# Making Health Reform More Affordable for Working Families: The Effect of Employee Choice Vouchers

## Summary

Current health reform bills in both houses of Congress include a barrier that excludes many lower-income workers with an offer of employer-sponsored health insurance from premium and cost-sharing subsidies, which they would have been able to use toward the purchase of exchange-based health insurance coverage if they did not have an employer offer. We investigate the effectiveness of employee choice vouchers, such as that proposed by Senator Wyden and included in the Senate bill as passed, in making health care more affordable for such families. The voucher concept would allow certain employees to use their employers' contributions toward health insurance to help pay for coverage in an exchange, permitting them to access federal premium and cost-sharing subsidies for which they might be eligible. We also consider concerns that the provision of such vouchers could cause adverse selection in the remaining employer-sponsored insurance (ESI) market, potentially leading to a decline in employer coverage.

We simulate the implications of two types of voucher programs: one based on Senator Wyden's proposal and a second option that would expand the availability of vouchers to everyone with incomes in the subsidy eligibility range. We find that:

- Employee choice vouchers make health coverage dramatically more affordable for the low-income families who take advantage of them. For example, under a Wyden-style reform, the median total health care expenses (premium plus out-of-pocket costs) for families using a voucher would fall from just over 12 percent of income when buying an employer's plan to less than 3 percent of income when using an employer voucher to buy exchange-based subsidized coverage;

- The expanded voucher program would increase insurance coverage very modestly;

- Vouchers would not change government or employer spending significantly;

- Voucher programs have little effect on overall employer spending on health care. Even under the expanded voucher program, the change in employer spending would be less than 1 percent;

- Either voucher program would have very little effect on ESI premiums, but would reduce the number of people covered by ESI outside the exchange. Neither of these effects is large enough to threaten the integrity of the ESI market.

## Introduction

Current health reform bills in both houses of Congress[1] include premium and cost-sharing subsidies[2] that could be used by those with incomes between 133 and 400 percent of the federal poverty level (FPL) to make health insurance policies purchased through the new health insurance exchanges more affordable.[3] However, both bills also include a barrier that would prevent many low-income workers with an offer of employer-sponsored health insurance (ESI) from accessing the subsidies that they could receive if they did not have an employer offer of coverage.

Both bills structure premium subsidies available for exchange coverage as caps on the share of income an individual or family would be required to contribute toward the cost of their coverage; these caps increase with income and are only available for exchange-based coverage. Under the House bill, these percentage income caps range from 1.5 to 12 percent of income; under the Senate bill they range from 2 to 9.8 percent of income. Both bills also provide subsidies to lower out-of-pocket cost-sharing burdens for low-income families. These subsidies are available to income-eligible individuals without employer sponsored offers in a straight-forward way. However, a modest-income worker with an employer offer may face higher financial burdens than their counterpart without such an offer.

> ***An Example of an Employee Choice Voucher***
>
> The following example illustrates how vouchers work. Suppose a family of three has one working parent and their income is 133 percent of the Federal poverty level, about $24,000 a year. The employer offers insurance. The total ESI premium for a family policy is $12,000, but the employer pays 80 percent of the cost, leaving $2,400 for the working parent to pay. This is 10 percent of the family's income, so they would not be eligible for any premium or cost-sharing subsidies under the House bill. Unless the family is granted a hardship exemption from the mandate, they would either have to buy this policy or an unsubsidized family policy in the exchange with an annual premium of, say, $9,000. If they are granted an exemption, they may choose to go uninsured rather than pay at least 10 percent of their income in premiums.
>
> We now introduce a voucher program. The amount of the voucher would be 80 percent of the total ESI premium, $9,600. This could be applied to the family premium in the exchange. The family could thus get the exchange policy at no premium, as well as a $600 refund. Also, the family would be eligible for the highest level of cost-sharing subsidies, so their out-of-pocket health care costs would be lower with the exchange plan than with the employer's plan.

Specifically, under the House bill (H.R. 3962), in order to qualify for subsidized exchange coverage, an employee's share of the lowest cost ESI premium offered to them must be more than 12 percent of their income. Under the Senate bill (H.R. 3590), that threshold was originally 9.8 percent of income. Senator Wyden proposed a system of employee choice vouchers as a way of making health insurance more affordable to some of those prevented from accessing subsidies due to these thresholds. These employee choice vouchers were added to the final Senate bill as passed through the Manager's Amendment. We evaluate two voucher policies, one based on the Wyden amendment and the other broader in scope, that would expand the availability of vouchers to everyone with incomes in the subsidy eligibility range.

