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Implications of the Affordable Care Act for American Business

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Executive Summary

Critics frequently characterize the Affordable Care Act (ACA) as a threat to American business and to the survival of employer-based health insurance. The law's new requirements, they argue, create business uncertainty, delay economic recovery, and will cost jobs. But objective analysis of the ACA's impact on coverage and costs demonstrates the opposite. In fact, the ACA's requirements have a negligible impact on total employer-sponsored coverage and its costs. The law leaves large businesses' costs per person insured largely untouched and reduces them for small businesses. Only among mid-size businesses (with 101-1000 employees) would costs per person be noticeably higher, largely attributable to those employers not offering coverage today.

This policy brief, drawing on several previous Urban Institute analyses,[1] describes what the ACA actually requires or offers businesses of different sizes and uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to update estimates of the law's effects on employer-sponsored health insurance coverage and costs. Our analysis focuses particularly on the impact of the law's penalties on mid-size and large employers not offering coverage or offering unaffordable or inadequate coverage.

Taking into account the ACA's effect on coverage, premiums and, if applicable, penalties or tax credits, we find that, had the law been in effect in 2012,

- Employer-sponsored coverage would have increased by 2.7 percent (from 151.5 to 155.6 million people) and employer spending by 2.2 percent (from $553.4 to $565.8 billion). The largest relative coverage increase (6.3 percent) would have occurred among workers in small firms, with 100 or fewer employees.
- For small businesses with fewer than 50 workers, which are exempt from penalties and may be eligible for premium tax credits, along with other employers with 100 or fewer workers, the law reduces the costs of coverage in aggregate. Our analysis shows that, on average, these employers, if they choose to offer coverage, would find average costs per person insured reduced by 7.3 percent and spending for the group as a whole reduced by 1.4 percent. The reductions reflect efficiencies in the insurance market and tax credits that offset premium costs for the smallest employers with low wage workers.
- The law leaves the cost per person insured virtually unchanged for large businesses (with more than 1000 employees). Our analysis shows these employers already cover the vast majority of their employees, will continue to do so, and will retain the flexibility to define their own benefits. Coverage increases (largely due to somewhat higher employee enrollment rates) would increase total spending by large businesses by 4.3 percent.
- Only mid-size businesses (with 101 to 1,000 employees), as a group, experience an increase in costs per person insured, reflecting penalties on as many as 5 percent of these employers who are not currently providing coverage. Expanded enrollment, however, is the primary factor contributing to an increase in overall spending of 9.5 percent for this group of employers.

These estimates do not take into account the ACA's cost containment provisions—focused on reducing overpayments and delivery innovations in Medicare—that may help slow growth in private as well as public health care costs. Private purchasers will benefit from Medicare cost containment if they similarly press insurers and providers for efficiency. Together, public and private cost containment may actually slow the decline of employer-sponsored health insurance occurring since 2000. Regardless, the ACA's reforms of the nongroup insurance market and establishment of health insurance exchanges create a workable and subsidized market outside the workplace, thereby extending and stabilizing health insurance coverage, particularly for modest income working Americans.

Provisions of the ACA Affecting Employers

Although some ACA provisions apply to all employers, others treat businesses quite differently based on their size. The following lays out these important distinctions.

ACA Provisions Affecting All Employers, Regardless Of Size[2]

ACA provisions prohibiting or constraining current limits on health insurance coverage that expose consumers to unexpected financial risk apply to all health plans (in the nongroup as well as the group market), regardless of the group or employer size. Already implemented without incident are prohibitions of dollar caps on lifetime benefits and unreasonable dollar caps on annual benefits, rescissions of coverage, and waiting periods (or delays in the start of coverage) of more than 90 days. Additional provisions across all plans have also been implemented to expand access to group as well as nongroup coverage—specifically by extending dependent coverage to adult children up to age 26 (already producing an increase in coverage[3]), eliminating pre-existing condition exclusions for children and requiring coverage of a specified set of preventive services without cost sharing.[4] According to federal estimates, confirmed by private actuaries, these provisions were expected to increase insurance premiums by less than 5 percent.[5] The fact that both the number and the share of people covered by employer-sponsored insurance remained statistically identical between 2010 and 2011[6] suggests that implementation of these reforms had little impact on costs.

