

RESEARCH REPORT

Monitoring the Impact of the Affordable Care Act on Employers

Literature Review

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Executive Summary

In this report, we analyze recent trends in the employer health insurance market and the anticipated effects of the Affordable Care Act on employers, with a particular focus on small firms with fewer than 50 workers. We first present a detailed picture of the employer market by identifying preexisting trends in key outcomes that could be incorrectly attributed to the Affordable Care Act. We also analyze the literature to identify economic factors that are important in current employer and employee decisions regarding health coverage. Overall, we find the following:

- Employers have a strong economic incentive to offer health insurance, primarily since employer-sponsored health insurance is not subject to federal or state income taxes or Medicare or the Social Security payroll tax.
- Before the Affordable Care Act, most of the nonelderly population had health coverage through an employer, but rates of employer-sponsored insurance (ESI) decreased nearly every year since 2000. The decline in ESI was even more drastic among small-firm workers. The share of full-time workers in the smallest firms and their dependents with employer-based coverage fell from 43 percent in 2000 to 33 percent in 2010. In contrast, coverage for full-time workers in firms with 1,000 or more employees and their dependents fell from 87 to 82 percent over the same period.
- ESI premiums have increased over time at a rate that exceeds National Health Expenditure Accounts growth. Among small firms with fewer than 50 workers, average single premiums grew from \$3,375 in 2002 to \$5,460 in 2012 (62 percent or an average annual rate of nearly 7 percent), and average family premiums increased at a slightly faster rate (71 percent). During this same period, the share of enrollees enrolled in a plan with a deductible and the average single deductible amount substantially increased.
- While nearly all larger firms offered ESI in 2012—99.5 percent of employers with 1,000 or more employees and 94.1 percent of those with 100–999 employees—only 35 percent of small firms with fewer than 50 workers offered coverage to their employees. Small firms have lower offer rates than larger firms because of the additional costs and challenges they face. ESI offer rates declined from 2002 to 2012, with larger declines occurring among small employers. The ESI offer rate among the two larger firm categories changed by only 1 to 2 percentage points since 2002. However, the offer rate among firms with fewer than 50 employees dropped by 9.3

percentage points, from 44.5 in 2002 to 35.2 percent in 2012. Rates of employee take-up of coverage modestly declined during this same period as well.

- Increases in health insurance premiums can partially explain the declines in offer rates and, subsequently, the long-term decline in the availability of ESI. Similarly, most economic studies find that higher out-of-pocket premiums have a significant negative effect on take-up.

In the next section of this report, we describe the key components of the Affordable Care Act that affect employers and summarize studies that analyze the anticipated or early effects of the law on employers. These components include, but are not limited to, insurance market reforms, a requirement for large firms with 50 or more workers to provide affordable coverage to their workers or pay a penalty, smaller employer tax credits and benefit requirements, and the establishment of Small Business Health Options Program (SHOP) Marketplaces for purchase of small-group coverage. Overall, we find the following:

- Much of the literature on the effects of the Affordable Care Act on employers has focused on the question of whether employers that offered health insurance before the Affordable Care Act would stop offering coverage after its major provisions take effect.
- Most microsimulation models find that the Affordable Care Act will have modest effects on ESI coverage, with estimates ranging from a loss of 6 million to a gain of 13.6 million covered lives. Although microsimulation models find modest impacts on overall ESI coverage, they consistently find larger gains in overall coverage among small firms than among large firms.
- Most employers will continue to have an economic incentive to offer coverage under the Affordable Care Act, although firms with many low-wage workers may have a disincentive to offer. The largest firms will continue to have a strong positive economic incentive to offer coverage under the reform, while small firms with fewer than 50 employees might face significantly lower, but still positive, economic incentives to offer coverage.
- Among seven surveys from five organizations, with one exception, the percentage of firms reporting that they expect to stop offering employee health benefits because of the Affordable Care Act is in the single digits.
- The Affordable Care Act could increase incentives for small firms to self-insure in states that do not regulate stop-loss coverage, particularly those with employees at low risk of high medical expenses.

- The Affordable Care Act increases incentives to convert full-time workers to part-time status to avoid the employer mandate penalty. However, early evidence indicates that there has not been a shift toward part-time work because of the Affordable Care Act, and the ultimate impact of these incentives is likely to be small.
- Taken together, these results do not suggest a massive upheaval in employer-sponsored coverage under the Affordable Care Act as some have speculated. However, there are several gaps in the literature—particularly on how the Affordable Care Act will affect health care costs—where researchers and policy analysts need additional information to better understand the potential effects of the law on employers. Monitoring the effects of the Affordable Care Act on small firms should focus on areas where the expected impacts would be largest.

Monitoring the Impact of the Affordable Care Act on Employers

The Affordable Care Act has the potential to expand the availability of health insurance options and the responsibilities of employers and their workers, particularly small firms. In 2010, small and low-wage employers became eligible for tax credits to assist them in purchasing health insurance.¹ Starting in November 2014, all firms with fewer than 50 employees (fewer than 100 in 2016) will be able to purchase coverage online in newly established Small Business Health Options Program (SHOP) Marketplaces.² All plans offered in the Marketplaces have to conform to new rating restrictions, benefit standards, and actuarial value tiers established in the law; the same is true for new policies issued outside the Marketplaces in the small-group and individually purchased markets as of January 2014. Premiums are allowed to vary in these markets based on age, tobacco use, geography, and policy type (e.g., single, family). No premium rating based on gender, health status, claims history, industry, group size, duration of coverage, or other factors is permitted.

The Affordable Care Act also establishes new requirements for some employers to contribute to the cost of their employees' health insurance coverage. The requirements are intended to encourage employers to provide affordable coverage and thereby limit the cost of federal subsidies to assist individuals in purchasing insurance coverage independently. Small businesses with fewer than 50 workers are exempt from the new requirements, but those with 50 or more employees will need to comply or pay a fee. These requirements have been delayed until January 1, 2015, for employers with more than 100 workers and until January 1, 2016, for employers with 50 to 99 employees.

In addition to the elements of the law that are directly aimed at employers, the establishment of individual insurance exchanges (or Marketplaces), the availability of federal subsidies for low- to moderate-income individuals, the individual coverage requirement, and the Medicaid expansion will also affect firms and their workers. For example, by expanding coverage options for individuals, the law enables workers to work at smaller firms more readily, even if those businesses are not able to provide health insurance.

Our literature review covers recent trends in the employer-sponsored group health insurance market and the anticipated effects of the Affordable Care Act on employers, with a particular focus on the small-group market. This literature review aims to answer three main questions and is divided into the following sections:

- What are the trends in the employer health insurance market leading up to the Affordable Care Act? The purpose of this section is to provide a comprehensive picture of the employer market, to identify preexisting trends that could be incorrectly attributed to the ACA, and to review the applied economic literature to identify important factors in current employer and employee decisions regarding health coverage.
- What are the likely effects of the Affordable Care Act's provisions on various aspects of the employer market?
- What are the gaps in the literature?

In this paper, we first discuss our findings on each of these questions, including common themes and lessons learned. We conclude by summarizing key results and highlighting topics that are not sufficiently covered in the existing literature, as these gaps indicate where further research is needed.

Methods

In the trends section, we rely heavily on 2002–12 data from the Medical Expenditure Panel Survey–Insurance Component (MEPS-IC), an annual survey of nearly 40,000 establishments that includes information on employer-sponsored insurance (ESI) offerings in the United States (Agency for Healthcare Research and Quality [AHRQ] 2002–12).³ In the exhibits below, health insurance plans are defined by AHRQ as insurance contracts that provide hospital and/or physician coverage to an employee or retiree for an agreed-upon fee for a defined benefit period, usually a year. Given this study's focus on small firms, particularly those eligible for the SHOP Marketplaces, **we emphasize estimates for establishments with fewer than 50 workers.** The figures in this paper also include estimates for establishments with 100–999 employees and those with 1,000 or more employees. We are unable to provide estimates for establishments with 50–99 workers because of a data gap in the MEPS-IC tables.⁴ The figures we feature in this study are drawn from a literature review conducted by Buettgens and colleagues (2013) on ESI at midsize firms before the Affordable Care Act.

We searched the most relevant peer-reviewed and gray literature. We included articles that represent a range of study designs, publication types, and settings. To find the most recent white papers and gray literature, we searched websites for the National Association of Insurance Commissioners, private-sector organizations such as consulting firms, state and federal agencies, foundations, advocacy groups, and academic and research organizations (e.g., the Robert Wood Johnson Foundation, the

Kaiser Family Foundation, and The Commonwealth Fund). Staff at the Urban Institute have also published several related literature reviews, such as Buettgens and colleagues (2013) and Garrett and Chernew (2008), which provide a core of key studies on the drivers of employer behavior. We also searched online databases (e.g., Google Scholar) to update the reference list to include more recent publications.

Trends

Employer-Sponsored Insurance

Before the Affordable Care Act, most adults and children had health coverage through an employer, even though employers were not required to provide health insurance: In 2011–12, 56 percent of the nonelderly population were covered by ESI, 6 percent were covered by other private insurance, 18 percent were covered by Medicaid or the Children’s Health Insurance Program (CHIP), 3 percent were covered by other public coverage, and 18 percent were uninsured.⁵ There are three major economic explanations as to why employers provide coverage to their workers (Buchmueller, Carey, and Levy 2013):

- Employers have a comparative advantage in providing health insurance. ESI premiums are not subject to federal or state income taxes or the Medicare or Social Security payroll tax. This subsidy reduces the cost of insurance by roughly one-third for workers in the 15 percent tax bracket, and the discount is even larger for higher-income workers.⁶ In addition, employers can mitigate adverse selection by serving as an effective risk pool of healthy and sick workers. Employers, particularly large firms, can also achieve economies of scale since large portions of administrative and marketing costs are fixed.
- Workers ultimately pay for health insurance through lower wages. Because these benefits are exempt from taxation, workers will find this tradeoff to be advantageous, especially if their marginal tax rate is high.
- Employers’ offerings of health insurance reflect worker preferences. Benefit offerings can arise through the collective choices and preferences of the existing set of workers in a firm or through the choices of employers seeking to balance these preferences.