As is well known, most employers who offer insurance to their workers make a substantial contribution to the cost of coverage (on average, 80 and 72 percent for single and family policies, respectively). [4] These contributions are not taxed as income to the employees. An employee choice voucher would allow someone offered ESI to take the amount their employer would contribute if they enrolled in the firm's plan and use it instead to buy a policy from an exchange. The worker would then have access to any premium and cost-sharing subsidies for which he or she might still be eligible after the employer's contribution was taken into account.

Such a program would have an effect not only on the employees receiving vouchers, but on those not eligible. This is because those workers choosing to purchase insurance in the exchange would not be in the firm's health insurance risk pool, the group of employees whose costs are used to determine ESI premiums. If the workers making use of the voucher option tend to have lower health care costs than those remaining in the firm's insurance plan, premiums in the employer's plan could increase, an effect known as adverse selection.[5] Also, many commercial insurers, particularly those selling coverage in the small group market, set a minimum share of a firm's workers that must enroll in ESI, so if too many workers take vouchers, the firm could be forced to drop ESI coverage altogether.

In this brief we examine the effects of vouchers on firms and employees. How much more affordable do vouchers make health insurance for those with ESI offers? Do vouchers increase the number of insured? How much will employers spend on vouchers? How much adverse selection or loss of ESI occurs as a result?

## The Reforms Simulated

Under the Wyden employee choice voucher proposal, employees in all firm sizes would be eligible for a voucher (single or family) if the contribution they would be asked to make toward minimum essential coverage offered by their employer was between 8 and 9.8 percent of their income. The amount of the voucher, paid by the employer, would be the amount the employer would have contributed if the employee had enrolled in the highest-cost plan offered by their employer. The value of the voucher would be deducted from the premium of a plan purchased through the exchange. If the voucher amount was greater than the exchange premium, the employee would receive the difference as additional (taxable) income. If the voucher did not cover the full cost of exchange coverage, the premium subsidy test would be applied. In addition to premium subsidies, qualifying employees would have access to cost-sharing subsidies and reduced cost-sharing limits.[6]

For compatibility with other recent policy briefs using The Urban Institute's Health Insurance Policy Simulation Model (HIPSM, described below), we use the House bill as our base of comparison of the voucher options.[7] While the highest percent of income in the Senate bill's subsidy schedule is 9.8 percent, the highest in the House bill's schedule is 12 percent. As a consequence, the Wyden-style voucher proposal modeled here is modified such that those workers with an ESI coverage contribution requirement of 8 to 12 percent of income would be eligible for the voucher option. In addition, eligibility is limited to the subsidy-eligible working population, those whose family income is below 400 percent of the Federal poverty line.[8]

Our second simulation extends eligibility for the voucher option to all workers with family incomes in the subsidy eligibility range: 133 to 400 percent of the FPL. This option would provide significantly more workers with access to vouchers and exchange-based subsidies than would the Wyden-style option.

## Methods

To estimate the effects of the reform options, we use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).[9] 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 costs, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specified reforms.[10] For this analysis, all reforms are simulated as if they were fully implemented in 2009, and results are presented for that single year.

Two important aspects of employee choice vouchers are easy to overlook. First, the structure of the most expensive insurance plan offered by the employer may differ substantially from the plan purchased in the exchange. For example, comprehensive ESI plans vary considerably, but estimates of their average actuarial value (the average share of covered services reimbursed by the insurance plan) are generally between 76 and 80 percent. Plans offered by large firms are typically more generous than average. Second, the premiums of the ESI plans will in general be based on a smaller risk pool than the exchange. If the plans and risk pools involved in the voucher decision are sufficiently different from that in the exchange, the resulting incentives may have undesirable disruptive effects on the ESI market. For example, vouchers based upon a high cost firm's premiums could encourage younger and healthier workers to leave firm coverage for

exchange coverage, compromising the stability of the firm's risk pool.

HIPSM explicitly models employer behavior. Workers are allocated among a nationally representative set of synthetic firms. Each firm decides whether to offer ESI based on the aggregated preferences of their workers for having versus not having and ESI offer, additional costs of offering insurance, and minimum worker participation requirements. These synthetic firms also determine the risk pools for premiums. As a simplified example of why this is important for the present analysis, suppose a firm has 10 workers. Suppose also that 6 would prefer to take vouchers and 4 would be better off remaining in ESI. All 10 would prefer the firm to keep offering ESI, but insurers generally require take-up rates much higher than 40 percent Under a voucher approach, the firm would be unable to offer ESI, a situation affecting all 10 workers. A model that simulated individual choice only would not capture this important effect.

