

# The Affordable Care Act and Employer-Sponsored Insurance for Working Americans

## Summary

The Patient Protection and Affordable Care Act (ACA) includes several new requirements for employer group health plans. As of 2014, the act's "play-or-pay" provisions will require medium and large employers to offer health insurance coverage to full-time workers or pay a penalty; further payments may be required if the coverage does not meet affordability standards for lower-income workers. The ACA also includes new benefit and administrative requirements that may increase employers' costs. Beginning in 2018, employer plans with costs above specified limits will pay an excise tax on their excess spending.

Employers' responses to the new rules are difficult to predict. The ACA play-or-pay penalties are lower than the cost of providing health benefits, and low-wage workers could use the ACA's new premium tax credits to buy insurance in the individual market. Some people believe that many employers will stop offering coverage and pay the penalties. Others contend that the trade-offs involved are complicated, especially for firms with a mix of low- and high-income workers. In this view, few employers are likely to abandon their health plans altogether, but they may modify premium contribution requirements or redesign their plans in other ways in response to the ACA's requirements. Many employers may also see increased incentives to move from insured to self-insured coverage, with potential effects on the stability of the group health insurance market.

Over the long term, the excise tax on high-cost plans may have a greater impact. As benefit costs rise, more and more employers could find their plans subject to the tax, but their ability to avoid the tax by curtailing benefits is limited by other provisions of the ACA. If employers cannot find more efficient ways of providing coverage, many may be pressed to reconsider their decision to continue offering health benefits.

## Introduction

Most non-elderly Americans with health insurance coverage are enrolled in employer-sponsored insurance (ESI). In 2009, 157 million people under age 65 had coverage through their own employment or as dependents of a covered worker.<sup>1</sup> The ACA is basically designed to provide insurance to people without access to ESI, through Medicaid expansions, reforms in the private individual market, and tax credits to help low-income families pay premiums for individual coverage. However, there are concerns that improved access to coverage outside the employer-based system could lead some employers to stop offering health benefits or encourage subsidy-eligible employees to leave their employer plan and obtain individual coverage.

Accordingly, the ACA includes incentives and penalties intended to minimize disruption of the existing employer-based system when the law's major provisions take effect in 2014. This brief begins with a summary of the "play-or-pay" rules and of other significant ACA

## Genesis of this Brief

This report is drawn, in part, from a panel discussion on the same topic held on February 7, 2011, at AcademyHealth's National Health Policy Conference in Washington, D.C. Panelists were Christopher Goff, J.D., M.A., CEO and general counsel, Employers Health Coalition of Ohio; James Klein, president, American Benefits Council; Frank McArdle, Ph.D., principal, Aon Hewitt; and Christopher J. Queram, M.A., chief executive officer, Wisconsin Collaborative for Healthcare Quality. Gary Claxton, vice president, Henry J. Kaiser Family Foundation, served as moderator.

provisions that could affect the availability and cost of employer coverage. It then considers some of the major decisions employers will have to make in the course of the ACA's implementation and the factors that may affect employers' choices. Finally, it reviews what employers are saying about the likely impact of the ACA as well as independent analyses of possible employer responses.

The focus throughout this brief is the large employers who currently account for the majority of employer-sponsored coverage. (An estimated 76 percent of people with ESI are covered through a worker in a firm with 100 or more employees.<sup>2</sup>) It is important to note that the ACA uses different definitions of "large employer" for different purposes. For market reforms and some other rules, large employers are those with an average of more than 100 employees over the course of a year. The play-or-pay rules, however, apply to firms with 50 or more full-time equivalent (FTE) workers.

### Significant ACA Provisions

The ACA contains several provisions that will directly or indirectly affect ESI. This summary is limited to a few of the most important.

#### Market reforms, health benefit exchanges, and premium subsidies

In each state there will be one health benefit exchange for individuals and one exchange for small employers; the latter is termed the Small Business Health Options Program (SHOP exchange). Initially, the SHOP exchanges will be open only to employers with 100 or fewer workers. Beginning in 2017, states may opt to open the exchanges to larger employers.