In 2014, the ACA will fully eliminate dollar caps on annual benefits and will eliminate pre-existing condition exclusions for adults as well. These reforms are likely to have the greatest impact on newly purchased small-group plans.[7]

ACA Provisions Affecting Larger Employers

The ACA does not require any employers to provide their workers coverage, and, for employers with more than 100 employees, the law establishes no requirements beyond those delineated above on the benefits that employers must provide if they choose to offer coverage. But beginning in 2014, employers with 50 or more employees will face penalties, whether or not they offer coverage, if at least one of their full-time employees receives a subsidy for the purchase of nongroup coverage in a health insurance exchange.

In general, individuals are eligible for subsidies that lower the cost of purchasing nongroup coverage if their incomes fall between 138 percent and 400 percent of the federal poverty level.[8] But employees of firms that offer coverage are only eligible for subsidized coverage in the exchange if the employee's share of the lowest cost premium for individual coverage exceeds 9.5 percent of income or if, on average, the plan reimburses less than 60 percent of covered expenses—conditions designed to protect most employers offering coverage from facing any penalties.

If a full-time employee in a business that does not offer coverage receives a subsidy in the exchange, the business is subject to a fine of $2,000 per full-time worker (minus the first 30 workers). If a full-time employee in a business that does offer coverage receives subsidized coverage, the employer is subject to a fine equivalent to the lesser of $3,000 for each full-time subsidized employee or $2,000 per full-time worker (minus the first 30 workers).

ACA Provisions Affecting Small Employers

The ACA exempts employers with fewer than 50 workers from any penalties associated with offering insurance coverage. On the contrary, as of 2014, small employers with 25 or fewer employees and average pay of $50,000 or less are eligible, for a period of 2 years, for tax credits toward premiums for coverage if they choose to provide it.[9] Eligibility for the full credit is limited to firms with 10 or fewer employees and an average wage of $25,000 or less. Critics have argued that many small employers may not benefit from the credit. But the credit is targeted to those employers who have been least likely to offer coverage and whose coverage offerings have declined the most in recent years.[10] According to the IRS, the ACA offers 4 million businesses the opportunity to receive a substantial tax reduction.[11]

Alongside the tax credits, beginning in 2014, the ACA will establish benefit requirements for newly issued health insurance plans offered to nongroup purchasers and by small employers (defined as having 100 or fewer workers, although states may choose to keep the definition as low as 50 prior to 2016), new rules regarding how plans' premiums can vary across employers, and new markets (or exchanges) through which small employers may choose to purchase insurance.[12]

Benefit Requirements. Small employers who choose to offer coverage will be required to offer plans with the essential health benefits package the ACA requires the Department of Health and Human Services to establish. Final regulations regarding these benefits are still forthcoming, but guidance issued by DHHS leaves it to states to select a benchmark plan from currently operating plans and to use its benefits as the standard for all plans offered to small groups and individuals.[13] The guidance allows

states to choose as the benchmark one of the dominant plans in the state's small group market; one of the dominant plans serving state or federal employees; or the state's largest non-Medicaid HMO. Whichever plan the state selects, the benchmark will reflect benefits currently offered by small as well as large businesses, since benefits differ by firm-size largely in cost-sharing and benefit limits, rather than in services covered. As a result, benefit requirements under the ACA are unlikely to impose new costs on small businesses.