Under the House bill, employers offering ESI coverage to their workers would be required to contribute to premiums on a

pro-rated basis for part-time employees.[11] In our simulation, the eligibility of part-time workers for ESI and the size of the employer contributions for part-time employees are representative of those currently observed.[12] Under the House bill rules, more part-time workers would be eligible for vouchers than simulated here. However, the voucher amounts would be far less for part-time workers than for full-time ones, so the additional eligibility is unlikely to change the results substantively.

There are two ways in which employers may change the benefits they provide to their workers in response to a voucher program. First, they may offer less comprehensive plans.[13] Second, they may reduce the amount of their premium contributions. We were not able to model either effect in the current version of HIPSM. In practice, it is not clear that either change would actually be in the interests of a large number of employers since non-discrimination rules would require that they make the same contributions to all workers, thereby disadvantaging those higher income employees ineligible for subsidies.[14]

### Figure 1. 2009 Health Insurance Coverage
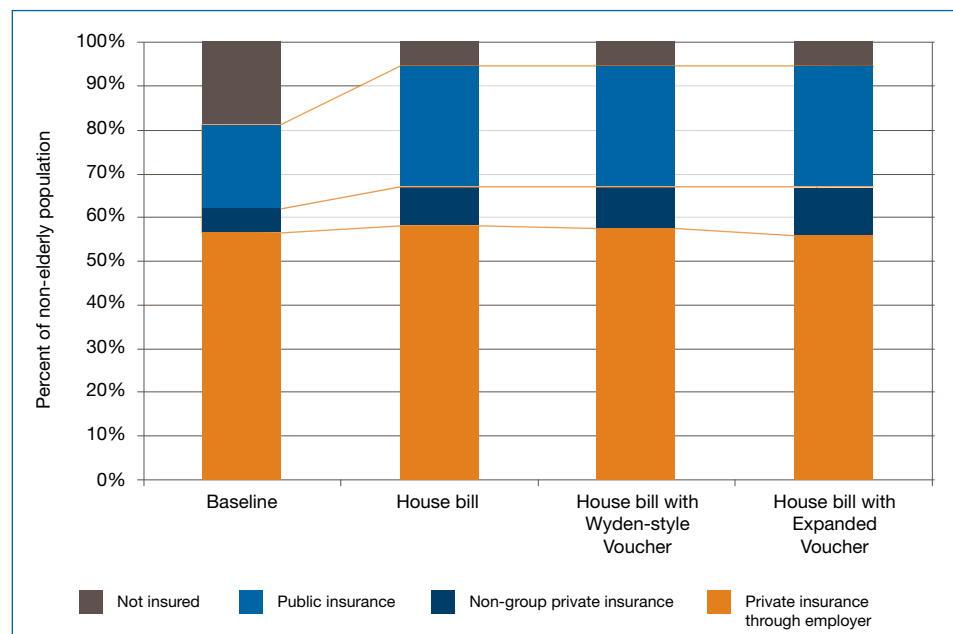


Source: Urban Institute Analysis, HIPSM 2010
Reforms simulated as fully implemented in 2009

