Avalere

The Affordable Care Act's Impact on Employer Sponsored Insurance: A Look at the Microsimulation Models and Other Analyses

Executive Summary

The Affordable Care Act (ACA) includes a number of provisions that will affect employer decisions to offer coverage to employees after 2014. Given that employer sponsored insurance (ESI) is the primary source of coverage for Americans, any change to this market is of significant interest. To assess the validity of differing estimates of the effect of the ACA on ESI, Avalere reviewed analyses conducted by economists and policy analysts. In addition, Avalere consulted published employer surveys and interviewed a wide range of experts.

The Overall ESI Market Will Likely Remain Relatively Stable after 2014

Overall, our analysis suggests that the ESI market will be fairly stable after 2014 when key ACA coverage provisions go into effect. The microsimulation models estimates from RAND, the Urban Institute, the Lewin Group and the Congressional Budget Office (CBO) show net changes to ESI ranging from –0.3 percent to + 8.4 percent compared to baseline projections without ACA implementation - not major changes in the market (Figure 1).[1] Similarly, large-scale employer surveys and analyses conducted by benefits consultants, investor groups, and other consulting firms also confirm that most employers will remain committed to providing coverage. Stability in ESI is driven by expectations that large firms, whose policies cover more people than small- and medium-firm policies combined, will continue offering health benefits.[2] Moreover, small businesses that will benefit from new economies of scale in the small business exchanges are likely to offer coverage for their employees through the exchange and possibly newly offer coverage if they previously did not.

ESI is Likely to Decline among Firms with Low Wage Workers, Small Firms and for Early Retirees

While the overall ESI market is likely to remain fairly stable, modelers and other experts agree that some firm types and covered subgroups are likely to experience changes in coverage soon after 2014. Large and small firms with low-wage workers are likely to pay the new ACA employer penalties and allow employees to enroll in Medicaid or subsidized coverage through the exchanges. Also, the offers of early retiree coverage are likely to decline dramatically. This type of coverage is a significant cost for many companies and does not provide direct benefit to the employer. As a result, many early retirees are likely to receive defined contributions from employers to purchase coverage through the exchange in 2014 or soon thereafter.

Other Analyses Differ From the Models and Have Less Robust Assumptions

In contrast to the prevailing viewpoint, former CBO Director Douglas Holtz-Eakin conducted a highly publicized analysis predicting significant erosion in ESI soon after 2014. However, a closer examination of the assumptions and calculations in this analysis uncovers flaws. Holtz-Eakin conducts a simple

[1] Garrett, B. & Buettgens, M. (2011) *Employer-sponsored insurance under health reform: Reports of its demise are premature*. Urban Institute and Robert Wood Johnson Foundation.; Eibner, C. Girosi, F. et al. (2010) *Establishing state health insurance exchanges: Implications for health insurance enrollment, spending, and small businesses.* RAND Corporation. Ahlquist, G., Borromeo, P. et al. (2011) *The future of health insurance: The demise of employer-sponsored coverage greatly exaggerated.* Booz & Company; Congressional Budget Office. *Score of the Patient Protection and Affordable Care Act.* March 20, 2010; The Lewin Group. Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers; June 8, 2010.

[2] Garrett, B. & Buettgens, M. (2011) *Employer-sponsored insurance under health reform: Reports of its demise are premature*. Urban Institute and Robert Wood Johnson Foundation.

calculation of whether or not dropping coverage and paying the employer penalty in ACA would be more financially beneficial to both employers and employees (if the latter's wages are increased by a commensurate amount) than continuing to offer coverage. However, when benefits consultants[3,4] conducted similar analyses – taking into account a number of additional factors that employers will undoubtedly consider - they come to the opposite conclusion. They determined that employers, on average, would spend $1,000 more per employee if they dropped coverage.[5]

Uncertainty Still Remains

While near-term changes in aggregate ESI rates are unlikely, longer term erosion – over 10 to 20 years - is possible under certain circumstances. Most notably, if the new health insurance exchanges created in ACA offer greater value and economies of scale relative to current ESI arrangements, employers and workers may seek access to the exchanges. If they elect to do so through the individual market exchange, this would accelerate any erosion of ESI. Second, if a few large employers drop coverage after 2014 others could follow in a "me too" effect. Both of these scenarios are difficult to model, but should be considered.

Introduction

ESI is the most common source of health insurance coverage for non-elderly individuals in the United States. In 2009, approximately 151 million individuals received health insurance coverage from an employer or a spouse's employer.[6] The ACA includes a number of provisions that will affect employer decisions to offer coverage to employees after 2014 including: the Medicaid expansion, new subsidies to purchase coverage through the new health insurance exchanges, small business tax credits, penalties on certain employers who do not offer coverage or offer unaffordable coverage, the individual mandate, and the high-cost plan excise tax. Significant changes to the ESI market will have considerable impacts across the health care industry and currently there is considerable debate surrounding conflicting projections of the future of ESI. This memo analyzes these various projections, assesses the likelihood of erosion in the ESI market and explores how employer response will vary depending on firm composition, sector, and size.