Individuals and small employers may purchase health coverage offered through either the exchange or an insurer outside the exchange. But all insurers, in or out of the exchange, will be subject to the same rules, including standardized benefit packages, prohibitions against discrimination, and restrictions on variation in premium rates.

People who purchase individual insurance through the exchange and whose income is below 400 percent of the federal poverty level (FPL) may be eligible for a refundable tax credit to help pay the cost of coverage for themselves and their dependents. The subsidy is not available to people eligible for other coverage, such as Medicare, Medicaid, or an employer-sponsored plan. One significant exception applies: people who decline available employer coverage may receive the credit if the employee's required premium contribution for that coverage exceeds 9.5 percent of the employee's income or the employer plan pays on average less than 60 percent of the allowable cost of covered services.

#### Play or pay

Under the ACA's "shared responsibility" or play-or-pay system, large employers—those with 50 or more FTEs—are subject to two basic rules:

- If the employer fails to offer health coverage meeting certain standards to every full-time employee and *any one* employee receives tax-subsidized coverage through an individual exchange, the employer must pay a \$2,000 penalty for *every* full-time employee. (The first 30 employees are not counted in figuring the penalty.)
- If the employer offers coverage but an employee obtains tax-subsidized coverage through the individual exchange, the employer must pay a \$3,000 penalty for that employee. Again, while any employee is free to decline the employer plan and shift to the exchange, the tax credit is available only if the worker's required contribution to the employer plan for single coverage is more than 9.5 percent of the employee's income or the plan pays less than 60 percent of the cost of covered services.

The ACA originally included a provision for "free choice" vouchers. If a low-income worker's required premium contribution for the employer plan was between 8.0 and 9.8 percent of income, the employee could remain in the employer plan or request a voucher from the employer. The voucher would have been equal to the amount the employer would have contributed to coverage. Workers taking this option would have been able to apply the voucher to the premium for an individual exchange plan. The voucher provision was repealed as part of the FY 2011 budget agreement reached in April 2011.

#### New plan requirements

The ACA includes a variety of new requirements that could increase costs for some or all employer plans. Some of the requirements are already in effect, including extension of family coverage to adult children under age 26; restrictions on annual coverage limits; a prohibition of lifetime limits on the dollar value of coverage; and required coverage without cost-sharing of specified preventive services. Employers and insurers have estimated that these rules may have accounted for 1 or 2 percent of the overall 8 percent increase in health plan costs for 2011.<sup>3</sup>

As of 2014, the ACA will prohibit annual limits on the dollar value of coverage. Until then, plans may still impose annual limits, but the limits may be no lower than floors established by the U.S. Department of Health and Human Services (HHS) (\$750,000 in 2011, rising to \$2 million in late 2012). Some employers have been offering highly limited benefit packages, known as "mini-med" plans, with very low annual

limits. The ACA allows temporary waivers of the annual limit rules to prevent these employers from dropping coverage. As of March 2011, 1,168 waivers had been granted, covering 2.9 million workers.<sup>4</sup>

Some of the new rules—such as required coverage of preventive services—do not apply to existing enrollees of “grandfathered” health plans, which are individual or group plans already in effect when the ACA was enacted in March 2010. HHS has issued regulations restricting the extent to which an employer or insurer can make changes in a plan and still retain grandfathered status. For example, there are tight limits on changes in employee premium contributions or cost-sharing. As a result, not many plans are expected to remain grandfathered: 88 percent of self-insured employers and 81 percent of those buying insurance expect at least one plan to lose its grandfathered status by 2014.<sup>5</sup>

In addition to benefit changes, the ACA imposes several new administrative and reporting requirements. A full review is beyond the scope of this brief, but a few that have aroused considerable comment are noteworthy. Beginning in 2010, employers must provide for an external appeals process for benefit decisions. Employers were supposed to begin reporting health benefit costs on employees’ W-2 statements for 2011, but the requirement’s effective date has been delayed until 2012. Beginning in 2014, employers must report information needed for enforcement of the individual mandate and other ACA requirements.