**Table 1. Health Insurance Coverage Distribution of Non-elderly in Baseline and Reform Under Various Policy Options**

| | Baseline | | H.R.3962 | | H.R.3962 with Wyden-style Voucher | | H.R.3962 with Expanded Voucher | |
|---|---|---|---|---|---|---|---|---|
| **Coverage (in millions)** | | | | | | | | |
| Employer (Non-Exchange) | 151.0 | 56.5% | 141.4 | 52.9% | 140.0 | 52.4% | 134.8 | 50.5% |
| Non-Group (Non-Exchange) | 15.7 | 5.9% | 0.0 | 0.0% | 0.0 | 0.0% | 0.0 | 0.0% |
| Exchange Employer | 0.0 | 0.0% | 14.4 | 5.4% | 14.0 | 5.2% | 14.1 | 5.3% |
| Exchange Non-Group | 0.0 | 0.0% | 22.7 | 8.5% | 24.3 | 9.1% | 29.1 | 10.9% |
| Medicaid/CHIP | 42.9 | 16.1% | 65.1 | 24.4% | 65.5 | 24.5% | 66.2 | 24.8% |
| Other (including Medicare) | 8.4 | 3.2% | 8.4 | 3.2% | 8.4 | 3.2% | 8.4 | 3.2% |
| Uninsured | 49.1 | 18.4% | 15.1 | 5.6% | 14.9 | 5.6% | 14.5 | 5.4% |
| **Change in Coverage** | | | | | | | | |
| Employer (Non-Exchange) | -- | -- | -9.6 | -3.6 | -11.0 | -4.1 | -16.2 | -6.1 |
| Non-Group (Non-Exchange) | -- | -- | -15.7 | -5.9 | -15.7 | -5.9 | -15.7 | -5.9 |
| Exchange Employer | -- | -- | 14.4 | 5.4 | 14.0 | 5.2 | 14.1 | 5.3 |
| Exchange Non-Group | -- | -- | 22.7 | 8.5 | 24.3 | 9.1 | 29.1 | 10.9 |
| Medicaid/CHIP | -- | -- | 22.2 | 8.3 | 22.6 | 8.5 | 23.3 | 8.7 |
| Other (including Medicare) | -- | -- | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Uninsured | -- | -- | -34.0 | -12.7 | -34.2 | -12.8 | -34.6 | -13.0 |
| **Decline in uninsured** | | -- | | 69.3% | | 69.8% | | 70.6% |
| **Covered or eligible for public coverage** | | 86.0% | | 96.6% | | 96.6% | | 96.7% |

\* Percentage point difference in coverage rate compared to baseline.

Reforms simulated as if fully implemented in 2009

*Source:* Urban Institute analysis, HIPSM 2010.

## Results

### *Coverage*

Table 1 and Figure 1 show the distribution of health insurance coverage prior to reform, under the House bill, under the House bill with a Wyden-style voucher option, and under the House bill with the expanded voucher option. The Wyden-style voucher would be available to those with ESI contributions between 8 and 12 percent of income, whereas the expanded voucher would be available to all workers with family incomes that fall in the subsidy eligibility range (133 to 400 percent of the FPL under the House bill). Changes in coverage follow the same basic pattern under both voucher programs. Those taking advantage of the vouchers would purchase nongroup coverage through the exchange using their vouchers and federal subsidies, decreasing the share of the population purchasing employer-based coverage and increasing the share buying nongroup insurance. There would be a 1.4 million person decrease in ESI coverage outside the exchange when Wyden-style vouchers are permitted and a 6.6 million person decrease under the expanded vouchers. Nongroup coverage (which, aside from grandfathered plans, would all be exchanged based under the House bill) would increase by 1.6 million and 6.4 million, respectively, under the Wyden and expanded voucher approaches. These would be accompanied by very small increases in Medicaid/CHIP with the voucher options. The net result is that both voucher programs would cover slightly more people than the House bill alone, reducing the uninsured by an additional 200,000 under the Wyden-style voucher and an additional 600,000 under the expanded voucher.

### *Costs*

Voucher programs would increase government costs only modestly as shown in table 2. Government costs would increase as more workers would enroll in exchange-based coverage, using the vouchers from their employers

### Table 2. Health Care Spending of Government, Employers, Individuals and Uncompensated Care in Baseline and Reform Under Various Policy Options (in billions)