Methodology

Avalere conducted a comprehensive review of estimates of ESI post-2014 when several important ACA provisions take effect. Specifically, we assessed:

- Publicly available information on microsimulation models that project the size of the ESI market post-ACA implementation. The models included in this study were created by the Urban Institute, RAND, the Lewin Group, and the Congressional Budget Office;
- Interviews conducted with modelers, academics, experts on ESI, benefits consultants, and trade associations representing employers;
- Other published analyses produced by Douglas Holtz-Eakin and Booz & Company; and,
- Employer surveys, such as Mercer, Towers Watson, and Aon Hewitt.

[3] Mercer (2010) *Few employers planning to drop health plans after reform is in place, survey finds.* Access at http://www.mercer.com/referencecontent.htm?idContent=1399495 .
[4] Avalere interview with benefit consultant on January 14, 2011.
[5] Avalere interview with benefit consultant on January 14, 2011.
[6] Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation. The Uninsured: A Primer. December, 2010.

Based on this review, this memo summarizes how employers currently make decisions to offer ESI, how employer decision-making may change as a result of the ACA, and how the estimates and projections on the future of ESI are similar and different across the microsimulation models and other analyses.

Why Employers Offer Coverage Today – and Why They Are Likely to Still Offer Coverage in the Future

"Employers that consider dropping coverage and paying the associated penalty will need a significant cost–value differential to offset the risks to employee morale and retention. Although some employers might save money by dropping coverage and paying penalties, many report that the savings may not be worth the potential downside. Many large employers, particularly those with more than 500 workers, and jumbo-sized companies also report a moral obligation to retain employee health insurance coverage."
– Booz & Company

Employers Offer Benefits Today for a Number of Reasons

Employers have historically offered health benefits for three primary reasons. First and foremost, employers offer health benefits to recruit and retain employees. While ACA does not change this motivation significantly, the value that employees place on ESI might change over time if the exchanges are viable and well-functioning. This would, in turn, reduce the salience of ESI in the recruitment and retention process. In addition, the importance of this factor could decrease if unemployment remains at currently high levels as employers will continue to be able to pick from a larger pool of applicants, and therefore might not need to offer health benefits to compete in the labor market. Overall, the role of ESI in recruitment and retention is expected to continue to be a strong motivator for employers to continue offering health benefits post 2014.

Second, employers offer health benefits because historically there has been no viable alternative for employees to obtain comprehensive coverage on their own. Currently, underwriting and other insurance market practices make the individual market prohibitively expensive and a difficult place for those with pre-existing conditions to obtain coverage. Insurance market reforms and the creation of insurance exchanges under the ACA change this factor and may alter employers' decision-making on offering health benefits.

Third, employers offer health benefits to boost worker productivity. Employers are expected to continue to emphasize wellness programs, and will be further supported in these efforts by ACA provisions. In addition, there are many intangible reasons why employers offer coverage to employees, such as the value employees assign to the benefit, and the feeling amongst some employers that offering health benefits is the "right thing to do." One expert interviewed noted that, "*We need to think about the intangible factors of how employees value the benefit. Providing health benefits gives employees a piece of mind that they don't have to figure their health insurance out in the marketplace*."[7] Again, it is unclear how the moral value placed on ESI may change if and when the exchanges offer a viable and stable alternative source of coverage.

ACA Will Introduce a Number of New Factors for Employers to Consider

After the passage of the ACA, employers will undoubtedly take new factors into account as they decide whether or not to offer health insurance coverage. They will consider whether the creation of a viable individual and small group market via the exchanges is a better alternative for both them and their

[7] Avalere interview with trade association representing employers, January 6, 2011

employees financially. Employers will also need to consider the cost of providing coverage to employees relative to the penalties that will be placed on them if they do not offer coverage.[8] The financial analysis that a firm would conduct to assess the cost of offering coverage versus dropping ESI and having workers purchase insurance through the individual exchange involves a number of components:

- The calculation of the amount by which to increase workers' wages if the employer drops coverage – known as the "gross-up" amount (this is highly dependent on subsidy and/or Medicaid eligibility).
- The tax deductibility of both the employer and employee contribution for ESI.
- The tax treatment of the penalty (i.e. it is not tax deductible).

The small business tax credit provision in the ACA could also affect some employers' decision to offer coverage. The tax credits are structured to encourage small employers to offer or continue to offer coverage, but most experts predict that they will not have a significant impact on ESI offer rates in the small business market. Additionally, ACA includes a high-cost plan excise tax on insurers of employer-sponsored plans beginning in 2018. The provision will impose a 40 percent excise tax on the amounts that an employer-sponsored plan exceeds threshold amounts set in ACA (indexed to the consumer price index for urban consumers). This new tax could compel employers to drop coverage for early retirees sooner than coverage for active workers.

At the same time, many employers may continue to offer benefits because they have always offered them - inertia is a very powerful behavioral force. While it is possible the ACA could create strong incentives for change, the extent to which it does largely depends on the viability and operating details of the exchanges, and the relative value of plans offered in the exchanges.