Consistent with economic theory, there are various cross-sectional differences between the nonelderly populations with and without ESI. For example, in 2010, nonelderly individuals with family incomes above 400 percent of the federal poverty level (FPL) were more likely to have ESI (87.2 percent) than lower-income individuals in the 200–399 percent (70.7 percent) and under 200 percent of FPL (26.5 percent) income groups. Not surprisingly, the number of full-time workers in the health insurance unit (HIU)⁷ is positively associated with having ESI: 83.8 percent of individuals with two full-time workers in the HIU have ESI, compared with 64 percent of individuals with one full-time worker in the HIU, 29.5 percent of those with only part-time workers in the HIU, and 17.5 percent of those with only nonworkers in the HIU. In addition, nonelderly white non-Hispanics are more likely to have ESI (67.1 percent) than blacks (45.4 percent) and Hispanics (39.2 percent), and workers in large firms are more likely to have ESI than workers in small firms. There are also differences in ESI rates across regions, as individuals in the Northeast and Midwest are more likely to have ESI than those in the South and West (Holahan and Chen 2011).

Despite strong economic incentives for firms to offer coverage, ESI rates have decreased nearly every year since 2000, with the largest declines occurring during the 2001 and 2007–09 recessions. This trend persists among various subpopulations, including parents, childless adults, and children; income groups; regions; worker firm sizes; and racial and ethnic groups. For example, from 2000 to 2010, ESI coverage decreased by 10 percentage points among parents and adults without dependent children and by 12 percentage points among children. There was more pronounced deterioration among those with incomes below 400 percent of FPL, the income group most affected by key provisions of the Affordable Care Act (Blavin, Holahan, Kenney, and Chen 2012a, 2012b; Blavin, Holahan, Kenney, and McGrath 2012; Holahan and Chen 2012).

The decline in ESI was even more drastic among small-firm workers. The share of full-time workers and their dependents with employer-based coverage in the smallest firms fell from 43 percent in 2000 to 33 percent in 2010. Coverage for their counterparts working in firms of 1,000 or more employees fell from 87 percent to 82 percent over the same period. These differences are also reflected in substantially higher rates of uninsurance for small-firm workers and their families (Holahan and Chen 2012).

The rest of this section describes potential drivers behind the declines in ESI, focusing on premium trends, employee contributions, and cost sharing (e.g., deductibles); employer offer rates; and employee take-up of coverage.

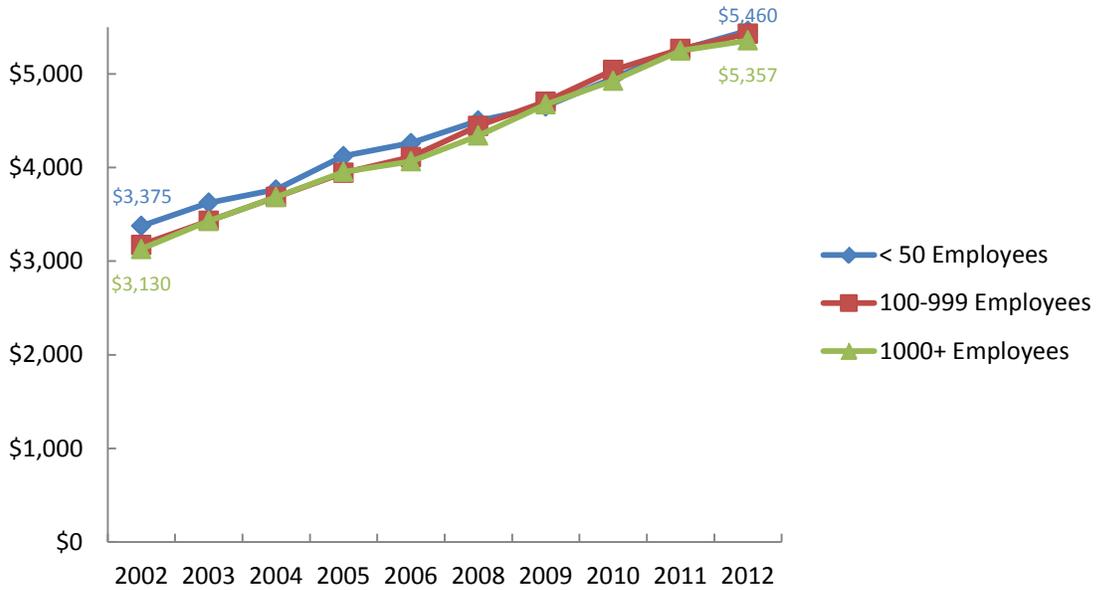
Premiums and Cost Sharing

National Health Expenditure Accounts (NHEA) data show that average annual per capita national health spending grew 5.9 percent per year from 1999 to 2009; growth slowed dramatically to 3.6 to 3.8 percent per year from 2009 to 2012 (Martin et al. 2014). The rise in health care spending can be attributed to a host of factors, such as the tax treatment of ESI, the development and dispersion of medical technology, the changing prevalence of chronic disease, and the consolidation of health care providers (Holahan et al. 2011). Several recent studies conclude that the recent slowdown in spending was partially due to the recession but also attributable to structural changes in health care that could persist as the economy recovers (Cutler and Sahni 2013; Holahan and McMorrow 2013; Ryu et al. 2013).

MEPS-IC data document an increase in premiums for employer-based coverage between 2002 and 2012 at a rate that exceeds NHEA growth. Exhibit 1 shows that firms of all sizes saw a rise in single premium costs between 2002 and 2012. Among small firms with fewer than 50 workers, premium costs grew roughly 62 percent, from \$3,375 in 2002 to \$5,460 in 2012, at an average annual rate of nearly 7 percent. As illustrated in exhibit 2, family premiums among small firms rose at a faster rate than single premiums, increasing from \$8,502 in 2002 to \$14,496 in 2012 (71 percent). Exhibit 2 also shows that family premiums at smaller firms grew at a slower rate in 2008 and 2009 than at larger firms.

EXHIBIT 1

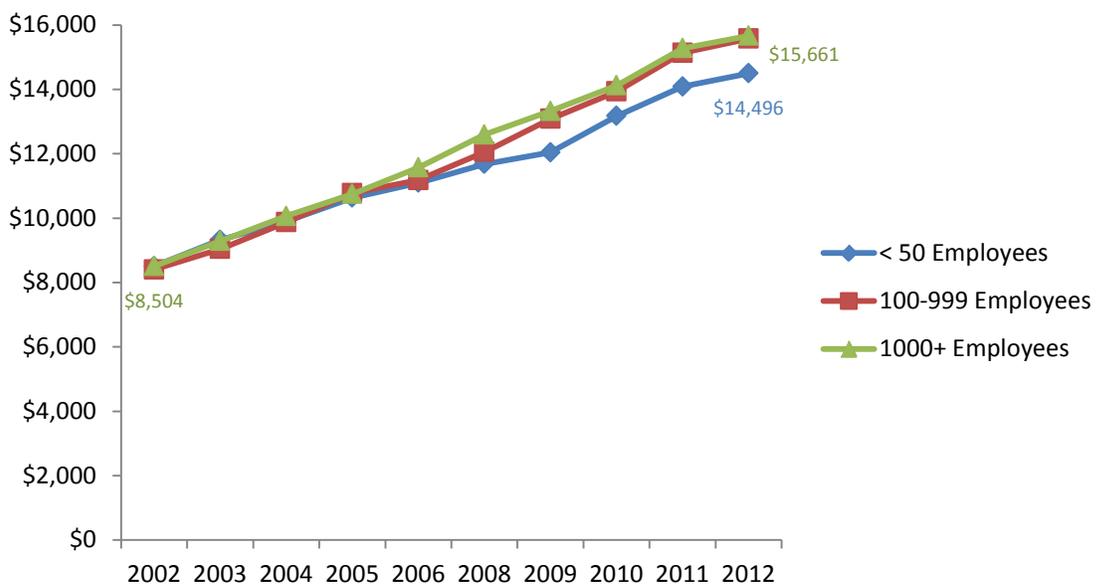
Average Total Single Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance by Firm Size, 2002–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

EXHIBIT 2

Average Total Family Premium per Enrolled Employee at Private-Sector Establishments Offering Health Insurance by Firm Size, 2002–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

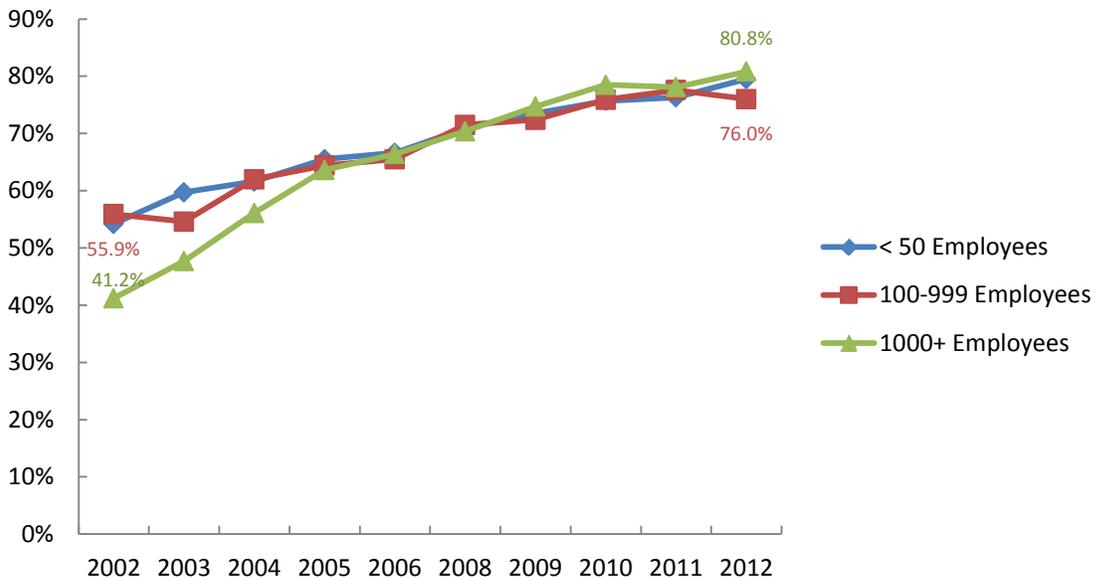
MEPS-IC data show that employee premium contribution rates vary across firm sizes and that the share of single and family premiums paid by employees at firms of all sizes has modestly increased over time (AHRQ 2002–12). In 2012, workers in small firms with fewer than 50 employees had a lower contribution rate to single premiums (17.9 percent) than workers at firms with 100–999 employees (20.7 percent) and 1,000 or more employees (21.9 percent). However, in 2012, the family contribution rate was higher among workers at small firms (30.1 percent) than at firms with 1,000 or more employees (25.7 percent). Employee contributions to family premiums across all firm sizes grew by an average of 1.8 percent a year from 2002 to 2012, a slightly higher growth rate than seen in contributions to single premiums. Among small firms, however, contributions to single premiums increased by 3.7 percentage points, from 14.2 percent in 2002 to 17.9 percent in 2012, and contributions to family premiums increased by 4.8 percentage points, from 25.3 percent to 30.1 percent (data not shown).