| | H.R.3962 | H.R.3962 with Wyden-style Voucher | H.R.3962 with Expanded Voucher |
|---|---|---|---|
| **Total Government Spending (federal + state)** | | | |
| **Baseline** | **246.8** | **246.8** | **246.8** |
| Post-Reform Medicaid/SCHIP | 308.9 | 309.3 | 311.0 |
| Post-Reform Cost-sharing Subsidies | 6.4 | 6.7 | 7.2 |
| Post-Reform Premium Subsidies | 25.5 | 26.4 | 27.1 |
| Post-Reform Employer Subsidies | 6.7 | 6.7 | 5.5 |
| Post-Reform Individual Mandate | 4.0 | 3.9 | 3.8 |
| Post-Reform Free-rider Penalty | 0.0 | 0.0 | 0.0 |
| Net Post-Reform | 343.5 | 345.3 | 347.1 |
| **Net Chng Post Reform** | **96.7** | **98.4** | **100.3** |
| **% Chng Post Reform** | **39.2%** | **39.9%** | **40.6%** |
| **Uncompensated Care** | | | |
| **Baseline** | **61.1** | **61.1** | **61.1** |
| Net Post-Reform | 25.2 | 25.1 | 24.8 |
| **Net Chng Post Reform** | **-35.9** | **-36.1** | **-36.4** |
| **% Chng Post Reform** | **-58.7%** | **-59.0%** | **-59.5%** |
| **Employer Spending** | | | |
| **Baseline** | **412.6** | **412.6** | **412.6** |
| Post-Reform | 423.8 | 419.4 | 403.7 |
| Post-Reform Employer Subsidies | 6.7 | 6.7 | 5.5 |
| Post-Reform Free-rider Penalty | 0.0 | 0.0 | 0.0 |
| Post-Reform Voucher Amount | 0.0 | 4.0 | 23.2 |
| Net Post-Reform | 417.2 | 416.6 | 421.3 |
| **Net Chng Post Reform** | **4.6** | **4.0** | **8.7** |
| **% Chng Post Reform** | **1.1%** | **1.0%** | **2.1%** |
| **Individual Spending** | | | |
| **Baseline** | **315.0** | **315.0** | **315.0** |
| Post-Reform | 354.4 | 358.0 | 369.5 |
| Post-Reform Premium Subsidies | 25.5 | 26.4 | 27.1 |
| Post-Reform Individual Mandate | 4.0 | 3.9 | 3.8 |
| Post-Reform Voucher Amount | 0.0 | 4.0 | 23.2 |
| Net Post-Reform | 332.9 | 331.5 | 323.0 |
| **Net Chng Post Reform** | **17.9** | **16.5** | **8.0** |
| 1. <133% FPL | -14.0 | -14.3 | -15.2 |
| 2. 133-199% FPL | -1.4 | -2.1 | -3.7 |
| 3. 200-299% FPL | 6.2 | 4.8 | 1.7 |
| 4. 300%-399% FPL | 7.1 | 6.6 | 2.8 |
| 5. 400%+ FPL | 19.7 | 20.2 | 19.5 |
| % Chng Post Reform | 5.7% | 5.2% | 2.5% |
| **Aggregate Change** | **83.2** | **82.9** | **80.7** |

\* Other net government costs include subsidies to employers, less revenues from individual mandate penalties and free-rider penalties

Reforms simulated as if fully implemented in 2009

*Source:* Urban Institute analysis, HIPSM 2010.

but also taking advantage of available government subsidies. The government would spend $1.8 billion more with a Wyden-style voucher program than under the House bill without vouchers. This is a change in government spending of 0.5 percent relative to the net government costs of the House bill. The expanded voucher program would cost the government $3.7 billion more, a change of 1.1 percent relative to the House bill alone.

The voucher amount is based on the highest-cost ESI plan offered by an employer and is applied to the premium of an exchange plan which would be much less comprehensive on average (70 percent actuarial value). The resulting voucher amounts would often be larger than the premium subsidies for which the family would have been eligible without an ESI offer. As a result, the cost of premium subsidies would not increase substantially. Some additional premium subsidies accrue to workers in the very small number of firms that stop offering coverage in the presence of vouchers. Many of those purchasing exchange-based coverage would also obtain cost-sharing subsidies, further

lowering their out-of-pocket costs. A small increase in Medicaid enrollment would occur as well.

Voucher programs would have little effect on employer spending, since employers essentially spend the same amount on vouchers for their workers as they otherwise would have spent on ESI premium contributions for those workers. Under the Wyden-style program, employers would spend $4 billion in vouchers, but would spend less on premium contributions. The net result would be $0.6 billion less spending on health care by employers than under the House bill without vouchers, a negligible percent change relative to net employer spending on health care. The expanded voucher program, not surprisingly, would greatly increase the amount spent on vouchers. Employers would spend, in total, $23.2 billion on vouchers. When offset by decreases in premium contributions, employers would spend $4.1 billion more than under the House bill without vouchers, a change of less than 1 percent. The dynamics producing these changes are complex, since firms must decide whether to offer ESI and

individuals must decide whether to take a voucher if offered one. In general, wider eligibility for vouchers increases costs as more workers who would decline ESI instead take vouchers.

Finally, vouchers would reduce individual spending since families would have both employer contributions *and* government subsidies for use in purchasing coverage; without the vouchers they have only the employer contribution for use in purchasing ESI. Under a Wyden-style program, individuals would spend $1.4 billion less on health care than under the House bill without vouchers, a change of less than 0.5 percent relative to net individual spending on health care. Individuals would save $9.9 billion under the expanded voucher program relative to the House bill alone, a change of 3 percent.