Most Experts Predict Stability in the ESI Market over the Next Ten Years, but There Are Some Highly Publicized Diverging Opinions

"Employers are reluctant to lose control over a key employee benefit… but beyond that, once you consider the penalty, the loss of tax savings and grossing up employee income so they can purchase comparable coverage through an exchange, for many employers dropping coverage may not equate to savings." – Mercer Survey[9]

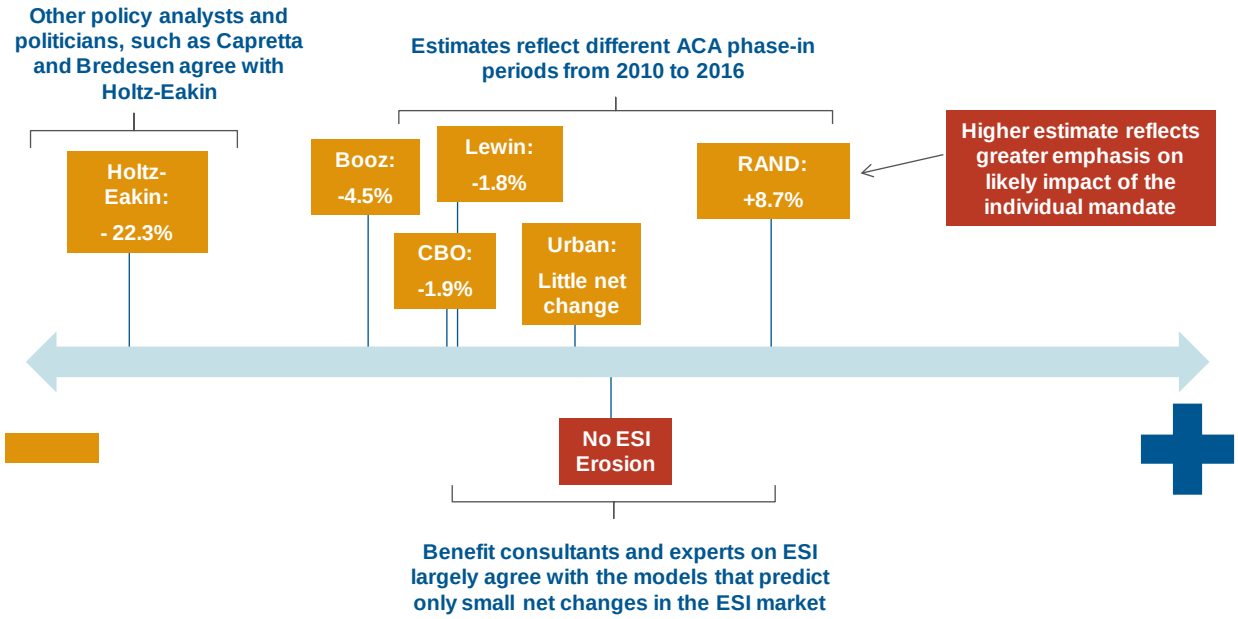
The majority of published reports and experts interviewed predict overall stability in the ESI market post-2014 when important provisions of the ACA take effect. The projections in the microsimulation models from RAND, the Urban Institute, the Lewin Group and CBO are highly consistent with each other. Overall, the estimates reflect relatively minor increases or decreases in ESI compared to baseline projections without ACA implementation. Specifically, the analyses predict net changes in ESI from –0.3 percent to + 8.4 percent relative to the baseline number of individuals with ESI coverage.[10]

Similarly, large-scale employer surveys conducted by a variety of benefits consulting firms and investor groups, modeling performed by Booz & Company, and interviewees report that most employers remain committed to providing coverage. Notably, the overall stability in the ESI market is primarily driven by

[8] Starting in 2014, employers with 50 workers or more must extend coverage to employees who work over 30 hours per week, or face a penalty.
[9] Mercer. 2010 National Survey of Employer-Sponsored Health Plans. Access at: http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place
[10] The estimates are not strictly comparable since they apply to slightly different time periods and make different assumptions about when provisions are implemented.

large employers who, with some exceptions discussed below, are expected to continue offering ESI. The highly publicized analysis published by Douglas Holtz-Eakin comes to a very different conclusion, which economists, academics, modelers, and benefit consultants Avalere interviewed, as well as the reports the team analyzed, such as the Urban Institute analysis, consider to be based on a number of inaccurate assumptions. We discuss all of these findings in greater detail in the following sections.

Figure 1: Estimates of Changes in the ESI Market Post-ACA Implementation



Sources: Garrett, B. & Buettgens, M. (2011) Employer-sponsored insurance under health reform: Reports of its demise are premature. Urban Institute and Robert Wood Johnson Foundation.; Eibner, C. Girosi, F. et al. (2010) Establishing state health insurance exchanges: Implications for health insurance enrollment, spending, and small businesses. RAND Corporation. Ahlquist, G., Borromeo, P. et al. (2011) The future of health insurance: The demise of employer-sponsored coverage greatly exaggerated. Booz & Company; Bredesen, P. "Obamacare's Incentive to Drop Insurance." Wall Street Journal, October 21, 2010; Congressional Budget Office. Score of the Patient Protection and Affordable Care Act. March 20, 2010; Holtz-Eakin, D. & Smith, C. Labor Markets and Health Care Reform: New Results. American Action Forum. May, 2010; The Lewin Group. Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers; June 8, 2010.

Taking a Closer Look at the Models

Each of the models is built on studies from the empirical economic literature, which most modelers and other experts felt were widely accepted in the field. These models predict how businesses and individuals are likely to respond to ACA policy changes such as the Medicaid expansion, new health insurance options, and subsidies for the purchase of insurance and insurance market reforms. Importantly, experts widely agree that based on the historical behavior of employers and the fact that large employers are not very price sensitive, they are relatively unlikely to drop ESI despite the significant changes expected in the health insurance market. While some experts question how relevant price elasticities from the literature will be in the new exchanges as there is nothing analogous to them currently, most experts seem to believe that the price elasticities will continue to apply (although the actual premium prices are unknown at this time).