As employee premium contributions have grown, the prevalence of these contributions has also increased. Gruber and McKnight (2003) analyzed this trend from 1982 to 1998, during which time the percentage of employees with ESI whose insurance was fully financed by their employer fell from 44 to 28 percent. The authors attributed the drop, in part, to four factors: lower tax rates, increased eligibility for insurance through Medicaid, higher medical costs, and increased availability of managed care. In 2013, 14 percent of covered employees worked for firms that paid 100 percent of premiums for individual coverage, compared with 24 percent in 2002. The rates are lower for family coverage: In 2013, 5 percent of covered employees worked for firms that paid 100 percent of premiums for family coverage, compared with 9 percent in 2002 (Kaiser-HRET 2013).

Deductibles have also become a more regular feature of ESI. Overall, the share of employees enrolled in health insurance plans with deductibles grew by 32 percentage points, from 47.6 in 2002 to 79.6 in 2012 (data not shown). This percentage rose among firms of all sizes (exhibit 3). Exhibit 4 shows that average deductibles increased across all firm size categories. Among small employers, the average individual deductible more than doubled, from \$602 in 2002 to \$1,628 in 2012. While the share of plans with a deductible is roughly the same across firm sizes, exhibit 4 shows that the smaller the firm, the larger the average single deductible. For example, the average individual deductible among workers in firms with fewer than 50 workers was \$1,628 in 2012, nearly twice that of workers in the largest firm size group (\$881).

EXHIBIT 3

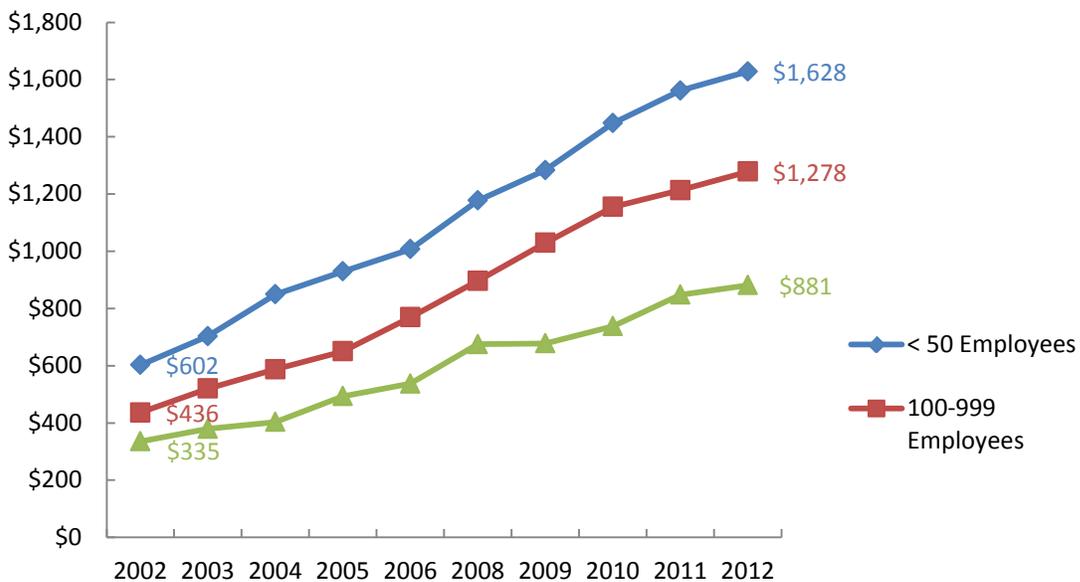
Percentage of Private-Sector Employees Enrolled in Health Insurance Plans with Deductibles by Firm Size, 2002–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

EXHIBIT 4

Average Individual Deductible per Employee enrolled with Single Coverage in Health Insurance Plans at Private-Sector Establishments by Firm Size, 2002–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

Decision to Offer Insurance

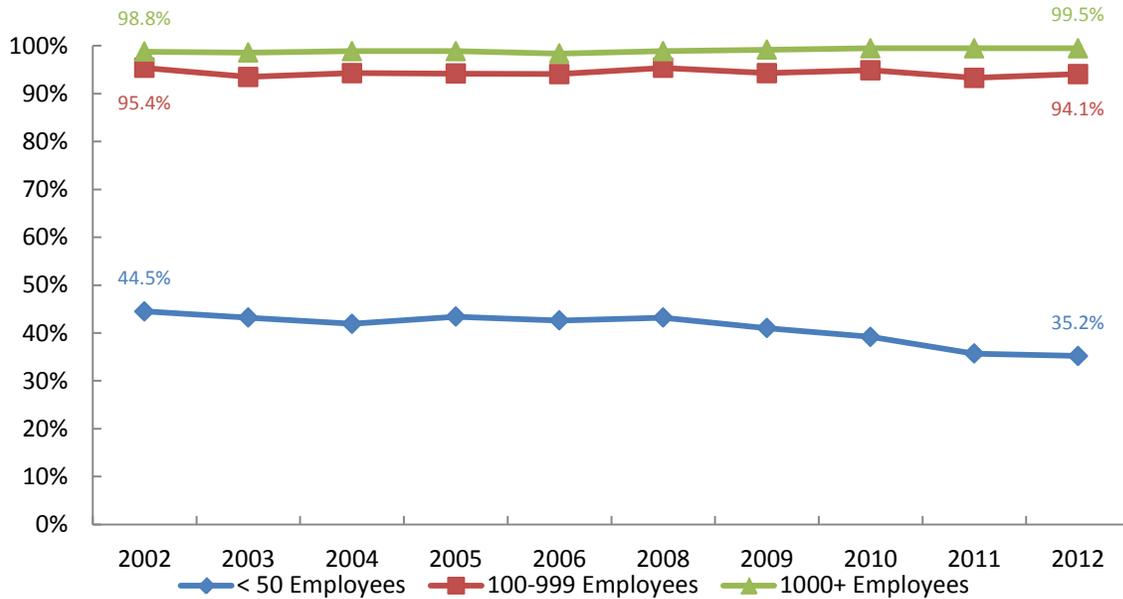
Offer rates among all employers fell from 57.2 percent in 2002 to 50.1 percent in 2012 (data not shown). While nearly all larger firms offered ESI in 2012—99.5 percent of employers with 1,000 or more employees and 94.1 percent of those with 100–999 employees—only 35.2 percent of small firms offered coverage to their employees (exhibit 5).

ESI offer rates declined from 2002 to 2012, with the largest declines occurring among small employers. ESI offer rate among the two larger firm categories changed by only 1 to 2 percentage points between 2002 and 2012. However, the offer rate among firms with fewer than 50 employees dropped by 9.3 percentage points, from 44.5 percent in 2002 to 35.2 percent in 2012.

Additionally, MEPS-IC data show that offer rates are lower and more volatile among even smaller employers (AHRQ 2002–12). Offer rates among firms with fewer than 10 employees decreased from 36.8 percent in 2002 to 28.2 percent in 2012 (an 8.6 percentage-point drop, signifying a 23 percent relative decline), while offer rates among those with 10 to 24 workers decreased from 67.8 percent in 2002 to 57.9 percent in 2012 (a 9.9 percentage-point decrease, and a 15 percent relative decline). Offer rates among small firms with 50 percent or more low-wage employees are even lower, as discussed in the subsection below on the employer decision to offer coverage.

EXHIBIT 5

Percentage of Private-Sector Establishments Offering Health Insurance by Firm Size, 2002-12



Source: Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) summary tables, AHRQ 2002-12.

These estimates highlight the fact that a growing share of firms did not offer health insurance leading up to the Affordable Care Act, particularly small firms facing a higher unit cost for a particular level of coverage. Economic models show that the determination of benefit offerings can arise through the collective choice and preferences of workers or through the choice of employers, whose goal is to minimize total labor costs (Goldstein and Pauly 1976). Empirical studies that focus on the nonprice correlates of firms' offer decisions find that large firms, firms employing high-wage workers, unionized firms, firms in the manufacturing sector, and public-sector employers are more likely to offer health insurance than other firms (Glied and Graff Zivin 2004; Gruber and Lettau 2004). These findings are consistent with MEPS-IC data, which consistently show that among small firms, those with higher average wages are more than twice as likely to provide health insurance for their workers than those with lower wages (Gabel 1999). For example, in 2012, 45.6 percent of small firms (fewer than 50 workers) with higher average wages offered health insurance, compared with just 17.6 percent of small firms with lower average wages. Declines in offers were also larger among low-wage employers. For example, the offer rate among low-wage employers with fewer than 50 employees declined from 27.2 percent in 2002 to 17.6 percent in 2012 (a 35.5 percent decline), whereas the offer rate among small firms with high-wage employees declined by 18.1 percent, from 55.7 percent in 2002 to 45.6 percent in 2012.

Small firms are at an additional disadvantage for providing health insurance coverage because of the lower wages their workers earn, on average.⁸ Employers cannot offer coverage if they cannot pass the costs back to their workers in the form of reduced wages. Workers with wages near the minimum wage cannot have their wages reduced to offset health insurance costs, and some workers may find the wage tradeoff undesirable because of the low value of the tax exemption for them and the need to spend their low incomes on other goods they consider to be greater necessities. If workers find the tradeoff undesirable, firms won't offer health insurance coverage.

Increasing health insurance premiums can be an important factor in firms' decisions to offer coverage and, subsequently, the long-term decline in the availability of ESI. Several studies have analyzed the price elasticity (sensitivity) of firm offer decisions and have produced a wide range of estimates, ranging from a high of -5.8 (Feldman et al. 1989) to a low of -0.07 (Thorpe et al. 1992), depending on how the price of health insurance is measured and how premiums are imputed for firms that do not offer coverage (Glied and Graff Zivin 2004).

One of these studies, Gruber and Lettau (2004), has several methodological advantages over other papers that estimate the price elasticity of insurance offerings.⁹ The study uses microdata from the 1983–95 Bureau of Labor Statistics' Employment Cost Index—matched with worker characteristics from the Current Population Survey (CPS) and family taxes from the Statistics of Income—and data on ESI tax subsidies as an exogenous measure of the after-tax price of insurance to estimate the effect of prices on firms' decisions to offer health insurance. Overall, Gruber and Lettau obtain central estimates of the elasticity of firm offerings of about -.25, with small firms particularly responsive to taxes in their offering decisions. This estimate corresponds to a decline in ESI offerings by almost 10 percent under policy proposals that would completely remove the income tax subsidy to insurance.