### Family Health Care Burdens

Table 3 shows that vouchers would make coverage more affordable for lower-income working families.[15] Financial burden is defined here as the share of income that a family spends on health care, including both insurance premiums and out-of-pocket

## Table 3. Median Financial Burdens of Family Health Care Costs

| | H.R.3962 | H.R.3962 with Voucher Program | Difference |
|---|---|---|---|
| **Families with at least 1 person taking a voucher in H.R.3962 with Wyden-style Voucher** | | | |
| Number of Persons (in millions) | 1.1 | 1.1 | 0.0 |
| Median Fiancial Burden | 12.2% | 2.6% | -9.6 |
| **Families with at least 1 person taking a voucher in H.R.3962 with Expanded Voucher** | | | |
| Number of Persons (in millions) | 6.5 | 6.5 | 0.0 |
| **Median Fiancial Burden** | | | |
| 133-399% FPL | 9.9% | 3.6% | -6.3 |
| 133–199% FPL | 11.0% | 1.3% | -9.7 |
| 200–299% FPL | 11.0% | 2.9% | -8.1 |
| 300–399% FPL | 8.6% | 4.7% | -3.9 |

*Source:* Urban Institute analysis, HIPSM 2010.

Reforms simulated as if fully implemented in 2009

expenditures. We also deduct from these expenditures any voucher refunds accruing to those whose exchange-based coverage costs less than the voucher amount. Since the voucher amount would not depend on income, the difference it would make in financial burdens would necessarily be larger for lower-income families than higher income families.

The first panel features those simulated to take a voucher under the Wyden-style program. There would be 1.1 million people in families in which at least one person would take a voucher. The median financial burden – premiums plus out-of-pocket costs – for such people under the House bill without vouchers would be 12.2 percent of income. This would decrease dramatically to 2.6 percent of income with the vouchers.

The second panel features those simulated to take a voucher under the expanded program. There would be 6.5 million people in families in which at least one person would take a voucher. The median financial burden would be 9.9 percent under the House bill without vouchers, decreasing to 3.6 percent with vouchers. We show further results by more detailed income category (the number of people in the previous panel is too small for further subdivision to give representative results).

*Premiums*

Table 4 shows that the voucher options would lead to a very modest amount of adverse selection in ESI premiums outside of the exchange. The more limited Wyden-style voucher program would increase ESI premiums by less than 0.5 percent on average compared to the House bill alone, while the expanded voucher program would increase ESI premiums by less than 1 percent relative to the House bill alone. Adverse selection would occur for two main reasons. First, the lower actuarial value of the exchange plan as compared to the more comprehensive typical ESI plans would likely attract lower-cost families. Second, the exchange package would be most attractive to young adults because the exchange policies would be age rated.[16]

The percentage of employers offering ESI is not affected much by the presence of voucher programs; there is a decrease of about 1 percentage point (data not shown).

## Discussion

In brief, our analysis found the following:

- Employee choice vouchers can substantially reduce health care burdens for lower-income working families.

- The expanded voucher program would increase insurance coverage very modestly.

- The increased coverage would be achieved with relatively little increase in government costs.

- Voucher programs have little effect on overall employer spending on health care. Even under the expanded voucher program, the change in employer spending would be less than one percent, as new spending on vouchers essentially offsets employer contributions to ESI.

- Both voucher programs would have very little effect on ESI premiums, but would reduce the number of people covered by ESI outside the exchange. However, neither of these effects is large enough to threaten the integrity of the ESI market.

The employee choice provisions included in the Senate bill which would tie the size of the employee choice voucher to the employer's most expensive health plan could, however, have some unintended effects. As mentioned earlier, employers may react to the introduction of such a

## Table 4. Average Single and Family ESI Premiums

| | Non-Exchange ESI | | Exchange ESI | |
|---|---|---|---|---|
| | Worker-Level Single Premium | Worker-Level Family Premium | Worker-Level Single Premium | Worker-Level Family Premium |
| **Baseline** | **$4,616** | **$11,517** | -- | -- |
| H.R.3962 | $4,502 | $11,145 | $4,185 | $10,703 |
| H.R.3962 with Wyden-style Voucher | $4,514 | $11,191 | $4,209 | $10,831 |
| H.R.3962 with Expanded Voucher | $4,536 | $11,230 | $4,075 | $10,519 |

Reforms simulated as if fully implemented in 2009

*Source:* Urban Institute analysis, HIPSM 2010.

voucher program by reducing the comprehensiveness of health insurance plans offered to their employees.