The ACA specifications for allowable cost-sharing similarly limit any likely impact on costs for small employers now offering any coverage. Small employers satisfy cost-sharing requirements by offering plans in any of four actuarial value tiers covering 60 percent, 70 percent, 80 percent, and 90 percent of benefit costs, respectively. These actuarial value tiers vary by the amount of the average cost-sharing responsibilities imposed by the plans. Bronze plans that set deductibles and out-of-pocket limits as high as the law allows could still find it necessary to charge co-insurance in excess of 50 percent. Thus, small employers will still be able purchase a plan that is essentially catastrophic coverage.[14]

Rating Requirements. The ACA's rating requirements, however, will make a difference to small business costs. Although previous federal law prohibited insurers from denying coverage to small businesses based on pre-existing conditions of their employees, in most insurance markets, small group premiums vary significantly by health status and claims experience of individuals in the group, by gender composition, by age composition, and by industry. The variations permitted within each of these factors today may have no limit or some limit, depending upon state law. Small-group markets in almost all states also allow pre-existing condition exclusion periods.

Under the ACA, rating variations in small groups and for nongroup purchasers will be limited to geographic area, age and tobacco use. States will define geographic areas, subject to review by the secretary of HHS. Rates for the oldest adults (64 years of age) cannot exceed rates for the youngest adults by more than a factor of three; tobacco users can be charged no more than 1.5 times the premium for a non-user of the same age for identical coverage. In addition, small businesses will be able to offer their employees discounts as high as 30 percent for participating in wellness activities and satisfying particular health benchmarks.

The impact of these requirements on rates will vary across states, based on each state's current rules and levels of insurance coverage. New inclusion of higher-need groups in the market will tend to place upward pressure on average premiums, but this upward pressure will be offset at least in part by increased enrollment of healthy groups. At the same time, significant premium savings will result for small groups in industries perceived to be higher risk and for those whose employees have health problems, are predominantly female, or are predominantly in older age groups.

New Markets through Exchanges. Alongside ACA rating rules that require greater sharing of risk across small groups is the creation of new marketplaces or exchanges that are expected to reduce administrative costs for the smallest groups and will promote transparency and competition in the small group (and nongroup) market. Centralizing marketing functions is expected to reduce the costs of selling insurance to the smallest employers. These administrative costs are currently significantly larger, relative to premiums, for small than for large employers. Further, the improved ability to evaluate and compare alternative plans will enhance small employers' ability to get value for their dollar and will enhance their employees' ability to choose a plan appropriate to their needs.

Enhanced capacity for comparative shopping may also significantly enhance competition, lowering premiums, or slowing premium growth, in the small group market. In particular, in areas with no dominant hospital systems and no dominant insurer, exchanges will offer both insurers and providers an opportunity to build their customer base by limiting service costs. Insurers able to build a network of providers willing to take lower than typical payment rates in order to expand their patient base will be able to offer small businesses lower premiums. If they are successful, other insurers—and providers—will behave similarly, creating pressure throughout the marketplace to hold premiums in check.[15]

Premium monitoring (rate review) at the state and federal levels and medical loss ratios—new requirements on small group coverage established by the law—will reinforce these market effects and help constrain premiums in markets less amenable to competition.[16]

Impact of ACA Requirements on Employer Health Insurance Costs and Coverage

The Urban Institute's Health Insurance Policy Simulation Model (HIPSM) allows us to simulate the impact of these ACA provisions on business costs and employer-sponsored coverage. HIPSM simulates

the decisions of individuals and businesses in response to policy changes and produces estimates of changes in coverage and spending by employers, individuals, and the government resulting from specific reforms. The results presented here reflect a simulation that modeled the main coverage provisions of the ACA as if they had been fully implemented in 2012. The results are compared with the HIPSM's 2012 pre-reform baseline results on employer costs and coverage. The results of our simulation are shown in tables 1-3 for small (100 employees or fewer), mid-size (101-1,000 employees) and large (more than 1,000 employees) firms.

Table 1. Changes in ESI Coverage Due to the ACA, Simulated as if the ACA is Fully Implemented in 2012

Persons covered by:	Without Reform (in millions)	ACA (in millions)	% Difference
All Employers	151.5	155.6	2.7%
Small Firms (100 or Fewer Employees)	28.2	30.0	6.3%
Mid-size Firms (101 - 1,000 Employees)	24.1	25.2	4.6%
Large Firms (More than 1,000 Employees)	75.6	78.6	3.9%

Note: Persons reporting ESI coverage in households where no policyholder is identified are included in the totals but not in the firm size groups.