### Small employer tax credit

Small employers with no more than 25 employees and wages of \$50,000 or less per employee may receive a credit if the employer pays at least 50 percent of premiums. The maximum credit for the smallest, low-wage firms (10 or fewer workers and wages up to \$25,000 per employee) is 35 percent of the employer’s contribution as of tax year 2010 and 50 percent for tax years 2014 and 2015. The credits phase down as employers approach the 25 workers/\$50,000 wage limit and are reduced for non-profit employers. No credits are available after tax year 2015. Some observers question whether the credits will induce very many employers who have not been offering coverage to begin doing so.<sup>6</sup> Except for the smallest firms, the credit does not make much of a dent in premium costs, and the phase-down is rapid. Survey data do show a surprising spike in the proportion of very small firms that offered coverage between 2009 and 2010. One reason may be that firms not offering coverage were more likely than those offering coverage to have gone out of business during the economic downturn.<sup>7</sup>

### Excise tax

Beginning in 2018, employer plans will pay a 40 percent tax on the amount by which the cost of the plan per enrollee exceeds a cap, initially set at \$10,200 for single workers and \$27,500 for families. (In theory, insurers or plan administrators pay the tax, which will presumably be passed through to the employer.) The initial cap

may be higher if health costs rise faster than currently projected and the cap will be higher for plans covering retirees or workers in high-risk occupations as well as for plans with a higher-than-average risk level (based on age and sex alone). The caps will increase annually, but only by the CPI-U plus 1 percentage point. Calculations of spending per enrollee will consider both employer and employee contributions to the plan, including employee contributions to flexible spending or health savings accounts.

### Retiree health plans

Although this brief focuses on ACA requirements likely to affect coverage of active workers, some provisions are likely to affect employer-provided benefits for retirees. First, a temporary federal reinsurance program for retirees under age 65 is already in effect; it compensates employers for individuals incurring catastrophic costs.<sup>8</sup> Second, the excise tax for high-cost plans will apply to plans covering early retirees. The cost caps are set slightly higher than those for active workers, but some observers speculate that employers are likely to curtail benefits.<sup>9</sup> Finally, employers who provide drug benefits to Medicare-eligible retirees have been receiving federal subsidies since 2006 and have been permitted to deduct the full cost of the benefits as a business expense. Beginning in 2013, they may deduct only the spending not covered by federal subsidies. Some analysts predict that many employers will terminate drug benefits for Medicare retirees.<sup>10</sup>

## Major Decisions Facing Employers

Employers will face several important decisions when the major ACA provisions take effect:

- Should they offer coverage at all or pay a penalty?
- If they offer coverage, should they redesign benefits and contribution rules to account for the new protections for lower-income employees?
- If they purchase group health insurance, should they shift to self-funded insurance?
- How can they avoid the excise tax on high-cost plans that takes effect in 2018?

### Play or pay?

Most employers subject to the play-or-pay requirement already offer health coverage. In 2010, 95 percent of firms with 50 to 199 workers and 99 percent of firms with 200 or more workers offered coverage to at least some of their employees.<sup>11</sup> The few large employers without health plans may be expected to pay the \$2,000 penalty per full-time worker rather than take on the much higher cost of offering an ACA-compliant health plan. The choices for employers who already offer coverage are more difficult.

Why would any firm continue its plan when it could reduce its costs to a small penalty per worker? True, the penalty is not deductible as a business expense while health benefit costs are deductible. But the deductibility issue may matter only if a firm actually pays corporate

tax; at most, the penalty could raise the cost to \$2,700 per worker. The penalty in years after 2014 is indexed to average premium growth but will still be much lower than the cost of operating a plan.

If the employer dropped its plan, employees would still be able to obtain coverage through the individual exchange, and those with lower incomes would qualify for premium tax credits. Some of the employer's savings could be "cashed out"—returned to the workers in the form of higher wages or other benefits. Even if the employer returned its initial savings in full, it would gain in the long run because wages or other benefit costs are unlikely to rise as rapidly as health plan costs.<sup>12</sup>

Nonetheless, several considerations may complicate an employer's decision to pay or play. First, while higher-income employees currently benefit from the exclusion of employer-provided health benefits from taxable income, they would receive little or no premium tax credit if they were thrown into the individual market. Even though the employer could cash out the health benefit, the wage increase would be taxable, so that workers would see a net decrease in total compensation. The employer could "gross up" compensation—pay even more than the previous health benefit contribution to help the employee pay income and Social Security/Medicare payroll taxes—but grossing up could considerably increase the employer's total costs.<sup>13</sup> In addition, it is not certain that the workers could find comparable coverage in the individual exchange for the price the employer was paying for the group plan; exchange plans will often have higher administrative costs, and the pool of exchange enrollees may be higher-risk.

