers to contribute at least 72.5 percent of premium for single coverage and 65 percent of premium for family coverage or pay 8 percent of payroll into the Health Insurance Exchange Trust Fund. Coverage would have to satisfy the minimum requirements for the essential benefits package provided in the bill. However, the assessment is reduced or eliminated for employers with annual payroll below \$750,000 as shown in table 4.

**Table 4. House Bill Assessments on Non-Offering Employers, by Annual Payroll**

Annual Payroll Amount	Assessment
Less than \$500,000	None
\$500,000 – \$584,999	2% of Payroll
\$585,000 – \$669,999	4% of Payroll
\$670,000 – 749,999	6% of Payroll

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Data from the Census Bureau's Survey of US Businesses indicate that 87 percent of the over 6 million firms in the US in 2006 fell below the \$500,000 annual payroll threshold.<sup>29</sup> An even larger share of firms would fall below that threshold in 2013 when the assessment would be implemented. These firms would face no assessment under the House bill as outlined above. An additional 4 percent of US businesses had annual payrolls in 2006 between \$500,000 and \$750,000; if the assessment had been in place that year those businesses would have been subject to reduced assessments. Only 9 percent of all firms would have been subject to the full assessment in 2006 – fewer would be in 2013. While we do not specifically know the size distribution of these firms, the 9 percent of firms with payrolls exceeding \$750,000 accounted for 77

percent of total employment in 2006 and thus were quite large. Because large employers are very likely to offer health insurance coverage even in the absence of a penalty, as a practical matter, the assessment would affect very few employers.

## Summary

Small employers and their workers face a broad assortment of barriers to obtaining health insurance coverage today. These include high administrative costs, limited ability to spread health care risk, and a low-wage workforce. These issues have led to low rates of employer-coverage offers by small employers and high rates of uninsurance among their workers. Left to purchase coverage as individuals, the workers in small firms have few if any options for obtaining adequate, affordable insurance for themselves and their family members today. A

new health insurance exchange, such as those proposed in the House and Senate bills, along with insurance market reforms would spread health care risk and reduce administrative costs. The financial assistance provided under the bill to the low-income population for the purchase of exchange-based coverage and the expansion of the Medicaid program would benefit many small-firm workers. Small employer tax credits for low wage firms would provide some additional short-term assistance to some employers. While the bills include some employer contribution requirements, they exempt all small firms of fewer than 50 workers under the Senate bill and will likely exempt most small firms under the House bill as well. In these ways, the legislation would make adequate and affordable coverage available to many more workers of small employers than is the case today.