Small firms have lower offer rates than larger firms because of the additional costs and challenges that smaller firms face. The administrative costs to insurers of providing coverage are largely fixed, and thus lead to higher burdens on small firms, where those costs are spread across fewer enrollees (Blumberg and Nichols 2004; Congressional Research Service 1988). This follows directly from the law of large numbers—the larger the group over which risk is spread, the more stable medical costs are likely to be over time. Small firms also pay more for the same health insurance coverage, endure more premium volatility, and are forced to change insurers more often than larger groups (Cutler 1994). Before the Affordable Care Act, most states allowed insurers to adjust small-firm group premiums to reflect the health status of the enrollees as well as other risk factors, including age and industry.¹⁰ Small firms seeking to offer insurance coverage could face higher costs of searching for, comparing, and

choosing plans—a time-consuming and therefore costly task. Most small firms do not have a dedicated staff for such tasks, making this burden particularly onerous.

Employee Take-Up of Insurance

As shown in exhibit 6, the share of employees enrolling in ESI when it is offered has declined over time. Across all firms offering employer-based coverage, the percentage of employees enrolled in health insurance fell by 3.5 percentage points, from 62.4 percent in 2002 to 58.9 percent in 2012. Workers at firms with fewer than 50 employees mirrored this trend: 61.3 percent of employees offered coverage were enrolled in 2002, dropping by 3.6 percentage points to 57.7 percent in 2012.

In addition, across all firms, about three-quarters of workers in firms that offer coverage are eligible to enroll in that coverage, a share that has remained essentially unchanged over the past decade (MEPS-IC data not shown). During the same period, the share of establishments that employed 50 percent or more full-time employees decreased by about 4 percentage points, from 80 percent in 2002 to 76 percent in 2012. This decline did not vary across firm size, even though small firms are less likely to employ full-time workers than large firms (data not shown).

The results in exhibit 6 underscore the importance of considering the factors faced by workers and their families that affect their decision to enroll in ESI. Most studies find higher employee premium contributions have a statistically significant effect on take-up. Most of these studies use the linked Household Component (HC)–Insurance Component (IC) of the MEPS (Abraham and Feldman 2010; Blumberg, Nichols, and Banthin 2001) or the MEPS-IC alone (Cooper and Vistnes 2003) and apply a wide range of econometric tools to address potential omitted variables or selection biases. Despite using different years of data and methods, these studies consistently find higher employee premium contributions associated with a lower rate of ESI take-up (although fairly small in magnitude), with lower-income workers being more price sensitive than higher-income workers.

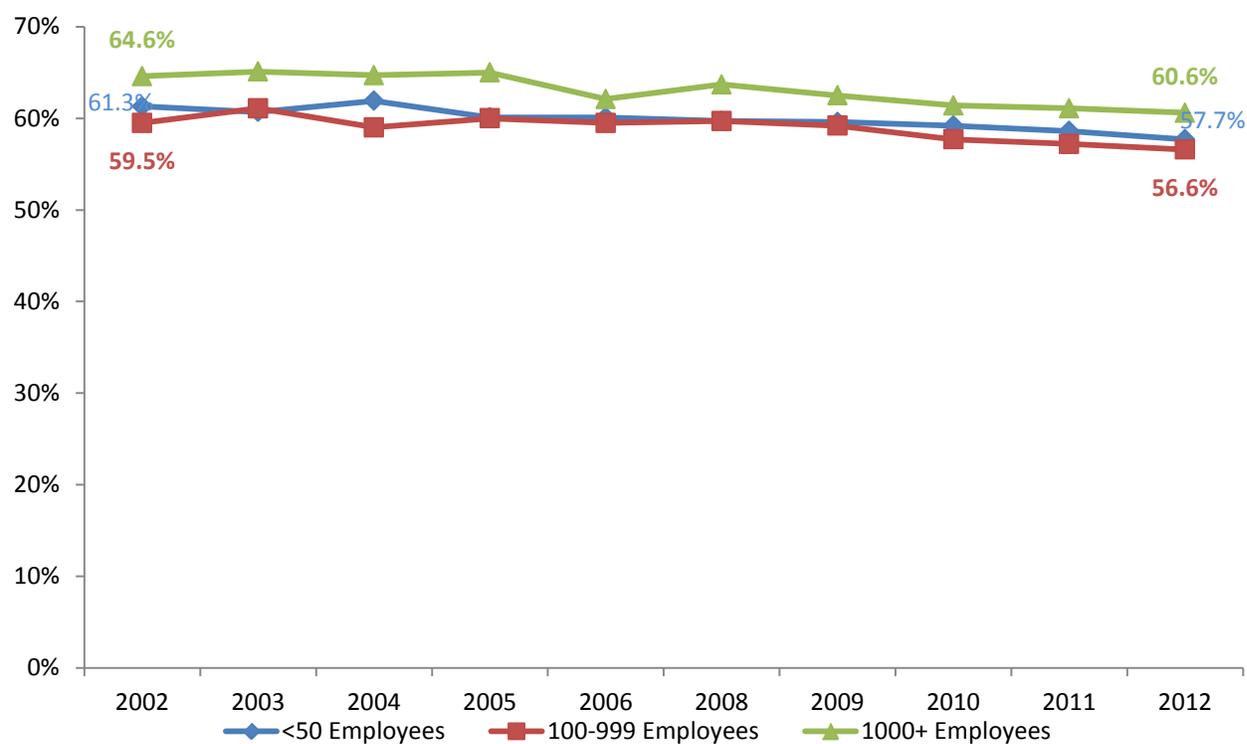
Studies that use other data sources yield similar results. Cutler (2003) finds that most of the decline in take-up during the 1990s was in response to higher premium contributions, noting an observed 3.6 percentage-point decline in take-up rates between 1988 and 1999. Using CPS survey data and premium data from the Kaiser Family Foundation and Health Research and Educational Trust’s employer health insurance survey (Kaiser-HRET), Cutler estimates that 75 percent of the 3.6 percentage-point decline in take-up rate was due to increases in employee premium contributions. Using data from the National Survey of America’s Families (NSAF), Shen and Long (2006) find that the drop in ESI take-up from 1999

to 2002 was driven largely by rising ESI premiums. Polsky and colleagues (2005) impute premiums on the Community Tracking Survey and also find that higher premiums lead to lower take-up of coverage for both single and married workers, although this decline is smaller than previous estimates.

Several nonprice factors also affect take-up. For example, older workers in one-person households are more likely to enroll in ESI than younger workers (Abraham and Feldman 2010), as are workers with worse health statuses (Abraham and Feldman 2010; Blumberg, Nichols, and Banthin 2001). The probability of ESI enrollment is also significantly lower when a child in the household is eligible for Medicaid or CHIP.

EXHIBIT 6

Percentage of Private-Sector Employees Enrolled in Health Insurance at Establishments Offering Health Insurance by Firm Size, 2002–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

Other Notable Trends

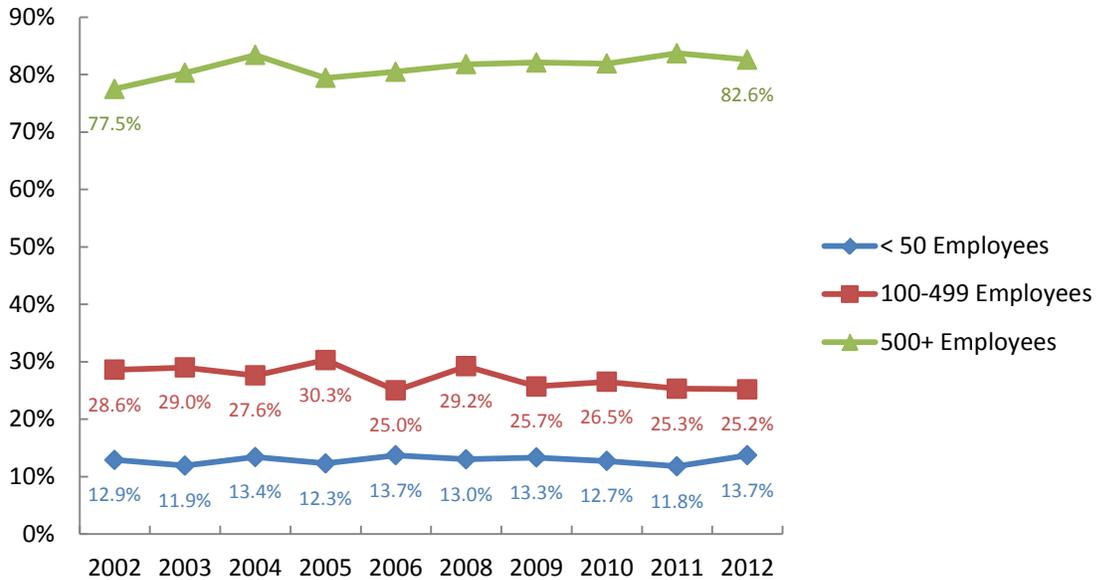
Self-Insurance

Self-insured health plans are those in which an employer takes on some or all of the financial risk of providing a defined set of health care benefits to employees and dependents. A self-insuring employer pays directly for the claims incurred by the plan's enrollees, as opposed to paying a set premium to an insurance company. Employers with self-insured plans usually purchase stop-loss coverage from a reinsurer who agrees to bear the risk for those expenses exceeding a predetermined dollar amount. Some self-insured employers contract with insurance companies or third-party administrators for claims processing and other administrative services (AHRQ 2002–12; Buettgens and Blumberg 2012).

Exhibit 7 shows that larger firms are more likely to offer self-insured plans than smaller firms.¹¹ In 2012, 82.6 percent of firms with 500 or more employees offered a self-insured plan, whereas just 25.2 percent of firms with 100–499 workers and 13.7 percent of firms with fewer than 50 workers did so. Exhibit 7 also shows that the percentage of large firms offering a self-insured plan increased from 2002 to 2012. The share of establishments with 500 or more employees offering a self-insured plan rose from 77.5 percent in 2002 to 82.6 percent in 2012 (5.1 percentage points).¹² In contrast, among those with 100–499 employees, the share offering a self-insured plan dropped from 28.6 percent in 2002 to 25.2 percent in 2012 (3.4 percentage points); the share among establishments with fewer than 50 workers slightly increased by 0.8 percentage points during the same period.