Second, many employer plans exclude some full-time workers—commonly those with lower incomes.<sup>14</sup> An employer that continued to offer coverage would have to include these workers. Other employers have benefit designs—plans with high deductibles or (once all current waivers expire) annual benefit limits—that would be disqualified. In other cases, employer plans may cover less than 60 percent of the costs of covered services. If an employer continued such a plan, workers below 400 percent of the FPL could shift to the exchange, and the employer would owe a \$3,000 penalty for each such worker.

In simple financial terms, the trade-offs for different employers will depend largely on their mix of high- and low-wage workers. A restaurant that has been covering management but not its kitchen or wait staff might be expected to drop its plan. A firm with a higher proportion of high-paid workers might retain its plan because the cash-out needed to maintain the higher-paid workers' current total compensation level would be greater than the cost of the health plan.

Can employers somehow game the system, retaining coverage for their higher-income workers while pushing the subsidy-eligible workers into the individual market? There are certainly options. Some workers' hours could be reduced below the 30-hour full-time threshold; others' jobs could be outsourced. One step that would not be permissible would be the restructuring of a company into separate high- and low-wage firms or several firms with fewer than 50 employees; the ACA retains existing rules in the tax code that require aggregation of related organizations.

Finally, the choice about whether to offer coverage may not be simply a matter of weighing premiums against penalties. Employers whose health plans offer effective wellness programs might continue those plans because they expect offsetting savings in the form of improved productivity, decreased absenteeism, and so on.<sup>15</sup> Employers might also perceive less tangible benefits from offering their own plan, such as maintaining employee good will or reinforcing employees' identification with the company.