As shown in table 1, the ACA slightly increases the total number of people covered by employer-sponsored insurance, from 151.5 to 155.6 million or 2.7 percent. The increase results largely from higher participation rates as employees seek coverage in response to the introduction of tax penalties for remaining uninsured. Increases in coverage occur across businesses of all sizes, with the largest relative increase (6.3 percent) occurring in small businesses.

At the same time, however, employer spending per person insured (shown in table 2) actually declines by 7.3 percent for small employers and remains virtually unchanged for large employers (and for businesses as a whole). Per capita spending for small employers declines because efficiencies in the new exchanges reduce average premiums, and because tax credits for the smallest, lowest wage firms more than offset penalties that apply to larger firms (with 50 to 100 workers) in this category. Only among mid-size employers is there an increase in per capita spending. The 4.6 percent increase largely reflects penalty costs that hit this group of firms more heavily than larger firms because firms in this group are less likely to offer coverage (95 percent of mid-size v. 99 percent of larger firms offer coverage) than their large firm counterparts. Per capita spending for the vast majority of employers in this group, who already offer coverage, will be unaffected by the penalties (data not shown).

The combined impact on businesses of ACA-induced changes in insurance coverage and costs per person insured is shown in table 3. Contrary to claims that the ACA substantially increases business costs, our estimates show that had the ACA been in effect in

Table 2. Changes in Per-Capita Employer Spending Due to the ACA, Simulated as if the ACA is Fully Implemented in 2012

		Without Reform	ACA	% Difference
All Employers	**Total Per-Capita Employer Spending**	**$3,653**	**$3,637**	**-0.4%**
	Per-Capita Employer Premium Contributions	$3,653	$3,640	-0.4%
	Per-Capita Employer Subsidies	$0	-$26	
	Per-Capita Employer Assessments	$0	$23	
Small Firms (100 or Fewer Employees)	**Total Per-Capita Employer Spending**	**$4,126**	**$3,824**	**-7.3%**
	Per-Capita Employer Premium Contributions	$4,126	$3,949	-4.3%
	Per-Capita Employer Subsidies	$0	-$133	
	Per-Capita Employer Assessments	$0	$8	
Mid-size Firms (101–1,000 Employees)	**Total Per-Capita Employer Spending**	**$3,509**	**$3,672**	**4.6%**
	Per-Capita Employer Premium Contributions	$3,509	$3,562	1.5%
	Per-Capita Employer Subsidies	$0	$0	
	Per-Capita Employer Assessments	$0	$110	
Large Firms (More than 1,000 Employees)	**Total Per-Capita Employer Spending**	**$3,683**	**$3,695**	**0.3%**
	Per-Capita Employer Premium Contributions	$3,683	$3,686	0.1%
	Per-Capita Employer Subsidies	$0	$0	
	Per-Capita Employer Assessments	$0	$8	

Note: Employer spending on persons reporting ESI coverage in households where no policyholder is identified are included in the total calculations but not in the firm size groups.

Source: Urban Institute analysis, HIPSM 2012.

Table 3. Changes in Aggregate Employer Spending Due to the ACA, Simulated as if the ACA is Fully Implemented in 2012

		Without Reform (in billions)	ACA (in billions)	% Difference
All Employers	**Total Employer Spending**	553.4	565.8	2.2%
	Employer Premium Contributions	553.4	566.2	2.3%
	Employer Subsidies	0.0	-4.0	
	Employer Assessments	0.0	3.6	
Small Firms (100 or Fewer Employees)	**Total Employer Spending**	116.5	114.8	-1.4%
	Employer Premium Contributions	116.5	118.5	1.8%
	Employer Subsidies	0.0	-4.0	
	Employer Assessments	0.0	0.2	
Mid-size Firms (101–1,000 Employees)	**Total Employer Spending**	84.5	92.5	9.5%
	Employer Premium Contributions	84.5	89.7	6.2%
	Employer Subsidies	0.0	0.0	
	Employer Assessments	0.0	2.8	
Large Firms (More than 1,000 Employees)	**Total Employer Spending**	278.6	290.4	4.3%
	Employer Premium Contributions	278.5	289.8	4.0%
	Employer Subsidies	0.0	0.0	
	Employer Assessments	0.0	0.7	

Note: Employer spending on persons reporting ESI coverage in households where no policyholder is identified are included in the totals but not in the firm size groups.