EXHIBIT 7

Percentage of Private-Sector Establishments Offering At Least One Self-Insured Health Plan by Firm Size, 2002–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

Data from Kaiser-HRET (2013) also show a higher prevalence of self-insurance among larger firms. In 2013, 83 percent of covered workers at firms with more than 200 employees were in partially or completely self-funded plans. At firms with 3–199 employees, just 16 percent were in these plans. In addition, firms with 5,000 or more employees had a higher share of employees in partially or fully self-funded plans than firms with 1,000–4,999 employees—94 percent and 79 percent, respectively.

There are several traditional arguments for why employers choose to self-insure, as outlined by Feldman (2012). First, employers can avoid state regulations, such as mandated benefits and premium taxes, by sponsoring self-insured plans. Second, not paying premiums to an insurer allows employers to keep interest earnings on reserves and avoid other costs, such as broker fees and profit and contingency expenses. Self-funding is more common among larger employers than smaller employers since larger employers usually have more resources and can spread the risk of high claims across a larger pool of people. However, large and small employers that self-insure and purchase a stop-loss policy require access to a provider network, claims processing, and other administrative services required to properly administer a health plan (Lucia, Monahan, and Corlette 2013).

Feldman (2012) argues that these reasons alone cannot explain the growing share of employers that have begun self-insuring. Alternatively, Feldman argues that employer moral hazard—where fully

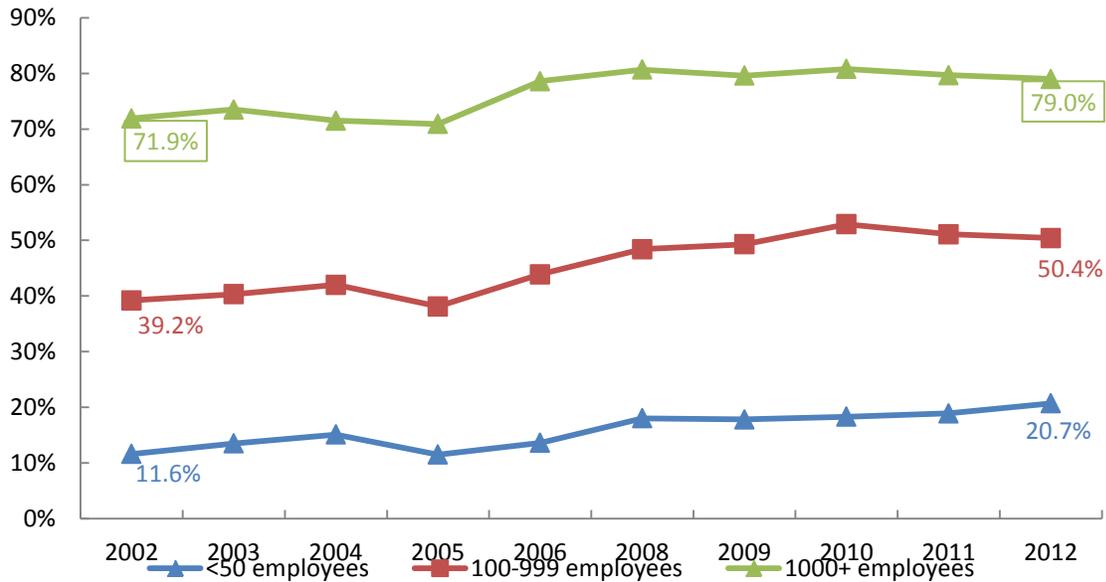
insured employers underinvest in programs that reduce health risks because of lack of experience rating in group health insurance underwriting—can pull employers toward self-insurance. In contrast, administrator moral hazard—where the plan administrator of a self-insured employer has no financial incentive to minimize the cost of covered medical claims—is likely to pull employers toward purchasing coverage. Feldman concludes that increasing the availability of health risk assessment tools can allow employers, particularly large firms that have the necessary resources, to better negotiate premiums and reduce administrator moral hazard. This trend goes hand in hand with the spread of self-insurance.

Employee Plan Choice

Exhibit 8 shows that the larger the firm, the more likely it is to offer employees a choice of plans. In 2012, 79.0 percent of firms with more than 1,000 employees offered two or more plans, while 50.4 percent of firms with 100–999 employees and 20.7 percent of small firms offered a choice. However, the share of firms offering a choice of plans substantially increased among all firm size categories from 2002 to 2012; the share of firms with fewer than 50 workers offering a choice rose by 78.4 percent (11.6 to 20.7 percent), compared with increases of 28.6 percent (39.2 to 50.4 percent) and 9.9 percent (71.9 to 79.0 percent) among firms with 100–999 and 1,000 or more workers, respectively. While the MEPS-IC data do not differentiate the type of plan choice offered (e.g., multiple plans from a single carrier versus plans from multiple carriers versus self-funded and fully insured plans), it is important to note that the SHOP, when fully implemented, will give choice options for the first time across multiple carriers for small firms.

EXHIBIT 8

Percentage of Private-Sector Establishments Offering Two or More Health Insurance Plans by Firm Size, 2000–12



Source: Medical Expenditure Panel Survey–Insurance Component (MEPS-IC) summary tables, AHRQ 2002–12.

Some employers offer plan choice to take into account the diverse set of preferences among their workers, allowing employees to pick plans with characteristics they value. Bundorf (2010) finds employers that offer plan choice have lower average premiums—due to the availability of less generous plans—and higher coverage rates, a finding consistent with this theory. Steinberg-Shone and Cooper (2001) find higher levels of coverage take-up and health care satisfaction among workers at firms offering choice, after controlling for basic demographic and employment characteristics. In addition, Moran, Chernew, and Hirth (2001) and Bundorf (2002) find that employee characteristics affect the likelihood that employers offer a choice of plans. Using an ordered probit model of plan offerings, Moran and colleagues (2001) find greater plan choice among firms with more diverse workers in terms of age and income. Bundorf (2002) finds that average plan generosity is higher in firms with a larger share of high-wage workers and that variation in employees’ health risk and wages is positively associated with the probability that an employer offers plan choice.

Employers must weigh the benefits of plan choices with the additional administrative costs of offering several plans. Moran and colleagues (2001) and Bundorf (2002) find that the diversity of plan

offerings is positively associated with firm and establishment size, as larger firms can spread fixed administrative costs over more employees and thus would find plan choice less prohibitive. For example, moving from a firm with 11 to 25 employees to one with 101 to 500 employees results in a 139.8 percent increase in the relative probability of being offered more than one plan (Moran, Chernew, and Hirth 2001).

Moving forward under the Affordable Care Act, health insurance exchanges could dramatically expand the scope of plan choice and the number of competing plans available. Since employer coverage options in the Affordable Care Act Marketplaces are limited to small firms at least until 2017, private health insurance exchanges provide another option for firms looking to provide more options and lower costs through competition. These private exchanges would make it possible for employers of any size to provide health benefits by making defined contributions to workers, who would then choose their own health plans. The potential benefits of private exchanges include greater certainty about and control over health benefit costs, reductions in benefit and administrative costs, greater transparency about total compensation to workers, and higher employee satisfaction with benefits (Fronstin 2012).

However, there are several concerns related to how private exchanges could affect employer decisionmaking. For example, employers would need to take into account worker preferences for traditional employer-sponsored health benefits versus defined contributions. An employer must also become familiar with private exchanges and decide how much choice to offer and how to educate workers to choose among plans. Fronstin (2012), Kapur and colleagues (2012), Kapur and colleagues (2013), Shutan (2013), and Sperling (2012) further discuss these issues.

Affordable Care Act Provisions That Affect Employers

Several components of the Affordable Care Act are likely to affect employers' health insurance options, responsibilities, and decisions.¹³ Some of the law's anticipated effects are ramifications of new incentives and policies designed specifically to meet particular goals in the employer marketplace. Other effects may be unintended or secondary effects of changes intended to meet different objectives. The implications of the reforms will vary, however, depending upon employer size. While understanding the extent of changes to employers of all sizes is valuable, a focus on small employers is particularly important, as the Affordable Care Act changes the insurance environment for them the most.

Affordable Care Act Provisions Affecting Employers of All Sizes

Several provisions of the Affordable Care Act that reform insurance markets have been in place for a few years already. These early provisions prohibit or constrain certain prior insurer practices that place limits on health insurance coverage. The goal of these reforms is to reduce the financial risks consumers face when they obtain coverage in both individual and group markets, regardless of employer size. These provisions include prohibitions of dollar caps on lifetime benefits or unreasonable dollars caps on annual benefits, rescissions of coverage, and waiting periods (or delays in the start of coverage) of more than 90 days.

Other provisions expand access to coverage. Starting in 2010, dependent coverage was extended to adult children up to age 26, a reform that has already produced an increase in coverage (Antwi, Moriya, and Simon 2012; Cantor et al. 2012; Sommers and Schwartz 2011). Provisions that eliminate preexisting condition exclusions for children and require coverage of a specified set of preventive services without cost sharing already affected many consumers before the start of 2014 (Clemans-Cope et. al 2014). Altogether these provisions were expected to increase insurance premiums by less than 5 percent (Blumberg 2010; Blumberg et al. 2012b; Carlson 2011). At the beginning of 2014, the Affordable Care Act fully eliminated dollar caps on annual benefits and preexisting condition exclusions for adults.

The Affordable Care Act also requires premium monitoring (rate review) at the state and federal levels and mandates all plans in all markets to report their medical loss ratios (MLRs)—the proportion of premium dollars spent on clinical services, quality, and other costs. Rebates to enrollees are provided when the proportion spent on clinical services and quality is below 85 percent for plans in the large-group market and below 80 percent for plans in the small-group and individual markets. Together, premium monitoring and MLR rules are expected to help constrain premium growth, particularly in less competitive health insurance markets.

Affordable Care Act Provisions Affecting Larger Employers

For employers with more than 100 employees, the Affordable Care Act establishes no requirements on the benefits that employers must provide beyond the market reforms listed in the previous section.¹⁴ But the Affordable Care Act does institute penalties on larger employers that do not offer workers coverage that is deemed affordable.

Employers with 50 or more employees will face penalties if they do not offer adequate, affordable coverage and if at least one of their full-time employees receives a subsidy for the purchase of nongroup coverage in a health care Marketplace. Originally slated to begin in 2014 but now delayed, these penalties are often referred to as the employer mandate or the employer responsibility requirement and are intended to encourage employers to provide affordable coverage, thereby limiting the cost of federal subsidies (tax credits) to assist individuals in purchasing insurance nongroup coverage in the Marketplace.

Individuals with incomes that fall between 138 percent and 400 percent of FPL are eligible for subsidies that lower the cost of purchasing nongroup coverage. But employees that are offered employer coverage are only eligible for subsidized coverage in the exchanges if the employee's share of the lowest cost premium for individual coverage exceeds 9.5 percent of his or her income or if, on average, the plan reimburses less than 60 percent of covered expenses—conditions designed to protect most employers offering coverage from penalties.