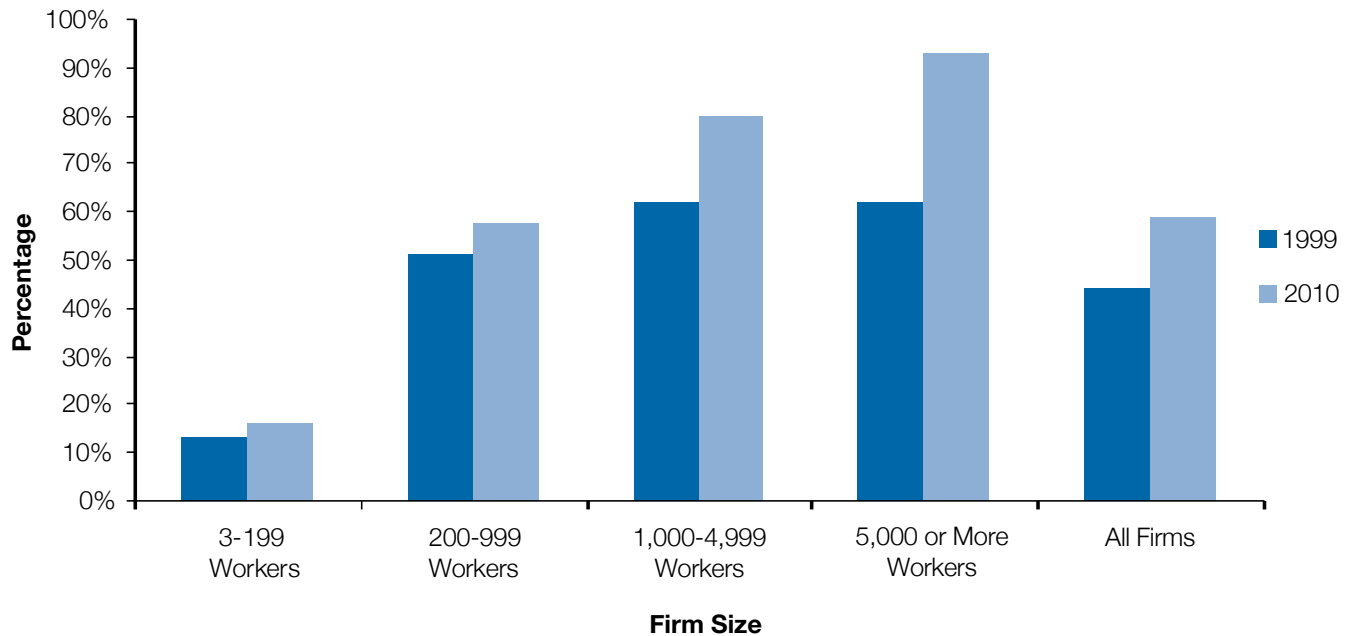
### Affordability test

As noted earlier, the ACA uses an affordability test to determine which individuals with access to employer coverage may nevertheless shift to subsidized coverage in the individual exchange. If a worker's premium contribution for single coverage is more than 9.5 percent of income, the worker may shift to the subsidized exchange while the employer pays a \$3,000 penalty.

Employers will need to decide whether to adjust their plan benefits or contribution schemes in order to pass the affordability test and avoid the penalty. Many firms are already contributing much more than \$3,000 per worker for health coverage and would have little reason to modify their arrangements to avoid the penalty. However, there are exceptions: in 2010, the average total premium for single coverage was \$5,049, and employers contributed an average 81 percent. At the same time, 20 percent of workers participated in plans with a total premium of \$4,039 or less, and 28 percent of workers contributed more than 25 percent of the premium for single coverage.<sup>16</sup> So there will probably be firms for which the penalty exceeds what they now pay. Moreover, it is the firms with a high proportion of low-wage workers that are most likely to require workers to pay a high share of their own premiums.<sup>17</sup> For some of these firms, the affordability rules could be a strong reason for dropping coverage altogether.

Analysts have suggested some options for avoiding the penalty without increasing overall employer spending. One option is to adopt a sort of reverse discrimination—contributing more to low-wage workers' premiums than to those of high-wage workers.<sup>18</sup> Another option would reduce the workers' share of costs for single coverage while raising the share paid by those electing family

FIGURE 1. **Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Sizes, 1999 and 2010**



Source: "Employee Health Benefits 2010 Annual Survey," Kaiser Family Foundation and Health Research & Educational Trust, September 2, 2010. Also see <http://ehbs.kff.org/>

coverage.<sup>19</sup> (Only the ratio of the single contribution to income is considered in assessing the penalty.)

Leaving aside the employers who require unusually high contributions from their workers, should employers with more generous plans be concerned if they fail the affordability test for some number of their lower-wage employees? The answer could be “yes”—not because the penalty would cost more than the employer is currently paying but because the rules create a risk of adverse selection.

It should be emphasized that workers who *could* shift to the individual exchange under the affordability rules may instead choose to remain in the employer plan. It is possible that workers will make choices according to their risk level or degree of risk aversion. A young, low-risk worker faced with a high contribution for the employer plan might choose to shift to the exchange and join a “young invincible” (catastrophic) plan with a premium subsidy. An older or higher-risk worker might be willing to pay somewhat more than 9.5 percent of income for a generous employer plan rather than accept less comprehensive coverage in the individual exchange. There is a real concern that such self-selection will lead to deterioration of some employer pools.

The pool may be further compromised if, as now, some low-risk employees for whom coverage is “affordable” nevertheless opt out. In theory, the individual mandate would encourage them to accept the employer plan. Employees who decline affordable employer coverage would be ineligible for a premium subsidy for

individual coverage and could face a penalty if they did not obtain such coverage. Some observers contend, however, that the penalties for non-compliance—\$695 for a single person in 2016—are small enough that opt-out will remain a potential problem.<sup>20</sup> (In 2010, the average worker contributed \$900 for single coverage, a figure that will surely be higher in 2016.<sup>21</sup>) It is true that, if an employee were to forgo the employer contribution, he or she would accept reduced total compensation, “leaving money on the table.” Employees whose required contribution for the employer plan was more than the penalty might, however, make such a choice.