Source: Urban Institute analysis, HIPSM 2012.

2012, total employer spending of $565.8 billion would have been 2.2 percent higher than the $553.4 billion that would have been spent in its absence. Small employer subsidies of $4.0 billion that reduce costs for the smallest businesses would have been roughly equal to penalty costs on larger businesses, at $3.6 billion.

For small businesses, reductions in per capita costs more than offset coverage increases to slightly reduce spending overall.[17] Large businesses' costs increase 4.3 percent, overwhelmingly attributable to increases in worker take-up of offered coverage. The 9.5 percent increase in spending by mid-size business is markedly higher, predominantly because of increased enrollment. Overall then, contrary to critics' claims, the ACA leaves employer costs (as a whole) little changed, small businesses better off, and employer-sponsored coverage slightly higher, not lower, than would be true in the absence of reform.

Impact of the ACA on Employers' Willingness to Offer Insurance Coverage[18]

That the ACA increases rather than decreases employer-sponsored coverage runs counter to claims that the ACA will lead employers to drop coverage—either because of its supposed cost burdens or, according to another argument, because employers can pay penalties and reduce their costs. These claims ignore the fundamental lesson of economics that employer-paid health insurance premiums are part of worker compensation, which, for each worker, is limited to the value the worker generates for the firm. As a result, any increase in employers' health-related costs will be offset by decreases in other compensation—whether wages or other benefits. Any decreases in benefit costs, such as health insurance, will lead to increases in other forms of compensation, such as wages.

Although most analyses (including those done by the Congressional Budget Office (CBO), the Rand Corporation, and Urban Institute) have concluded that the law will leave employer-sponsored health insurance largely intact, critics of the ACA, armed with reports from business consultants, nevertheless make the argument that that CBO and others have seriously misjudged employers' incentives and significantly underestimated subsidy costs under the ACA. But the key to the ACA's actual impact on employer-sponsored insurance (ESI) will be whether most workers' employers continue to see their employees as valuing employer-provided health insurance over the alternative created by the ACA. And, under the terms of the ACA and the pressure of a competitive marketplace, our analysis shows they overwhelmingly will.

The bottom line is that most workers' firms will be dominated by workers who will receive better benefits and, through the tax system, better subsidies through employer-provided coverage than through newly created insurance exchanges. The strength of employee preferences may be hard to read in the short term, and some employers may seek immediate

financial gain in benefit reduction as markets adjust to new circumstances. But over time, coverage reductions inevitably would make the workers that employers most want to keep worse off, and if those workers sought employment elsewhere as a result, then the firm would be worse off as well. It is therefore unlikely that large numbers of employers currently providing insurance coverage will change their decisions to offer it.

Prospects for the Future

That the ACA leaves the future scope of employer-sponsored health insurance coverage largely unchanged does not mean that employer-sponsored insurance will necessarily expand to cover a growing proportion of Americans. On the contrary, the share of the population covered has been and is likely to continue to drop. The future of employer-sponsored coverage is overwhelmingly determined by the state of the economy and by the growth in health care costs. As long as health care costs grow faster than inflation, the proportion of the population ESI covers will continue to drop. That trend should not be confused with or attributed to the impact of the ACA.[19]