For an employer that does not offer coverage, if at least one full-time employee receives a subsidy in the Marketplace, the employer is subject to a penalty of \$2,000 per full-time worker minus the first 30 workers. For an employer that does offer coverage, if a full-time employee receives a subsidy in the Marketplace, the employer is subject to a penalty 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.

Affordable Care Act Provisions Affecting Smaller Employers

SMALL-EMPLOYER TAX CREDITS

Small employers with fewer than 50 full-time employees are exempt from the coverage mandate. Certain small businesses are eligible for tax credits to help them purchase health insurance. The credits became available in 2010, and only the smallest and lowest-wage employers are eligible. The maximum size of the credit increased in 2014, and credits are now available to eligible employers for up to two consecutive years.

Small employers with 25 or fewer employees with an average pay of \$50,000 or less are eligible for tax credits to help cover health insurance coverage premiums. Eligibility for the full credit is limited to firms with 10 or fewer employees with average wages of \$25,000 or less. The credit phases down for larger small firms and firms with higher average wages, up to the 25 workers, \$50,000 average pay limits. The IRS estimates that 4 million businesses are eligible to receive a substantial tax reduction for

offering ESI. Others have noted that administrative hassles and the fact that the subsidies only last two years severely decrease the number of employers taking advantage of this benefit, and that participation has been very low (GAO 2012; Jost 2013). Gabel and colleagues (2013) find that among small firms that were aware of the tax credit, 61 percent determined whether they were eligible.

BENEFIT REQUIREMENTS

Fully insured, non-grandfathered plans for small businesses and individuals are required to provide essential health benefits as delineated in the law and as consistent with benchmark plans chosen by the states as of 2014. These plans must fit into actuarial value tiers and satisfy maximum cost-sharing limits.

The Affordable Care Act establishes benefit requirements for newly issued, fully insured health plans offered by small firms and in the nongroup market. These requirements apply to firms having 50 or fewer workers as of 2014, and apply to firms of 100 or fewer workers beginning in 2016. Small employers are required to offer plans that cover the essential health benefits established by the Department of Health and Human Services (DHHS). DHHS (2013) provided states with the option to select a benchmark plan from a set of choices: 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. States opting not to choose a benchmark plan were assigned their state's most enrolled small-group plan as their benchmark. Benchmark plans that did not include some of the categories of benefits specified in the language of the Affordable Care Act were adjusted to do so. The regulations also provide some flexibility for carriers to substitute benefits within categories, although the substitutions must maintain actuarial equivalence. Corlette, Lucia, and Levin (2013) report that 19 states and the District of Columbia chose one of the three largest small-group plans, and 26 states defaulted to the state's most enrolled small-group plan, as their benchmark plan.

These requirements will increase the adequacy of some coverage offerings in these markets and will make cost comparisons across options more feasible than in many of today's markets. Blumberg and colleagues (2012) suggest that the benefit requirements are unlikely to impose significant new costs on small businesses. Increased benefit requirements under the Affordable Care Act are substantially more significant in the nongroup market than in the small-group markets.

RATING REQUIREMENTS

The Affordable Care Act significantly changes rating requirements for coverage in the small-group market. Premiums now can only vary by geographic area, age, and tobacco use. 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 of nonusers of the same age for identical coverage.

SHOP MARKETPLACES FOR PURCHASE OF SMALL-GROUP COVERAGE

Starting in 2014, all firms with 50 or fewer employees (100 or fewer in 2016) became eligible to purchase coverage in the newly established SHOP exchanges, in addition to the option of purchasing coverage in the reformed small-group market outside the Marketplaces. The SHOP exchange option is expected to reduce administrative costs and promote transparency and competition in the small-group market. Historically, administrative costs, relative to claims, have been higher for small firms than large firms. By centralizing market functions, SHOP Marketplaces are expected to reduce the costs of buying insurance for small employers. Improved price transparency and the ability to comparison-shop can make it easier for small employers to get coverage at good prices. Employee choice options will enhance employees' ability to choose plans that are appropriate for their needs. The Affordable Care Act provides several employer/employee choice options as detailed by Blumberg and Rifkin (2013a), ranging from full employee choice (employee may choose any plan at any tier level) to full employer choice (employer selects a qualified plan at a specified coverage level), with additional intermediate options.

HEALTH INSURANCE MARKETPLACES FOR INDIVIDUAL COVERAGE, MEDICAID, AND THE INDIVIDUAL MANDATE

In addition to the elements of the law that are directly aimed at employers, the establishment of individual insurance Marketplaces, the availability of federal subsidies for low- to moderate-income individuals, the individual coverage requirement, and the Medicaid expansion will also affect employers and their workers, especially small firms. Expanding coverage options for individuals enables workers to work at smaller firms more readily, even if those businesses are not able to provide health insurance. At the same time, improved availability of coverage outside of employment relationships, particularly when subsidized, could reduce firms' incentives to offer health insurance to their employees. Medicaid expansion could reduce the total health care costs of firms that offer affordable coverage to the rest of their workers, but it also could reduce overall workforce demand for health insurance in firms with many eligible workers. At the same time, the individual mandate will tend to boost demand for employer-sponsored coverage among workers, particularly higher-income workers whose preferences may carry more weight in employers' decisions to offer.

Evidence on the Likely Impacts of the Affordable Care Act on Employers

Much of the literature on the effects of the Affordable Care Act on employers has focused on the question of whether employers that offered health insurance before the Affordable Care Act would stop offering coverage after its major provisions take effect. Evidence on this question comes from microsimulation models of the law's effects, studies that compute the size of incentives created by certain provisions, actuarial estimates, surveys of employer attitudes and intentions, and experiences in Massachusetts after the state enacted health reform.

Microsimulation Model Estimates of Effects of the Affordable Care Act on ESI Coverage

Microsimulation models seek to estimate the impacts of reforms on ESI offer decisions and ESI coverage. They use detailed information on the characteristics of employers, workers, and families; detailed modeling of the key provisions of the Affordable Care Act and how these provisions affect the cost and availability of different types of coverage; and behavioral assumptions regarding the decisions of employers and individuals, based on empirical studies from the economic literature. Where evidence from the literature is lacking, researchers make assumptions based upon the best available information and economic theory.

Though there are notable differences, all published microsimulation models suggest the overall effects of the Affordable Care Act on ESI coverage will be modest (exhibit 9). In its most recent estimates, the Congressional Budget Office (CBO) predicts a decline in overall ESI coverage of 6 million people (CBO 2014). This represents a modest reduction of 3.7 percent relative to CBO's forecast that 161 million people would have ESI coverage in 2016 without the law. The RAND model estimates that the Affordable Care Act would, on net, increase ESI coverage by 8 million people relative to a no-reform scenario. Other models (e.g., the Lewin Group and the Urban Institute's Health Insurance Policy Simulation Model [HIPSM]) predict changes in overall ESI coverage within the range of the CBO and RAND estimates.

EXHIBIT 9

The Affordable Care Act’s Estimated Effects on ESI Coverage, from Microsimulation Models

Study	Estimated change in ESI coverage	Notes
CBO 2010	-3 million	Estimate for 2016. Relative to projected pre-reform baseline. Reduces ESI by 4 million in 2019.
CBO 2014	-6 million	Estimate for 2016. Relative to projection under prior law. Reduces ESI by 7 million in 2019.
Lewin Group 2010	-2.8 million	Estimates for 2011 as if law was fully implemented.
RAND Corporation (Eibner, Girosi, et al. 2010)	+8.0 million	Estimates for 2016 compared to projected no reform scenario.
Urban Institute (Buettgens, Garrett, Holahan 2010)	-0.5 million	Modeled law as if fully implemented in 2010.
Urban Institute (Blumberg, Buettgens, Feder, Holahan 2012)	+4.1 million	Modeled law as if fully implemented in 2012.

The RAND study presents additional details behind its overall numbers. The predicted increase in ESI coverage is primarily driven by many more small firms offering coverage, not by firms with 50 or more employees starting to offer coverage to avoid penalties. The predicted increase in offer rates in small firms is driven by increased demand for insurance due to the individual mandate. The RAND study predicts little change in premiums, with single premiums falling from an average \$5,754 without the Affordable Care Act to an average \$5,655 (1.7 percent) with the Affordable Care Act (in 2010 dollars).

The Urban Institute’s 2010 and 2012 HIPSM estimates both find that average costs per person with ESI fall for small firms in response to the Affordable Care Act. In the 2012 estimates, per capita premium contributions fell by 4.3 percent for firms with 100 or fewer employees because of long-term efficiencies created by the new SHOP Marketplaces. When employer tax credits are taken into account, total per capita employer spending falls by 7.3 percent (we note that these numbers do not reflect recent estimates of low take-up of employer tax credits, and should be viewed as potential savings until the numbers are updated). Only among midsize employers is there an increase in per capita spending (4.6 percent). The increase largely reflects penalty costs that fall on the roughly 5 percent of midsize firms in this group that do not offer coverage. McMorrow, Blumberg, and Buettgens (2011) find increases in offer rates and coverage for small-firm workers.

The Centers for Medicare and Medicaid Services' Office of the Actuary estimated that the Affordable Care Act would reduce employer-sponsored coverage by 1.4 million people (Department of Health and Human Services 2010). We did not include that estimate in exhibit 9, as the methodology used to produce the number was not provided.

Estimated Changes in Incentives for Employers to Offer Coverage under the Affordable Care Act

Although the microsimulation models typically calculate the economic incentives to employers (based on demand from workers) to offer coverage or not, with or without the Affordable Care Act, these calculations are an intermediate modeling step and generally not reported. Rather, microsimulation models report the resulting employer decisions that involve additional modeling steps. But the incentive calculations have value in themselves and yield useful insights into likely employer behavior.

Abraham, Graven, and Feldman (2012) conduct a detailed analysis of the economic incentives employers face to offer coverage before and after implementation of the Affordable Care Act. Their analysis is based largely on use of detailed (including nonpublic) MEPS-IC data, conducted at a research data center. Their calculations focus on three major policies that drive whether firms benefit financially, on net, from offering ESI. These policies are the tax exemptions for ESI premiums, which remain in place under the Affordable Care Act; the penalty on larger employers that do not offer affordable coverage; and the premium tax credits for individual coverage in the Marketplace for people with lower incomes.