The models draw on a consistent data set to inform predictions related to employer and employee behavior, but they differ in many of their assumptions. For example, each of the models constructs "firms" of different sizes, average wage levels, and employee characteristics such as age, gender, and single versus married status differently. The cost-benefit analysis of offering ESI versus shifting employees into exchanges depends on these individual variables, so differences in these assumptions can yield varying results across models.

Experts, including authors of some of the models cited in this paper, pointed to a number of other assumptions that are likely to differ across the models and analyses. Some of these include the:

- Effectiveness of the individual mandate and relevance of the Massachusetts experience in estimating the likely impact of the mandate;
- Impact of the employer penalty;
- Price of products in the individual and small group exchanges relative to ESI; and,
- Stability and efficiency of the exchanges

Individual Mandate. The microsimulation models and some experts, such as economists and benefit consultants, assume that the individual mandate will raise demand for coverage. They point to the following implicit behavioral effects from a legal mandate enforced through the tax code: 1)that most individuals inherently want to comply with the law and 2) enforcement through the tax code tends to increase compliance. The individual mandate also played a role in the increase in ESI coverage in Massachusetts. While this could be an indicator of what may happen nationally, there is disagreement about how generalizable Massachusetts is to the rest of the nation. In fact, other experts contend that the mandate will not significantly induce demand for coverage because the penalty amounts for noncompliance are low relative to the costs of purchasing insurance and due to imperfect enforcement. Last, the individual mandate is a politically charged provision and if it is weakened, the current ESI projections may significantly change.

Employer Penalty. There is no previous experience to draw from on the impact of the employer penalties on ESI. Similar to the individual mandate, the level of compliance and the effectiveness of the enforcement of the employer penalties are unknown. Additionally, it is unknown whether the penalties willmove employers to drop coverage, or will incentivize them to offer it to more workers. According to Mercer, approximately one-third of employers with 50 or more employees are not currently in compliance with this provision.[11] However, when asked what they might do to meet this standard, 45 percent of employers reported they would extend their full-time employee plan to part-time or hourly employees who work 30 hours or more.[12] Thus, the employer penalties in conjunction with the individual mandate - which many contend will increase demand among employees for coverage - could increase the prevalence of ESI.

Other State Experiences. Health reform laws enacted in the past 20 years in Massachusetts, Vermont, and Hawaii require employers over a certain size to offer and contribute to health insurance for their workers or pay an annual fee. The large-scale reform in Massachusetts is the strongest state experience we have to examine when attempting to predict the future of the ESI market after ACA implementation.

[11] Mercer. 2010 National Survey of Employer-Sponsored Health Plans. Access at: http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place
[12] Mercer. 2010 National Survey of Employer-Sponsored Health Plans. Access at: http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place

After passage of the Massachusetts reform, firm offer rates, including those exempt from the penalties due to size, increased significantly.[13] However, many experts we spoke to believed that the Massachusetts experience is not a valid predictor of what could happen nationally under the ACA for reasons such as:

- The Massachusetts reform did not apply to self-insured or ERISA employers with workers across state lines. However, the employer penalties in ACA do apply to these large employers, which many experts believe will reduce the likelihood that we will see a Massachusetts-type increase in ESI offer rates.
- The individual mandate, which experts believe increased uptake of and demand for ESI, was very effective in Massachusetts - reducing the percentage of uninsured in the state to under five percent[14]. However, experts question whether the individual mandate in ACA will be as effective, and thus, could have a different effect on ESI nationally than in Massachusetts.

For these reasons, the Massachusetts experience was not a significant factor in the microsimulation models examined in our analysis.

Hawaii and Vermont also adopted employer penalties to induce employers to offer insurance to their employees. Analyses on the impact of Hawaii's law indicate that there has been a decrease in the number of uninsured, but many exempt classes of workers (e.g. those who work 20 hours or less a week) largely remain uninsured.[15] Similarly, the assessment on employers in Vermont has increased the number of insured in that state, but uninsured workers remain.[16] Overall, these state experiences suggest that employer requirements are likely to increase the number of insured – but only for the populations the penalties apply to.

Price of Products in the Exchange. The premium cost of the products in the exchange will have an impact on employers' decisions to offer coverage; however, these prices are currently unknown. Since small employers are significantly more price sensitive than large employers[17], assumptions related to pricing in the exchange will have a greater effect on ESI estimates for small employers.

Stability, Efficiency, and Administration of the Exchanges. There are a number of other sources of uncertainty within the models that will affect the future viability of the ESI market. For instance, there is significant regulatory uncertainty on how the exchanges will function, whether or not large employers will be able to participate in them after 2017, and whether or not the individual and small group markets will be combined. Other issues that are difficult to quantify in models, but that will affect the functioning of the exchanges include the stigma associated with the exchange or the hassle and administrative red tape to enroll in coverage.