### Self-insurance

Employers have always had a choice between buying a group plan from a health insurer or self-insuring—paying claims directly, usually relying on a third-party administrator that processes claims and performs other management tasks. Self-insured plans are typically less costly than comparable insured coverage because of their lower administrative costs and exemption from state mandatory benefit laws, premium taxes, or other regulation. Typically, large firms have been more likely to self-insure because they have large enough pools of participants and command enough resources to carry the insurance risk. Many smaller and medium-sized firms, however, also self-insure, often passing a large share of the risk to a private reinsurance company.

The ACA contains several provisions that will strengthen the incentives for some employers to self-insure as of 2014. Two may be especially important.

First, plans sold by insurers in the individual and small group markets will have to provide standardized benefits. These will cover a set of “essential” services to be defined by HHS, and will pay on average a specified percentage of total allowed costs for those services—ranging from 60 percent for a “bronze” plan to 90 percent for a “platinum” plan. Self-insured plans will define their own benefit packages. To avoid the play-or-pay penalty, the plan will have to pay at least 60 percent of the costs for whatever services are included. But the employer decides what these services are (except for required preventive services).

How much difference the benefit rules will make at the outset is unclear. Large employers are exempt even if they buy insurance, and most are probably providing benefits comparable to what is likely to be defined as essential benefits. (Essential benefits are supposed to be equal to the “scope of benefits provided under a typical employer plan,” as determined through a survey of employers of all sizes.) Smaller employers who currently offer less generous packages, however, might shift to self-insurance. Even those whose current plans would meet essential benefit standards could elect self-insurance if they wish to reduce benefits in the future.

Second, if states choose to open the SHOP exchanges to large employer groups, insurers selling to large groups—whether or not through the exchange—would be subject to the same rating requirements as insurers operating in the individual and small group markets. Large group rates could vary only by geographic area, family size, age, and tobacco use rather than—as is now common—by claims experience or expected risk levels. Consequently, large employers with low-risk populations could decide to self-insure while high-risk groups would seek coverage in a steadily deteriorating large group market.

Even if states don’t open the exchange to larger groups, there will be incentives for low-risk small groups to self-insure, while the high-risk groups enter the SHOP exchange. These incentives will be enhanced by the fact that self-insured small groups will not be required, as insured groups will, to participate in the risk adjustment system, which will transfer revenues among insurers on the basis of their risk profiles. (Some people have suggested limiting small employers’ ability to self insure by restricting the amount of risk that can be passed off to a private reinsurer.<sup>22</sup>)

### Excise tax

The excise tax, while initially proposed as a way to discourage a few so-called “Cadillac” plans, is set at levels that could affect a substantial number of employer plans. One analysis contends that as many as 60 percent of employers could hit the cost ceiling in 2018.<sup>23</sup> Whether or not this is the case, the number will almost

certainly rise in later years because ceilings will increase by only 1 percentage point above inflation. While the CPI-U grew at an annual rate of 2.4 percent between 2000 and 2010, average family premiums in employer plans rose by 7.9 percent per year. The Joint Committee on Taxation’s revenue estimates show proceeds from the tax nearly doubling, from \$12 billion to \$20 billion between 2018 and 2019 alone.<sup>24</sup>

The committee’s analysis assumes that most employers potentially subject to the excise tax will initially cut their benefits in order to bring costs below the ceiling. Economists tend to suppose that employees have some fixed total market value and that reductions in one form of compensation would be offset by increases in another. Therefore, the committee and other analysts assume that wages would rise when health benefits are cut. A substantial share of the revenues projected for 2018 and 2019 consists of taxes on these higher wages rather than the excise tax itself.<sup>25</sup> Over the longer term, this simple offset seems less likely. Arguably, if employers cut benefits year by year to keep costs from hitting the ceiling, they will not be reducing compensation but instead preventing compensation from growing faster than inflation.