The study finds that employers of the vast majority of workers currently offered ESI (81 percent) will continue to have an economic incentive to offer coverage under the Affordable Care Act. The largest firms will continue to have a strong positive economic incentive to offer (net incentive per worker of \$2,503 under the Affordable Care Act versus \$3,074 pre-reform) because the benefit of the ESI tax exclusion and penalties avoided by offering ESI substantially outweigh the value of the premium subsidies workers would receive if their employers did not offer ESI. Firms with fewer than 50 employees will face significantly lower economic incentives to offer coverage (\$990 under the Affordable Care Act versus \$2,490 pre-reform). But this calculation includes many small firms that already do not offer coverage. Small firms that already offer coverage and tend to have higher wages will still face (on average) a positive economic incentive to offer coverage under the Affordable Care Act. These findings suggest that most small firms that already offer ESI will continue to offer it, although the strength of this incentive will be reduced for many. Abraham, Graven, and Feldman (2012) also find that different types of firms will face different financial incentives under the Affordable Care Act. For

instance, the incentive to offer ESI rises under the Affordable Care Act in high-wage firms where the median worker makes \$26 an hour or more (to \$4,301 from \$3,884), but the incentive to offer ESI becomes a disincentive in low-wage firms in which the median worker earns less than \$11 an hour (a change to a \$704 disincentive from an incentive of \$1,827).

A study by the American Action Forum (Holtz-Eakin and Smith 2010) found that a worker with income at 200 percent of FPL could be better off with subsidized individual coverage in the Marketplace than with ESI. While this finding is debatable, the study's inference from this result was controversial: that 35 million workers would lose employer coverage and shift to Marketplaces, raising premium subsidy costs by \$1.4 trillion over 10 years. This study assumed that a worker with income at 200 percent of FPL works at a firm consisting only of workers with the same income, all of whom would equally benefit if the employer dropped coverage, paid the penalty, and shared the savings with the employees (Academy Health 2011).

Avalere (2011), Blumberg and colleagues (2012), Buchmueller and colleagues (2013), and Garrett and Buettgens (2011) address the flaws of this assumption and a number of additional reasons why the conclusion of the American Action Forum study is unwarranted. For example, most workers who have ESI (79 percent) have incomes above 250 percent of FPL. Firms would not have an incentive to drop coverage for these workers and would need to compensate them with higher wages if they did (Garrett and Buettgens 2011). Also, Holtz-Eakin and Smith only considered federal income taxes, but employer premium contributions are excluded from payroll taxes and state income taxes (if applicable) as well, which increases the value of ESI. They also modeled only family coverage, whereas most ESI policyholders with incomes under 250 percent of FPL have single coverage. Taking this into account would greatly reduce any savings from dropping ESI.

Colla, Dow, and Dube (2013) examined the effect of a pay-or-play employer mandate implemented in San Francisco in 2008 and found that under the mandate, more employers offered insurance and coverage increased relative to coverage among employers outside San Francisco not subject to the mandate.

Evidence from Massachusetts on Effects of Health Reform on ESI Coverage

In Massachusetts, which enacted health reforms similar to (and served as a model for) the Affordable Care Act, the rate of employer-sponsored coverage increased about 3 percent from fall 2006 to fall 2009, a period covering both the implementation of the state reforms and a 4.5 percentage-point rise in

the state unemployment rate (Long and Stockley 2010). The Massachusetts experience suggests that the combination of individual and employer mandates can increase ESI coverage, even when subsidized alternatives to ESI are introduced. In modeling reform options for Massachusetts, Blumberg and colleagues (2006) concluded that the individual mandate would increase ESI coverage. Gruber (2011) attributes the increase in employer coverage in Massachusetts after reform to the effects of the individual mandate. Employer penalties in Massachusetts are low and substitution of coverage in the Marketplace would tend to reduce employer-sponsored coverage, leaving the individual mandate as the likely cause of the increase in ESI following reform implementation.

After peaking in Massachusetts in 2008, ESI coverage (as measured by the CPS) declined at a rate consistent with the rest of the nation and with a group of states that experienced similar trends before Massachusetts's implementation of health reform. Therefore the decline cannot be attributed to health reform (Dubay, Long, and Lawton 2012).

Employer Attitudes about Continuing to Offer Health Benefits under the Affordable Care Act from Employer Surveys

Employer surveys provide a different perspective on likely employer responses to the Affordable Care Act. While they can capture aspects of real decisionmaking that microsimulation or other economic/financial models may miss, these surveys may also reveal trends in sentiment that can be volatile and unrelated to actual future business decisions or the Affordable Care Act. Among seven surveys from five organizations, with one exception, the percentage of firms expecting to stop offering employee health benefits because of the Affordable Care Act is in the single digits (exhibit 10). Among very large firms with 1,000 or more employees, 98 percent of respondents expected health benefits to remain an important component of their workers' compensation three to five years from now (Towers Watson/National Business Group on Health 2013). These survey findings are consistent with the economic theory explaining why employers offer coverage (see Blumberg et al. 2012a) and the microsimulation results in that they do not suggest a massive upheaval of employer-sponsored coverage as some have speculated.

The one exception to this finding is the McKinsey study by Singhal, Stueland, and Ungerman (2011). In that survey, 30 percent of respondents said their company would definitely (9 percent) or very likely (21 percent) drop coverage, with little variability in responses by firm size (28 percent of respondents in large firms said their company would definitely or very likely drop coverage). The respondents in the survey appear to have been drawn somewhat differently than in surveys administered to employers or

their representatives, in that they were self-screened from a broader panel of respondents as having influence over their companies' decisions regarding health benefits. It is unclear, however, what role sample differences play in explaining discrepancies with other surveys. The initial report garnered substantial reaction, particularly as its findings contrasted with those from other surveys and analyses (Freudenheim 2011). McKinsey released additional details regarding the survey methodology, including the full survey instrument, after the initial article was published: "The survey was not intended as a predictive economic analysis of the impact of the Affordable Care Act. . . . As such, our survey results are not comparable to the health care research and analysis conducted by others such as the Congressional Budget Office, RAND and the Urban Institute. Each of those studies employed economic modeling, not opinion surveys, and focused on the impact of health care reform on individuals, not employer attitudes."¹⁵

In the latest International Foundation of Employee Benefit Plans (IFEBP) and Mercer surveys (see exhibit 10), interest in dropping employer-sponsored coverage is less than what it was in the organizations' respective prior surveys. This may reflect an increased understanding that employers have gained over time of the potential financial and workforce effects of dropping coverage. According to the latest IFEBP survey from March 2013, 84 percent of employers were still studying the Affordable Care Act.

EXHIBIT 10

Employer Attitudes toward Dropping ESI Coverage

Survey	Description	Findings
Deloitte/Advanced Analytical Consulting Group (Brien and Panis 2012)	Survey (web-based) of 560 employers with 50 or more employees offering health benefits.	9 percent of large firms currently offering health insurance (representing 3 percent of workforce) anticipated dropping coverage in next three years.
IFEBP (Mrkvicka et al. 2012)	Survey of single employer plans in the organization's database. Responses received from 968 human resources and benefits professionals and industry experts.	5 percent of respondents were considering terminating health plan for active employees. 46 percent of employers said they would definitely offer coverage in 2014.
IFEBP (Mrkvicka et al. 2013)	March 2013 survey of single employer plans in the organization's database. Responses received from 966 human resources and benefits professionals and industry experts.	2 percent of respondents were considering terminating health plan for active employees. 69 percent of employers said they would definitely offer coverage in 2014. 84 percent of employers were still studying the ACA.

Survey	Description	Findings
McKinsey (Singhal, Stueland, and Ungerman 2011)	February 2011 survey of 1,329 individuals who indicated they had primary decisionmaking authority or influence over decisionmaking processes regarding employee benefits at their company.	30 percent of respondents who said that their companies offered ESI said they would definitely (9 percent) or very likely (21 percent) drop coverage.
Mercer (Watts and Gaertner 2013)	July 2012 survey of 1,215 employers of all sizes, industries, and geographic locations in the United States.	1 percent of respondents said they were very likely and 5 percent said they were likely to terminate medical plans after 2014 and have employees seek coverage in a state health insurance Marketplace, revealing less interest in dropping coverage than seen in Mercer surveys conducted in 2010 and 2011.
Towers Watson 2010	May 2010 survey of 650+ mid- to senior-level benefits professionals (96 percent represented firms with 500 or more employees).	3 percent of respondents said they would discontinue employer-sponsored health plans in 2011 or beyond; 22 percent did not know; 74 percent said they would not take that action.
Towers Watson/National Business Group on Health 2013	Survey of 583 employers with more than 1,000 employees.	98 percent of large firms (>1,000 employees) said they expected health benefits to be an important component of compensation three to five years from now.

Employer Choices Relating to Part-Time Work

The Affordable Care Act's employer responsibility requirement penalty applies to firms with 50 or more full-time equivalent employees. As noted earlier, penalties are triggered if at least one of a firm's full-time employees obtains subsidized insurance coverage through one of the nongroup health insurance Marketplaces. For the purpose of the Affordable Care Act, a full-time worker is defined as working 30 or more hours in a typical week. Employers who would otherwise be subject to a penalty could reduce or eliminate the penalty by converting full-time workers to part-time workers. In addition, there have been several well-publicized examples of large firms discontinuing the offering of (often limited) health plans to their part-time workers (e.g., Home Depot, Trader Joe's, and most recently Target) in order to make these workers eligible for subsidized Marketplace coverage without triggering penalties for the employers (Kaiser Health News 2014).

In the Mercer survey conducted in 2012 (Watts and Gaertner 2013), 51 percent of employers that did not currently offer coverage to all employees working 30 hours or more per week said they would likely change workforce strategy so that fewer employees worked 30 or more hours per week; 27 percent said they would offer a lower-cost plan for hourly employees being redefined as full-time

workers and thus newly eligible for coverage; 24 percent said they would make all employees eligible for the full-time employee plan(s); and 17 percent said they would offer full-time employee plan(s) to some, but not all, newly eligible employees. Only 8 percent said they would pay the penalty, and 3 percent said they would terminate medical coverage for all employees after the Marketplaces became available.

There is little evidence of a shift toward part-time work in aggregate data, net of what would be expected at this stage in the economic cycle and in light of normal volatility in monthly statistics (Bernstein 2013). Valletta and Bengali (2013) confirm that the recent trend in part-time work and its current level are not unusual relative to past experience. They conclude that the Affordable Care Act's effect on part-time work has been small so far and will likely be so in the future. The authors also note that IRS rules already gave most large employers an incentive to create part-time work to avoid rising health benefit costs. Graham-Squire and Jacobs (2013) estimate that the workers most at risk of having their hours reduced because of the ACA (those working 30 to 36 hours per week, who are uninsured or have individual coverage, and have incomes less than 400 percent of FPL) represent only 1.8 percent of the workforce. Evidence from Hawaii suggests part-time work increased only slightly following enforcement of the state's employer health care mandate (Buchmueller, DiNardo, and Valletta 2011).