Differences in Time Period of Analysis and Phase-In of Policies. Direct comparisons of the estimates are difficult because the models assume different start dates for the phase-in of ACA, thereby modelingand making the implementation path variable across the analyses. For example, the CBO shows the impact of the law over a ten year window, but base their assumptions on the coverage

[13] Gabel, J. et al. *After The Mandates: Massachusetts Employers Continue To Support Health Reform As More Firms Offer Coverage Health Affairs 27-6* (2009): *566-575.*
[14] Gallup. *Texans Most Likely to Be Uninsured, Mass. Residents Least.* March 11, 2011. Access at: http://www.gallup.com/poll/146579/texans-likely-uninsured-mass-residents-least.aspx
[15] Buchmueller, Thomas C., John DiNardo, and Robert G. Valletta. 2009. "The Effect of an Employer Health Insurance Mandate on Health Insurance Coverage and the Demand for Labor: Evidence from Hawaii." FRBSF Working Paper 2009-08, April.
[16] Deprez, R. et al. *Achieving Universal Coverage through Comprehensive Health Reform: The Vermont Experience.* Robert Wood Johnson Foundation and SHADAC. October, 2009
[17] Gruber, Jonathan, and Michael Lettau. "How Elastic Is the Firm's Demand for Health Insurance?" *Journal of Public Economics* 88 (2004): 1273-293.

expansion going into effect by 2014, and being fully phased in by 2016. Given the uncertainty surrounding the viability of the exchanges, this timeframe may be inaccurate. RAND attempts to model the law's phase-in after CBO's whenever possible. They report results for 2016, and their monetary estimates use 2010 dollar amounts. While the Lewin group analysis presents the expected impact of the ACA over a ten year window starting in 2010, their analysis assumes full maturation of the law by 2011. Further adding to the difficulty of directly comparing the model's estimates, the Urban Institute models their results as if the law is fully implemented in 2010.

However, it is important to note that although there may be aspects of assumptions that differ between the models, the modelers we spoke to reported that the analyses were relatively insensitive to these differences and believe comparisons can still be made across the models despite the varying phase-in dates. While the models make a number of assumptions, on the whole they converge on a relatively narrow range of predicted changes in ESI relative to baseline (i.e. in the absence of ACA).

What the Models and Experts Tell Us: Near-Term ESI projections

Reports, employer surveys, and the microsimulation models all suggest that the large employer market is likely to remain fairly stable in the near-term. For instance, the Urban Institute's model projects that in the absence of ACA large firms (more than 1,000 workers) would cover 67.3 million individuals and with the passage of ACA, 68.8 million individuals would be covered[18], and the RAND model predicts no net change in the mid- to large employer market (more than 100 workers)[19]. Benefit managers, chief human resource officers, and chief financial officers in large firms have stated they will "wait and see" over the long-term[20], supporting the microsimulation model projections that large employers will not immediately drop coverage and that the market will remain fairly stable over the next five to ten years. In addition, employer surveys have consistently found that a minority of large employers say they will drop coverage after 2014– 6% of those with 500 employees and 3% of those with 10,000 employees or more in one Mercer survey.[21]. A Towers Watson survey, which consisted mainly of firms with 1,000 employees, reported that 88 percent of employers said they are likely to or will definitely continue to offer health coverage.[22]

While the microsimulation models reviewed do not show a significant *net* change in ESI, the models do predict more significant shifts within ESI, with some employers exiting the ESI market and others starting to offer coverage (see Table 1). Interviews and other published analyses uniformly conclude that firms with certain characteristics are very likely to drop coverage. Large and small firms with low wage workers are likely to pay the new penalty and allow employees, many of whom will meet eligibility criteria for Medicaid or federal subsidies (available only through the individual market exchanges) to enroll in Medicaid or obtain the subsidized exchange coverage. In these cases, it is more costly for employers to provide health benefits than for employees to gain coverage through Medicaid or the exchanges. Employers can pay the penalty and even increase wages somewhat to offset the additional cost of coverage borne by employees and still have lower overall costs than continuing to provide coverage. Similarly, employees who qualify for Medicaid or subsidized coverage are likely to experience lower costs in the new government programs than with ESI. On the other hand, small businesses with high-wage

[18] Garrett, B. & Buettgens, M. (2011) *Employer-sponsored insurance under health reform: Reports of its demise are premature*. Urban Institute and Robert Wood Johnson Foundation.
[19] Eibner, C. Girosi, F. et al. (2010) *Establishing state health insurance exchanges: Implications for health insurance enrollment, spending, and small businesses.* RAND Corporation.
[20] Ahlquist, G., Borromeo, P. et al. (2011) *The future of health insurance: The demise of employer-sponsored coverage greatly exaggerated.* Booz & Company.
[21] Mercer. 2010 National Survey of Employer-Sponsored Health Plans. Access at: http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place
[22] Towers Watson (2010). *Health care reform: Looking fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards.*

workers may not immediately drop coverage[23] because of the traditional reasons employers offer coverage and because the tax subsidy for ESI benefits higher-income workers who would be ineligible for subsidies.