That said, however, the ACA includes cost containment measures that, if successful, have the potential to slow the growth in health care costs. Health care costs have historically risen considerably faster than the economy, but overall spending growth has slowed significantly in recent years, partly because of the recession. This slowdown (for both private and public payers) actually began as early as 2004—before the recession, and may also reflect changes in the structure of insurance (in particular, a shift toward high deductible plans) and provider payment and delivery changes (in particular, the evolution of value-based purchasing aimed at reducing unnecessary hospitalizations and promoting clinically integrated care).[20]

The cost containment measures in the ACA have the potential to sustain and extend the slowdown in health care cost growth. The law's provisions to slow growth in rates Medicare pays hospitals is largely responsible for slowing projected Medicare per beneficiary cost growth to the rate of growth of the economy. Arguments that these payment constraints undermine hospitals' economic viability or lead hospitals to shift costs to private purchasers are not supported by the evidence. Medicare payment constraints produce greater hospital efficiency in hospitals that are largely dependent on Medicare revenues and in markets with competition among private insurers that have no dominant hospital system. In these markets, employers committed to cost containment have the opportunity to adopt effective Medicare payment reform initiatives, slowing growth in their own health care spending.[21]

The ACA's initiatives for payment and delivery reform are equally important in slowing cost growth over the long term. These initiatives—including pay-for-performance, accountable care organizations, and bundling—aim to move private as well as public insurance away from payment per service, which drives up volume, and toward payment for value, or rewards to integrated care. In piloting these initiatives, Medicare not only sets an example for employer-sponsored insurance; it explicitly offers the opportunity for collaboration across public and private payers. If these initiatives are successful, future growth in health care costs will be slower than is projected, employer spending growth will slow, and employer-sponsored health insurance will be more extensive than is now projected.

Even if that is not the case, the ACA's establishment of a viable nongroup insurance marketplace—with subsidies—not only benefits individuals whose employers do not offer coverage. It benefits small employers of low wage workers. These firms are unable to offset the costs of health insurance with reduced wages, as large employers employing a mix of low and higher wage workers are able to do. In addition, large firms have greater economies of scale in purchasing insurance, allowing them to obtain greater value for their health care dollar than small employers. Accordingly, the small low wage employers are very unlikely to offer insurance coverage to their workers and often find themselves at a disadvantage in competing with large employers for workers. The ACA will create a much more level playing field for these small employers, owing to the law's market reforms, exchanges, and subsidies that will allow their workers to purchase affordable, adequate coverage directly.

Overall, the evidence simply does not support critics' arguments that the ACA will burden employers and undermine employer-sponsored health insurance. On the contrary, except for a cost increase to mid-size employers due largely to enrollment increases, the ACA benefits rather than burdens small employers who want to provide health insurance, leaves the overall costs of employer-sponsored health insurance largely unchanged, and offers the potential, through cost containment, of slowing the growth in health care costs, benefiting private along with public purchasers of health insurance.