Increased Self-Insurance by Small Firms

Several studies indicate that self-insurance among small and midsize firms could rise in the future and that the Affordable Care Act could increase incentives for small firms to self-insure, particularly those with employees at low risk of high medical expenses (Academy Health 2011). Brin (2011) identifies several large stop-loss insurers that are increasingly focused on small to midsize companies, citing greater health care cost transparency and potential cost savings as the main benefits. Jost and Hall (2012) give examples of companies offering stop-loss attachment points as low as \$5,000 to \$10,000, much lower than the average attachment points reported in Kaiser-HRET (2013). Using the Urban Institute's HIPSM, Buettgens and Blumberg (2012) find that low-risk stop-loss policies can cause firms to self-insure, leading to higher premiums in the fully insured small-group market. They find that average single premiums would be up to 25 percent higher and family premiums would be 19 percent higher if stop-loss insurance that mimics full insurance is allowed, as it is in most states barring further state action. This study finds that up to 60 percent of small businesses could self-fund.

To describe factors that may influence adoption of self-insurance by small firms, Lucia and colleagues (2013) conducted stakeholder interviews in 10 study states, with small-employer

representatives, health insurers, stop-loss insurers, agents and brokers, and state officials, including insurance regulators and Marketplace representatives. While stakeholders expressed concerns, many were hesitant to predict what the market for firms with 50 employees and under would look like in 2014 and beyond. Many stakeholder sources thought states should improve monitoring of the stop-loss market and of trends in self-funding by small firms to enable quick and appropriate responses if self-funding among small employers begins to increase significantly in the coming years.

SHOP Marketplaces

Companies with 50 or fewer employees were able to begin signing up for coverage in the SHOP Marketplaces on October 1, 2013, with coverage starting as early as January 1, 2014. Seventeen states and the District of Columbia operate their own SHOP Marketplaces. DHHS runs federal Marketplaces in the rest of the states. Online enrollment in federal SHOP Marketplaces was delayed in November 2013. At this point, information is just beginning to emerge on SHOP Marketplace product offerings and enrollment.

Blumberg, Rifkin, and Wengle (2014) examine the implementation of SHOP Marketplaces in eight states. They find that in many state-based Marketplace states, the SHOP portal is functioning and allows consumers to apply for coverage as well as tax credits, select a plan or develop an employee choice model, and enroll in coverage. The New York SHOP Marketplace, in particular, offers significant transparency in plan options, premium rates, and benefit details without requiring website users to create an account. Functionality in the federally facilitated Marketplaces is more limited, with no online enrollment and no employee choice options.

A survey of small firms (Gabel et al. 2013) finds that employers value certain features of SHOP Marketplaces. Ability to compare plans was the most highly rated feature, with 68 percent saying it was very important and another 22 percent saying it was somewhat important. More than 40 percent rated more choice of plans very important, while 30 percent rated access to an online marketplace as very important.

Discussion

This review covers the current nature of and recent trends in the employer group health insurance market and the anticipated effects of the Affordable Care Act on employers, with a particular focus on

the small-group market. The current literature provides sound insight into the economic principles behind employer decisionmaking; an understanding of how the law can change incentives among employers and their workers; knowledge of data trends in ESI coverage, premiums, offer rates, and take-up; understanding of key cross-sectional differences among individuals (e.g., those with and without ESI) and firms (e.g., those that offer versus those that do not offer coverage); and evidence from microsimulation models and surveys on how the Affordable Care Act could affect ESI offer and coverage rates.

However, there are several gaps in the literature where researchers and policy analysts need targeted information to better understand the potential effects of the Affordable Care Act on employers. For example, while several microsimulation models and surveys analyze the likely aggregate impact of the law on employers, few studies focus on how different types of firms will respond to new incentives created by market reforms or how the Affordable Care Act will likely affect the internal behavior of firms. For instance, will parameters related to the employer responsibility requirements affect firms hiring at the 50-worker margin? Will there be measurable changes in the number of hours offered to part-time workers? Will more work be contracted out than would otherwise have been the case? While most analysts believe these types of effects will be small, it will be important to measure them effectively.

Additionally, it is unclear how the types of coverage offered by firms may evolve. Medium and large employers not bound by the law's health benefit requirements and not previously offering coverage to their workers could avoid penalties by offering plans that meet affordability requirements and the 60 percent actuarial value requirement but are more parsimonious than typical ESI plans have been in the past. Whether they can do so and still attract workers of desired quality and quantity is an open question, however. How much and in what manner wellness discounts will be used, and the extent to which they create a significant barrier to coverage for those with chronic health problems, is another area for future study. Other areas of uncertainty include adverse selection (e.g., how it relates to employer decisions to offer plan choice and participate in wellness programs), the popularity of private exchanges, and consumer choice (e.g., how consumers in small firms will make decisions if they have additional health plan options).

Perhaps the area of most uncertainty is how the Affordable Care Act will affect ESI premiums and health care costs in general. The Medicaid expansion and availability of subsidies through the Marketplaces—and the consequent reduction in the uninsured and changes in cost-sharing responsibilities—will likely increase health care expenditures for those who previously were constrained by lack of insurance coverage. In contrast, cost-containment initiatives introduced under

the Affordable Care Act could reduce long-term health care spending and ESI premiums relative to current trends. Other components of the law that could affect costs include increased insurance market competition; increased payments to primary care providers under Medicaid; emphasis on preventive services and wellness programs; use of comparative effectiveness research; and changes in public and private payment and delivery system strategies, including bundling provider payments, accountable care organizations, and patient-centered medical homes. The emergence of lower-cost Marketplace-based plans with narrower provider networks than have been typical in ESI plans in the past may garner attention from employers, potentially changing the types of plans offered by both large- and small-group plans. In addition, as the economy continues to recover, increasingly cost-conscious payers may place continued pressure on providers to operate more efficiently and to expand upon changes to the delivery system. If these reforms prove to be effective over time, then a return to historically high rates of health care spending growth may not materialize (Holahan and McMorro 2013).

Grasping the full impact of the Affordable Care Act on employers will involve careful data collection and analysis and considerable learning going forward. It will be useful to understand how insurance products and premiums offered in the SHOP Marketplaces compare with what was available previously and what continues to be offered in the non-SHOP small-group market. In addition, participation rates will need to be carefully monitored. Fortunately, much research has already identified many trends, potential outcomes, and economic factors that influence employers' and workers' responses to the options they face. Moving forward, it will be important to engage in ongoing policy question development and to track key metrics over time, incorporating new information about the central issues and data sources that arise.

Notes

1. The maximum size of the credit increased in 2014; credits are available to eligible employers for up to two consecutive years.
2. For most states—some states with state-based Marketplaces and federally facilitated Marketplace states—online enrollment in the SHOP exchange was delayed one year from the planned launch date. Small businesses have been able to apply for exchange coverage by paper application since October 1, 2013, and will have additional ways of enrolling in the SHOP exchanges, including through an agent or broker or directly through an insurer (Kliff 2013; Millman 2013).
3. MEPS-IC was not collected in 2007. This gap is reflected in exhibits 1–8.
4. The MEPS-IC provides estimates for establishments with fewer than 50 workers and 50 or more workers, and establishments with fewer than 10 workers, 10–24 workers, 25–99 workers, 100–999 workers, and 1,000 or more workers. The MEPS-IC tables do not provide information for establishments with 50–100 workers.
5. These Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates are based on the Census Bureau's March 2012 and March 2013 Current Population surveys (CPS: Annual Social and Economic Supplements). <http://kff.org/other/state-indicator/nonelderly-0-64/>.
6. This tax exclusion is extremely costly—it reduces federal and state tax revenues by \$248 billion per year (Congressional Budget Office 2013) and is the government's third largest expenditure on health care, after Medicare (\$572 billion) and Medicaid (\$421 billion) (Martin et al. 2014).
7. Before the Affordable Care Act, an HIU included members of the nuclear family who could be covered under one health insurance policy (i.e., policyholder, spouse, children under age 19, and full-time students under age 23). Under the Affordable Care Act, an HIU can contain an adult child up to age 26 without student status constraints, although these adult children often live outside of the parents' residence and may remain difficult to identify with existing data sets.
8. In 2008, the median wage for workers in firms with fewer than 10 workers was \$10,000 less than those in firms with more than 1,000 employees (author tabulations from the Current Population Survey, available at <http://www.nber.org/data/current-population-survey-data.html>).
9. For example, the tax subsidy data provide exogenous variation in the after-tax price of insurance since the price varies across workers of different income levels, over time, and across states. In contrast, other studies (Feldman et al. 1997; Long and Marquis 1999), which use premiums faced by offering firms and imputed premiums for firms that do not offer insurance, yield a wide range of elasticity estimates (-0.1 to -6).
10. As of January 2010, 11 states restricted small-group insurers from basing premiums on health status. Details are available at Kaiser State Health Facts, <http://www.statehealthfacts.org/comparetable.jsp?ind=351&cat=7&sort=560>.
11. The MEPS-IC defines a self-insured plan as “a plan offered by employers where the financial risk for the enrollee's medical claims is assumed partially or entirely by the employer offering the plan. Employers with self-insured plans commonly purchase stop-loss coverage from a reinsurer who agrees to bear the risk (or stop the loss) for those expenses exceeding a predetermined dollar amount. Some self-insured employers contract with an insurance company or third party administrator for claims processing and other administrative services. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (including Conventional Indemnity, PPO, EPO, HMO, and POS) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.” MPPs are plans “where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.” A glossary of terms that appear in the MEPS-IC questionnaires is available at http://meps.ahrq.gov/survey_comp/ic_ques_glossary.shtml#Minimumpremiumplan.
12. The share of employers of all sizes offering a self-insured plan rose from 32.1 percent in 2002 to 37.2 percent in 2012 (data not shown).

13. The description of the various Affordable Care Act provisions affecting employers draws from Blumberg and Rifkin (2013)a.
14. These reforms include the elimination of dollar caps on lifetime benefits or unreasonable dollars caps on annual benefits, preexisting condition exclusions, rescissions of coverage, and waiting periods (or delays in the start of coverage) of more than 90 days. Other provisions include the dependent coverage expansion to adult children up to age 26 and required coverage of a specified set of preventive services without cost sharing.
15. Details regarding survey methodology in Singhal, Stueland, and Ungerman (2011) are available at http://www.mckinsey.com/features/us_employer_healthcare_survey.

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