Given that the excise tax is large and non-deductible, employers are likely to make substantial changes in their plans to avoid hitting the ceilings. They cannot simply shift costs to employees because both employer and employee premium contributions are counted. Employers may try to improve efficiency or cut benefits—increasing cost-sharing, shifting to high-deductible plans, and so on. But there is a catch: if the employer cuts benefits to the point at which the plan no longer pays 60 percent of the cost of covered services, every employee with income below 400 percent of the FPL would be eligible to shift to subsidized exchange coverage, and the employer would pay a \$3,000 penalty for each employee receiving a premium subsidy. In this scenario, continuing to offer an employer plan may no longer make sense.<sup>26</sup>

### What Will Happen to ESI?

Many employers—like many other Americans—have little understanding of how the ACA will affect them and thus are not at all sure what health benefit changes they might make in response to the law’s requirements. The Congressional Budget Office (CBO), the administration, and various independent analysts have offered varying projections of likely employer responses over the near term. But these projections are, perhaps even more than other such forecasts, full of uncertainty—because of data gaps, the many important policy decisions yet to be made, and the usual difficulty of guessing what will happen to health care costs and to the general economy in the years ahead.

**What employers think**

Even before enactment of the ACA, employers were doubtful about their ability to continue offering health benefits in the face of steadily increasing costs. Among large employers surveyed at the end of 2009, 57 percent were “very confident” they would still offer health insurance in 10 years, down from 73 percent just two years earlier.<sup>27</sup> Post-ACA polls so far show little change: in one survey, 51 percent of employers had concluded that they would not drop coverage as a result of the ACA while less than 1 percent were planning to drop their plans. Most of the rest were still analyzing the law or simply unsure about what they might do.<sup>28</sup>

There are at least two explanations for employers’ uncertainty. First, many employers do not feel that they fully understand the ACA. In January 2011, 62 percent of employers reported that they were “comfortable” with what they knew about the law, up from 48 percent in July 2010.<sup>29</sup> But this still leaves over a third pleading lack of knowledge, and many of the rest—especially smaller employers—are relying on insurance brokers as their chief source of information on the ACA. (One might wonder how many commissioned brokers are counseling clients to drop coverage.) Second, it is difficult for employers to be sure about what they want to do when so much of the law and policy is still in flux. Regulations covering many subjects (such as essential benefits) have not

yet been issued, and portions of the law could still be modified, repealed, or struck down.

As this brief was in press, McKinsey & Co. reported that 30 percent of employers surveyed in 2011 would “definitely or probably stop offering ESI in the years after 2014.” The authors note that this finding is different from those of other surveys, and explain that the survey “educated respondents about [the ACA’s] implications for their companies and employees before they were asked about post-2014 strategies.” Until more detailed information about the survey methodology is made available, it is difficult to assess whether it reflects how employers really will respond when they fully understand the ACA or whether respondents were simply reacting to specific scenarios posed by the surveyors.<sup>30</sup>

Employers do know what parts of the law they do not care for—a laundry list of controversial provisions such as the excise tax on high-cost plans, the individual mandate, and play-or-pay. Table 1 shows the results of a survey conducted by the Midwest Business Group on Health. Although this is just one survey, it raises a few points worth observing. First, large employers are generally more supportive of specific existing provisions than smaller employers, perhaps because they expect little direct impact from these provisions. Smaller firms even dislike provi-

**TABLE 1. Employer Views about How the New Congress Should Deal with Specific Provisions of the ACA, by Firm Size, December 2010**

	Small employers (up to 500 employees)			Large employers (more than 500 employees)		
	Repeal	Modify	Retain	Repeal	Modify	Retain
Excise tax on high-cost plans	65%	19%	16%	56%	33%	11%
Individual mandate for health insurance coverage	58%	22%	20%	39%	29%	32%
Penalties for employers with >50 workers who do not offer health insurance coverage	58%	23%	19%	39%	33%	28%
Creation of health insurance exchanges	38%	31%	33%	22%	31%	47%
Capping annual contributions to flexible spending accounts (FSAs) at \$2500	64%	23%	13%	64%	28%	8%
Extending coverage to employees’ adult children up to age 26	42%	19%	37%	45%	21%	34%
Elimination of annual and lifetime limits	29%	24%	47%	24%	26%	50%
Requiring free choice vouchers	56%	20%	22%	49%	27%	24%
Removal of co-pays for preventive services	42%	17%	41%	19%	14%	67%

Source: “Key Findings Of Employer Reaction To Health Reform--Post Election Survey,” Midwest Business Group on Health, December 22, 2010. Also see [https://www.mbg.org/templates/UserFiles/Files/Key%20Findings%20of%20Dec%202010%20Survey%20of%20Employers%20Reaction%20to%20Health%20Reform\(2\).pdf](https://www.mbg.org/templates/UserFiles/Files/Key%20Findings%20of%20Dec%202010%20Survey%20of%20Employers%20Reaction%20to%20Health%20Reform(2).pdf) Small employer responses calculated from published data.

sions intended to benefit them, such as health exchanges, perhaps because of general skepticism about the efficacy of government interventions. Second, employers' responses are not necessarily related to the expected costs of a specific provision. For example, most favor the elimination of lifetime and annual limits and of co-payments for preventive services.