According to the microsimulation models and many of the experts Avalere interviewed, a shift in ESI may occur in the small business segment, though there is considerable divergence of opinion expressed in interviews and among the microsimulation model results. For small employers that offer benefits, they pay proportionately more than large employers for the same health coverage today[24] and their capacity to offer coverage is limited by high administrative costs, low bargaining power to negotiate benefit design and premiums, and a small number of enrollees for risk pooling.[25] The small business exchanges are expected to offer lower priced plans and sizable economies of scale to this segment, which coupled with the fact that small firms are more price sensitive than other employer segments[26], leads to the conclusion that small employers are likely to quickly shift workers into the small business exchanges, or possibly drop coverage altogether if the individual exchanges offer attractively priced options. RAND and Urban Institute predict increases in offer rates among firms with fewer than 10 employees, whereas the Booz and Company analysis predicts lower offer rates because firms are exempt from the employer penalties (especially if they employ lower-wage workers that will qualify for Medicaid or subsidies).[27]

A significant decline is coverage is expected among early retirees. Employers have been struggling with the financing and administration of early retiree benefits for many years. While the ACA includes a $5 billion temporary reinsurance fund for early retirees to mitigate erosion of coverage this cohort, overall, ESI among early retirees has been declining rapidly and is expected to drop significantly following the implementation of the exchanges. One report found that 85% of employers believe a large number of firms will terminate retiree benefit arrangements because of the ACA and over 40% of employers that currently offer retiree health benefits plan on reducing or eliminating them altogether.[28] By giving early retirees defined contributions and transitioning them into the exchanges, companies will immediately lower costs on their balance sheets.

Additionally, if the exchanges and new insurance regulation function well, the new arrangement in 2014 may also benefit early retirees. The exchanges could offer this group more plan choices, benefit designs, cost-sharing options, and higher-value plans to choose from than they currently have available to them, as well subsidies in some cases. Given that the motivation of recruitment, retention, and boosting worker productivity do not apply to this population and that the ACA provides a viable alternative through the exchanges to obtain more and potentially higher-value coverage choices, employers are likely to drop coverage for this group in 2014 or soon after.

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[23] Ahlquist, G., Borromeo, P. et al. (2011) *The future of health insurance: The demise of employer-sponsored coverage greatly exaggerated.* Booz & Company.
[24] Blakely, S. (2010) *Employers, workers, and the future of employment-based health benefits.* Employee Benefit Research Institute.
[25] Eibner, C, Hussey, PS, Girosi, F. The Effects of the Affordable Care Act on Workers' Health Insurance Coverage, N Engl. J Med 2010: 363;15
[26] Gruber, J. & Lettau, M. (2004) *How elastic is the firm's demand for health insurance? Journal of Public Economics,88,* 1273-1293.
[27] Ahlquist, G., Borromeo, P. et al. (2011) *The future of health insurance: The demise of employer-sponsored coverage greatly exaggerated.* Booz & Company.
[28] Towers Watson (2010). *Health care reform: Looking fears mask unprecedented employer opportunities to mitigate costs, risks and reset total rewards.*

Table 1: Estimated Shifts in ESI

	CBO	Lewin Group	Urban Institute	RAND
Change in ESI	**-3 million**	**-3 million**	**-.5 million**	**+13.6 million**[29]
Newly Offer ESI	**6 – 7 million** Drivers - Increased demand from individual mandate	**14.4 million** Drivers: - Avoid penalty - Lower premiums because of elimination of health status rating or new small employer credit	Drivers: - Increased participation due to individual mandate - Premiums decline for small firms (<100) - Offer rates increase most for small firms; smallest firms (<10) have biggest increase in offer rates because of premium tax credit and savings available through small business exchanges	Drivers: - Increased demand from individual mandate and lower cost options through exchanges for small businesses - ESI offer rates increase for small firms (<50) The majority of this increase is driven by firms with ten or fewer employees
Drop ESI	**-8 to -9 million** Drivers - Lower-wage workers and small businesses may drop coverage due to subsidies	**- 17 million** Drivers: - Employers will drop coverage primarily if many employees are subsidy or Medicaid eligible - 8.6 M receive subsidy - 3.7 M enroll in Medicaid - 3.9 million move to individual exchange w/o subsidy - 1.0 million will go uninsured		Drivers: - 13% of firms drop ESI because employees are eligible for Medicaid and subsidized coverage in the individual exchanges. - 93 percent of firms that drop coverage have <10 workers; less than 3 percent of people are affected - Increased offerings among small businesses

What the Models and Experts Tell Us: Longer-Term ESI Projections

Several interviewees expressed the view that while they agreed with the near-term microsimulation model projections, declines in ESI coverage over the longer term – anywhere from 10 to 20 years – were possible under certain circumstances. First, if the exchanges are a superior option to current ESI arrangements, then employers and workers may seek access to the individual market exchange

[29] Eibner, C., Hussey, P. et al. (2010) The effects of the Affordable Care Act on Workers' Health Insurance Coverage. *New England Journal of Medicine,* 363, 15, 1393-1395.

(although it is possible that they seek access to the small business exchange, which would actually increase ESI levels). Large employers could drop coverage for employees several years after ACA is fully implemented if the exchanges are viable and stable markets that offer employees with more choices and greater value than current ESI options. One economist interviewed predicted that down the road exchanges will attract 15 – 20 percent of the ESI market.[30] However, this depends on the success of federal and state implementation efforts and competition and participation among private plans.