## Notes

- <sup>1</sup> Here low wage means at or below the 25th percentile for all hourly wages.
- <sup>2</sup> L. Clemans-Cope and B. Garrett. 2006. "Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001 to 2005," report to the Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/uninsured/upload/7599.pdf>
- <sup>3</sup> The Henry J. Kaiser Family Foundation. 2009. "The Uninsured: A Primer," Supplemental Data Tables, available at <http://www.kff.org/uninsured/7451.cfm>.
- <sup>4</sup> Congressional Research Service. 1988. *Costs and Effects of Extending Health Insurance Coverage*. Washington, DC: U.S. Government Printing Office.
- <sup>5</sup> L. J. Blumberg and L. M. Nichols. 2004. "Why Are So Many Americans Uninsured?" *Health Policy and the Uninsured*, Catherine G. McLaughlin, ed. Washington, DC: Urban Institute Press.
- <sup>6</sup> D. Cutler. 1994. "Market Failure in Small Group Health Insurance." Working Paper No. 4879. Cambridge, MA: National Bureau of Economic Research, Inc.
- <sup>7</sup> Mila Kofman and Karen Pollitz. 2006. "Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change." Briefing Paper prepared for the Alliance for Health Reform. Available at: <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>
- <sup>8</sup> L. J. Blumberg. 1999. "Who Pays for Employer Sponsored Health Insurance? Evidence and Policy Implications," *Health Affairs*, November/December, vol. 18, no. 6, pp. 58-61.
- <sup>9</sup> Rick Curtis, Stephanie Lewis, Kevin Haugh, and Rafe Forland. 1999. "Health Insurance Reform in the Small Group Market," *Health Affairs*, May/June, vol. 18, no. 3, pp. 151-160.
- <sup>10</sup> Clemans and Garrett. 2006. op cit.
- <sup>11</sup> See Jonathan Gruber and Brigitte Madrian. 2004. "Health Insurance, Labor Supply and Job Mobility: A Critical Review of the Literature." In *Health Policy and the Uninsured*, Catherine McLaughlin, ed., Urban Institute Press, Washington, DC.
- <sup>12</sup> Under the House bill, states could opt to develop their own exchanges, and under the Senate bill, states not prepared to establish their own exchange would rely on a federal fallback option. Both bills would allow more than one state to join together for purposes of establishing an exchange.
- <sup>13</sup> Linda J. Blumberg and Karen Pollitz. 2009. "Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals." Urban Institute Policy Brief Series, Timely Analysis of Immediate Health Policy Issues. Available at [http://www.urban.org/UploadedPDF/411875\\_health\\_insurance\\_marketplaces.pdf](http://www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf)
- <sup>14</sup> An additional rating factor under the Senate bill would allow smokers to be charged premiums up to 50 percent higher than that for non-smokers of the same age. In addition, the Senate proposal allows employers to vary insurance premiums by up to 30 percent for employee participation in various "wellness" programs.
- <sup>15</sup> While the sharing of risk would undoubtedly be broader under the reforms for small employers than is the case today, small firm workers obtaining coverage through a House health insurance exchange would face age rated premiums. Currently it is prohibited in all but the smallest firms (fewer than 10 workers) for employers to charge older workers higher premium contributions than younger workers. However, workers obtaining coverage with an employer contribution in an exchange would be purchasing an individual age-rated policy. As a consequence, if an employer makes equal contributions to insurance for all workers, older workers would be required to pay a larger share of their insurance coverage than would a younger worker. The Senate bill provisions are less clear as to whether small employer coverage through an exchange would be sold as individual or group contracts.
- <sup>16</sup> Congressional Budget Office. 2007. "CBO's Health Insurance Simulation Model: A Technical Description." Washington, DC: Congressional Budget Office.
- <sup>17</sup> Linda Blumberg and Karen Pollitz. 2009. op. cit.
- <sup>18</sup> "Broker Commission Schedule," presentation to Commonwealth Connector Board Meeting, March 8, 2007.
- <sup>19</sup> However, those with access to an employer-sponsored insurance offer are unlikely to be eligible for income related subsidies for the purchase of exchange coverage.
- <sup>20</sup> Blumberg and Pollitz. 2009. op. cit.
- <sup>21</sup> John Holahan and Linda J. Blumberg. 2009. "Is the Public Plan Option a Necessary Part of Health Reform?" Urban Institute Policy Brief Series, Timely Analysis of Immediate Health Policy Issues. Available at [http://www.urban.org/uploadedpdf/411915\\_public\\_plan\\_option.pdf](http://www.urban.org/uploadedpdf/411915_public_plan_option.pdf).
- <sup>22</sup> The same is true for those purchasing non-group insurance prior to reform.
- <sup>23</sup> The Henry J. Kaiser Family Foundation. 2009. op. cit.
- <sup>24</sup> See a full analysis of the subsidies provided through the non-group exchanges under the bills in Bowen Garrett, Lisa Clemans-Cope, and Matthew Buettgens. 2009. "Premium and Cost Sharing Subsidies Under Health Reform: Implications for Coverage, Costs, and Affordability." Urban Institute Policy Brief Series, Timely Analysis of Immediate Health Policy Issues. Available at: [http://www.urban.org/UploadedPDF/411992\\_health\\_reform.pdf](http://www.urban.org/UploadedPDF/411992_health_reform.pdf)
- <sup>25</sup> See House of Representatives Small Business Guide to Health Care Reform, available at: [http://waysandmeans.house.gov/media/pdf/111/hcare/SMBUSINESS\\_GUIDE.pdf](http://waysandmeans.house.gov/media/pdf/111/hcare/SMBUSINESS_GUIDE.pdf).
- <sup>26</sup> TPC tables containing estimates of the House provisions are available at: <http://www.taxpolicycenter.org/numbers/displayatab.cfm?DocID=2501> and <http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2500&DocTypeID=7>
- <sup>27</sup> TPC tables containing estimates of the Senate provisions are available at: <http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2526&DocTypeID=7> and <http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2527&DocTypeID=7>
- <sup>28</sup> The fee for employers not offering health insurance coverage would be equal to \$750 times the number of full time employees. In cases of employers that do offer coverage but have at least one employee that obtains subsidized coverage through an exchange, the employer would be required to pay the lesser of \$3000 per full time employee receiving a subsidy or \$750 per full-time employee.
- <sup>29</sup> U.S. Small Business Administration, Office of Advocacy. 2006. "Statistics of U.S. Businesses."

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*The views expressed are those of the authors and should not be attributed to any campaign or to the Robert Wood Johnson Foundation, or the Urban Institute, its trustees, or its funders.*

## **About the Authors and Acknowledgements**

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