Endnotes

1. Robert A. Berenson and John Holahan, "Preserving Medicare: A Practical Approach to Controlling Spending," Urban Institute, September 2011; Linda J. Blumberg, "How Will the PPACA Impact Individual and Small Group Premiums in the Short and Long Terms?" The Urban Institute, July, 2010; Linda J. Blumberg, Matthew Buettgens, Judith Feder, and John Holahan , "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act. *Inquiry*: Summer 2012," Vol. 49, No. 2, pp. 116-126; Linda J. Blumberg and Shanna Rifkin, "State Progress in Implementing Health Insurance Exchanges: Results from Ten State Analyses," Urban Institute, September 10, 2012; Bowen Garrett and Matthew Buettgens, "Employer-Sponsored Health Insurance Under Health Reform: Reports of Its Demise Are Premature," Urban Institute, January 2011; John Holahan, "Plan Participation in Health Insurance Exchanges: Implications for Competition and Choice," Urban Institute, September 10, 21012; Kevin Lucia, Sabrina Corlette, Katie Keith, "Monitoring Implementation of the Affordable Care Act in Ten States: Early Market Reforms," September 10, 2012; Sabrina Corlette, Kevin Lucia, Katie Keith, "Monitoring Implementation of the Affordable Care Act in Ten States: Rate Review," September 10, 2012; Stacey McMorrow, Linda J. Blumberg, Matt Buettgens, "The Effects of Health Reform on Small Businesses and Their Workers," Urban Institute, June 2011.
2. This section draws from Blumberg, 2010.
3. Uninsurance among people aged 19-25 declined more than 2 percentage points between 2010 and 2011, dropping from 29.8 percent to 27.7 percent. Carmen DeNavas-Walt, Bernadette D. Proctor, Jessica C. Smith, "Income, Poverty and Health Insurance in the United States, 2011." U.S. Census Bureau, September, 2012.
4. On implementation of early insurance reforms, see Katie Keith, Kevin Lucia and Sabrina Corlette, "Implementing the Affordable Care Act: State Action on Early Insurance Reforms." The Commonwealth Fund, March 2012.
5. This estimate aggregates distinct actuarial estimates of each provision and does not take into account interactions among the provisions that would likely lower the total effect. Blumberg, 2010; and "Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care", July 14, 2010.http://www.healthcare.gov/law/resources/regulations/prevention/regs.html
6. DeNavas-Walt, Proctor, & Smith, 2012.
7. Small employer and nongroup purchasers that maintain the insurance plans they held at the time of the ACA's enactment are considered to be "grandfathered," meaning their plans are exempt form the new essential health benefits, actuarial value tiers, and premium rating rules discussed below. However, in order to maintain grandfathered status, a plan cannot significantly increase cost-sharing requirements (e.g., co-payments, deductibles, co-insurance), cannot significantly lower employer contributions or add or tighten annual benefit limits. In addition, grandfathered status is forfeited if the purchaser changes insurance companies. Given these restrictions and the attraction of the consumer protections and tax credits provided in the market for newly purchased plans, attrition from grandfathered plans is expected to be relatively high among small group and nongroup purchasers in the early years of the ACA's full implementation.
8. In states that choose not to implement the ACA's Medicaid expansion, individuals with incomes as low as 100 percent of the federal poverty level will be eligible for subsidies. In addition, lower income individuals who are legal resident non-citizens and have resided in the U.S. for fewer than 5 years but would otherwise be eligible for Medicaid will also be eligible for exchange-based subsidies.
9. Under the ACA, similar tax credits that pay small employers a somewhat lower share of their premium expenses than will apply in 2014 have also been available to the same types of employers since 2010. The maximum wage for eligible employers presented in the text apply from 2010 to 2013. After 2013, wage levels will be adjusted by the annual change in the cost of living.
10. McMorrow, Blumberg, & Buettgens, 2011.
11. Tim Jost, "Implementing Health Reform: The Small Employer Tax Credit," *Health Affairs Blog*, May 18, 2010 http://healthaffairs.org/blog/2010/05/18/implementing-health-reform-the-small-employer-tax-credit/
12. The following discussion draws from Blumberg, 2010.
13. Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdfCite bulletin
14. The law allows maximum deductibles of $2,000 for individual policies and $4,000 for family policies in 2014. Out-of-pocket limits may be as high as the limits for Health Savings Account (HSA) qualified high deductible health plan in each year. In 2013, these limits will be $6,250 for individual policies and $12,500 for family policies.
15. Holahan, 2012.
16. On the implementation of rate review see Corlette, Lucia, & Keith, 2012.
17. Although penalties potentially apply to small businesses with 50 or more workers, as a group businesses with 50—100 workers experience negligible increases in total costs (1.2 percent), because the exemption from penalties for 30 of their workers leads to relatively small assessments (data not shown).
18. This section draws from Blumberg, Buettgens, Feder, & Holahan, 2012.
19. See Garret and Buettgens, 2011.
20. John Holahan and Stacey McMorrow, "Medicare and Medicaid Spending Trends and the Deficit Debate," *New England Journal of Medicine*, 367;5, August 2, 2012, pp. 393-395.
21. Robert A. Berenson and John Holahan, "Preserving Medicare: A Practical Approach to Controlling Spending." Urban Institute, September 2011.

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