Second, if a one or two prominent large employers dropped coverage others could follow in a "me too" or domino effect. One interviewee noted that, "Nobody wants to be first (to drop coverage) but everyone is OK being second."[31] If a "me-too" effect is observed, interviewees pointed to examples such as the proliferation of managed care in the 1990s and consumer directed health plans over the last decade as examples of how changes could spread in the employer market. These changes did not occur overnight, and the latter took place over several years. Therefore, the timeframe for large firms to drop coverage altogether could also occur over several years.

Making Sense of Conflicting Estimates

The Holtz-Eakin analysis comes to a significantly different conclusion than the microsimulation models and the analyses of the benefits consultants, predicting a reduction in ESI of up to 35 million individuals. His analysis takes a different approach as it assumes that the tax subsidies provide a mutual incentive for employers to drop coverage and correspondingly increase worker wages, and for employees to take up subsidized coverage. At a minimum, Holtz-Eakin concludes that employers will drop coverage for any workers below 250% FPL.[32]

Along the same vein, Governor Bredesen (D-TN) arrives at a similar conclusion to Holtz-Eakin's in a *Wall Street Journal* opinion piece he authored in the fall of 2010.[33] Bredesen argues that the subsidies in ACA are so generous that they create a strong incentive for employers to drop coverage and will prevent new businesses from offering coverage. He uses his own state of Tennessee, as an employer of 40,000 state workers, to illustrate that the state could save $146 million annually by dropping coverage for state workers, paying the employer penalties, increasing worker salaries to offset the loss in employer contribution to health coverage, and allowing state workers to purchase coverage through the exchanges. However, while Governor Bredesen (D-TN) made assertions about the future of ESI using a Holtz-Eakin type approach, his opinion piece does not provide data or calculations to support his conclusion.

Many of the experts interviewed described a number of concerns with the Holtz-Eakin approach including:

- The analysis did not group people into firms, but an individual firm's decision to offer coverage is based on a calculation of what is best for all the workers in the firm.
- A predominance of workers in most firms would not benefit from moving into the exchange post-2014 as most would not qualify for a subsidy and would lose the tax advantage of ESI.
- The Holtz-Eakin analysis does not take the effect of age distribution and single versus family plans on premiums in the exchange into account.[34]
- If employers dropped coverage it is unlikely that they would increase worker wages by the exact amount that they are saving by not providing coverage.

[30] Avalere interview with health economist on December 21, 2010.
[31] Avalere interview with employer trade association on January 6, 2011.
[32] Holtz-Eakin, D. & Smith, C. *Labor Markets and Health Care Reform: New Results.* American Action Forum. May, 2010;
[33] Bredesen, P. "Obamacare's Incentive to Drop Insurance." *Wall Street Journal,* October 21, 2010.
[34] In the exchanges, older individuals with families may end up paying considerably more than under ESI where there typically are no rating bands and family coverage is often subsidized more than in the exchanges.

A closer look at the assumptions and calculations in the Holtz-Eakin analysis suggest that simply comparing the employer penalty amount and the amount an employer would increase employee wages by and the cost of an employer offering coverage to an individual worker is oversimplified. There are a number of other factors that increase the cost of an employer dropping coverage – especially for workers above 250% FPL:

- The tax treatment of ESI and its relative benefit to employees as income increases;
- The tax treatment of the penalty (i.e. it is not tax deductible);
- The likelihood that the penalty will increase over time; and,
- The determination of the amount to increase workers' wages by if coverage is dropped – or the "gross-up" amount.

In fact, benefits consultants have conducted similar analyses that take these additional factors into account, and have come to the opposite conclusion – that employers on average would spend $1,000 more per employee if they dropped coverage.[35]

Note that some experts have suggested that some companies may attempt to split low-income workers and higher-income workers into separate operating entities to be able to maintain insurance coverage for higher-wage employees, but not those that would benefit from enrolling in Medicaid or receiving the subsidies. However, discrimination law is likely to make this difficult to do.

Conclusion

"Until you have a real system instead of a theoretical one, it's hard to make a decision." – Employer trade association[36]

The ACA will fundamentally change the way many Americans receive their health insurance – especially in the individual and small business markets. The changes will stem from the Medicaid expansion, the creation of health insurance exchanges, the individual mandate, and the employer penalties, among other provisions. While the ACA will increase access to insurance for many, it will also change the way some currently receive coverage. The majority of Americans receive health insurance through their employers and many question whether the ACA will signal an end to this practice and lead to erosion of this relatively stable market; however, the long-term impacts of the legislation on ESI are difficult to predict.

Avalere's analysis finds that the ACA will have differential impacts on ESI depending on factors such as firm size, composition, and sector. Certain segments of ESI – such as firms employing low-wage workers, microbusinesses, and early retirees – are likely to obtain coverage through the new health insurance exchanges in either 2014 or soon after because the ACA provides alternatives or new economies of scale for these segments that do not currently exist. On the other hand, large employers are unlikely to stop offering coverage in the near-term as the benefit to dropping coverage may not outweigh the costs for both the employer and their employees. Thus, large employers are likely to take a "wait and see" approach, making long-term large employer actions difficult to predict. If the exchanges offer high-value coverage and economies of scale relative to current ESI arrangements, large employers could either 1) elect to drop coverage, pay the required penalties in ACA and allow workers to obtain coverage through the exchanges, or 2) lobby for entry into the small business exchange thereby increasing ESI levels.

[35] Avalere interview with benefits consultant on January 14, 2011.
[36] Avalere interview with employer trade association on January 6, 2011.