This concern could be addressed by allowing employers to compute their voucher amount using a plan more comparable to the standard exchange plan. Many large employers already offer multiple ESI plans; a provision such as this would encourage some to offer a plan option of similar actuarial value to the standard exchange plans. With the voucher amount tied to a somewhat lower cost option than the typical ESI plan, the incentive for younger healthier workers to leave employer-based coverage in order to obtain lower cost, less comprehensive coverage would be significantly reduced.

Another option that would help ameliorate this concern is to increase the size of the employers eligible to purchase coverage through exchanges at the same time as expanding the voucher program. Larger employers could then offer coverage to their workers through the exchanges, providing vouchers for essentially identical coverage to those low-income workers who could take advantage of the additional subsidies available.

Current health care reform bills would bar many lower-income working families offered ESI insurance from the financial assistance they could have received without such an offer. This analysis shows that voucher programs could redress this inequity and could do so with little change in employer and government costs and little disruption to employer-based insurance markets.

## Notes

1   H.R. 3962 was passed by the House on 7 November 2009 and H.R. 3590 was passed by the Senate on 24 December 2009.

2   Refundable premium tax credits, in the language of the bills.

3   Under the Senate bill, exchange-based subsidies are available to eligible individuals with incomes between 100 and 400 percent of the FPL.

4   Source: http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tic3.pdf; http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tid3.pdf

5   While new rating rules would prevent health status rating of small employer plans under reform, both the House and Senate bills include age rating of small employer premiums. If those leaving the employer insurance pool tend to be younger, the adverse impact on small employer premiums could occur. The Senate bill language does not seem to extend the same insurance market reforms related to health status rating to large groups purchasing commercial coverage. In addition, larger firms that self-insure would likely continue to do so under reform, and the effective premiums for self-insuring firms will always be based upon each firm's own enrolled risk pool.

6   Garrett, Clemans, and Buettgens, "Premium and Cost-Sharing Subsidies under Health Reform: Implications for Coverage, Costs, and Affordability" (Washington, DC: The Urban Institute, 2009), http://www.urban.org/uploadedPDF/411992_health_reform.pdf

7   Clemans-Cope, Garrett, and Buettgens, "Health Care Spending under Reform: Less Uncompensated Care and Lower Costs to Small Employers" (Washington, DC: The Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412016.

8   In the forty-eight contiguous states and the District of Columbia, the 2009 Federal Poverty Level is $14,570 for a family of two and $22,050 for a family of four. For more information, see http://aspe.hhs.gov/poverty/09poverty.shtml.

9   Garrett, Holahan, Headen, and Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009) http://www.kff.org/medicaid/upload7901.pdf.

10  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 US Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount. Behavioral modules in HIPSM represent individual and family demand for health insurance coverage through a utility-based approach in which each individual is assigned a utility value that measures the relative desirability of each health insurance option. These utilities then shape decisions when reform options are introduced. The responsiveness of health insurance decisions to changes in health insurance options and premiums are calibrated in HIPSM to findings in the empirical economics literature.

11  Under the Senate bill, firms would not be required to offer ESI to part-time employees nor to contribute to their premiums if they are offered insurance.

12  http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tib4.pdf, http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tib4b.pdf, and http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2008/tib4b1.pdf.

13  For example, suppose an employer offers a moderately comprehensive plan which a majority of workers take and a very comprehensive plan taken by a much smaller number. All vouchers would be based on the employer's share of the most comprehensive plan under this proposal. The employer may then decide to drop it and only offer the moderate plan; it can save money on vouchers while respecting the preferences of most of its employees. Certain employers might also react by decreasing their contributions.

14  Also, the House bill sets minimum standards for employer contributions, though these are lower than the rates at which many employers currently contribute.

15  A "family" in this table is, more precisely, a health insurance unit, whether single or family. A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students younger than age 24.

16  Blumberg, Buettgens, and Garrett, "Age Rating under Comprehensive Health Care Reform" (Washington, DC: The Urban Institute, 2009), http://www.urban.org/uploadedpdf/411970_age_rating.pdf

## About the Authors and Acknowledgements

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