Appendix: ACA Provisions Most Likely to Affect ESI

Employer play-or-pay/free-rider penalties

- Employers with more than 50 workers will face penalties if they do not offer coverage or offer unaffordable coverage.
- For instance, an employer with 75 employees:
    - Who does not offer minimum essential coverage will be subject to a $2,000 penalty for each employee after the first 30 or $90,000; or,
    - Who offers coverage with costs that exceed 9.5% of an employee's household income will be assessed a $3,000 penalty per employee receiving a subsidized through the exchange; however, this penalty cannot exceed $2,000 times the number of employees over 30.

This provision can either increase or decrease the likelihood that an employer drops coverage, depending on the individual employer's overall penalty amount calculation

Exchanges

- Requires states to establish an exchange for the individual and small group markets by 2014. If a state does not do so, the Department of Health and Human Services (HHS) may operate an exchange in that state.
    - States may allow employers with more than 100 employees into the state exchange in 2017.
    - For plan years before January 1, 2016, a state may limit the small group market to 50 employees.
    - States may elect to combine the two markets into a single exchange.
- Exchanges will certify participating qualified health plans (QHPs), maintain a website, determine eligibility for subsidies, coordinate enrollment with Medicaid and CHIP, and perform various other functions.
- Requires exchanges to be self-sustaining beginning January 1, 2015.
- Allows states to form regional or interstate exchanges, subject to approval by the Secretary.

This provision will create a viable alternative to obtain comprehensive coverage on the individual market, thereby changing a major reason why employers have historically offered coverage.

Individual mandate

- Sets penalties for noncompliance at the greater of:
    - $95 in 2014 $325 in 2015, $695 in 2016, and indexed for subsequent years, or
    - 1.0% of household income in 2014, 2.0% in 2015, 2.5% in 2016 and beyondup to a maximum amount equal to the average national premium for a Bronze plan.
- Exempts individuals who cannot afford coverage, incarcerated individuals, individuals outside the U.S., those with religious objections, and individuals with incomes below the tax filing threshold.

The individual mandate should increase take-up rates for ESI; however, the magnitude of its impact on ESI may depend on the effectiveness of the mandate.

2014 Insurance market reforms

- A number of insurance market reforms go into effect in 2014, including:
    - Guaranteed issue and renewability;
    - Limited premium rating bands; and
    - No denial for pre-existing conditions, among others.

- Requires all plans to issue coverage to those seeking it, prohibits pre-existing condition exclusions, effective January 1, 2014.

The insurance market reforms provide consumer protections that will allow the individual market for insurance and the exchanges become viable alternatives for employees to gain comprehensive coverage. The impact of the exchanges on ESI is difficult to predict, but they could 1) be an incentive for employers to drop coverage, or 2) be an option through which small and even large employers offer coverage if exchanges offer high-value plans and significant economies of scale relative to current ESI arrangements.

High-cost plan excise tax

- Imposes an excise tax on employer-sponsored health insurance plans that offer policies with generous levels of coverage, which can be
- levied on group health insurance plans as well as plan administrators for self-insured companies
- The excise tax is equal to 40% of the plan's value that exceeds $10,200 for an individual and $27,000 for family coverage, beginning in 2018
    - The dollar thresholds are indexed to the Consumer Price Index for Urban Consumers thereafter
- For qualified retirees and individuals in high-risk professions, the thresholds are set at $11,850 for individuals, and to $30,450 for family coverage

The high-cost plan excise tax may result in employers reducing benefits or eliminating high-end health plans. Employers may also drop coverage altogether if they are threatened by the penalty, especially for early retirees

Small business tax credit

- Provides a sliding scale tax credit to small employers with fewer than 25 employees and average annual wages below $50,000 beginning 2010
    - For years 2010-2013, employers could receive a credit of up to 35% of their contribution toward the employee's health insurance premium if the employer contributes at least 50 percent of the premium.
    - For years 2014 and beyond, employers could receive a credit of up to 50% of their contribution for purchasing coverage through the exchange if they contribute at least 50 percent of the premium. The credit will be available for two years.
    - A full credit is available to employers of 10 or fewer workers with average annual wages less than $25,000

Could incentivize some employers to continue to provide coverage, or to start providing coverage to employees; however, this may not have a significant impact on ESI overall.

Premium subsidies (tax credits)

- Provides sliding-scale tax credits to limit premium spending from 2 percent of income for individuals at 133 percent of FPL to 9.5 percent of income for individuals with incomes up to 400 percent of FPL.
- The subsidy is based on the second lowest cost Silver plan available in an exchange.
- Subsidies may only be used for purchasing coverage in the individual market exchanges and cannot be used by individuals getting employer coverage through the Exchange.

The premium subsidies could incentivize employers with low-wage workers that would qualify for subsidies to drop coverage.

Medicaid expansion

- In 2014, states must cover all individuals that are under 65 years and have incomes below 133% of the FPL through their Medicaid programs.
- HHS will provide a higher federal matching payment for the cost of covering the adult populations that states will be required to cover in 2014 as follows:
    - 100% in 2014 through 2016, 95% for 2017, 94% for 2018, 93% for 2019, and 90% for 2020 and thereafter

The Medicaid expansion could incentivize employers with low-wage workers that would be eligible for Medicaid to drop coverage.