### Projections of employer behavior

While employers themselves are unsure about their choices, several analyses of the ACA have attempted to model employers' likely behavior. The Congressional Budget Office had to make forecasts of employer responses to develop its projections of the ACA's budgetary impact and effects on the number of people with coverage from different sources. There have also been independent studies, some projecting that the ACA will have minimal impact on ESI, and at least one predicting a potentially dramatic shift from ESI to subsidized individual coverage.

Analysts have been attempting to model how firms might behave in a play-or-pay environment since the concept first emerged 20 years ago, but they have always encountered a key barrier: the absence of reliable information on the distribution of earnings *within* firms. Data are available on average worker earnings for firms of different sizes or in different industries or regions. But a firm whose average worker earns \$50,000 might have a mix of two workers earning \$25,000 for every one earning \$100,000; in another firm, most workers might have earnings clustered around \$50,000. Without better information on the heterogeneity or homogeneity of incomes in firms, it is hard to guess how firms will behave. (Even the firms themselves cannot know how their workers would fare under the two options because firms do not know their workers' total family incomes, including other family members' wages, and so may not be able to estimate how many would qualify for premium credits.) Some models attempt to deal with the income data problem; others do not.

The CBO projections show an initial slight increase in employer coverage—3 to 4 million people newly covered in 2011 through 2014, partly as a result of increased offers and partly because some people (such as dependents up to age 26) will be added to existing plans. After full ACA implementation, the CBO projects a slight drop in employer coverage: 3 million fewer people with employer coverage in 2016 through 2019 than would have been covered under the previous law. Of these, 1 million are workers moving into exchange coverage because the employer plan was not affordable.<sup>31</sup>

A study by the American Action Forum suggests that as many as 35 million workers would lose employer coverage and shift to exchanges, raising premium subsidy costs by \$1.4 trillion over 10 years.<sup>32</sup> However, the study assumes, for example, that a worker at 200 percent of poverty (and hence eligible for a large premium subsidy) works at a firm consisting entirely of such workers, all of

whom would benefit if the employer dropped coverage, paid the penalty, and shared savings with the employees.

Other analyses show much more modest effects. An Urban Institute study shows virtually no change in employer coverage. It assumes that firms dropping coverage would be offset by those newly offering it and also figures that enrollment in large employer plans would increase, mainly because workers who previously declined coverage would comply with the individual mandate. As suggested earlier, some other analysts are not so confident that workers will respond in this way. Another study, limited to effects in California, projects a drop in ESI of less than 1 percent.<sup>33</sup>

What will happen to ESI over the longer term is even harder to predict. How many firms will eventually drop coverage because of the long-range squeeze of the excise tax? Will the curve of premium growth be bent by payment reforms, new delivery models, and other innovations promoted by the ACA? Or will cost pressures lead to a gradual shift away from reliance on tax-favored employer coverage and toward tax-favored (and partially employer-supported) coverage through the individual exchanges?

Not everyone believes that a shift to individual coverage would be unwelcome. Many people have long argued that tying health insurance to employment reduces job mobility and discourages entrepreneurship. In addition, the current exclusion of employer-paid coverage from taxable income is regressive, giving greater benefits to workers in higher tax brackets. Some analysts have also suggested that a shift away from employer coverage would make people more conscious of the costs, especially people whose incomes exceed the premium subsidy level and who would pay their own premiums in full. The effect might be to reduce political resistance to cost containment measures.<sup>34</sup>

On the other hand, a large-scale shift from ESI to the individual market could dramatically increase the cost of the federal premium tax credits. The cost might be partially offset by a reduction in the current tax expenditure for ESI—if employers converted non-taxable health benefits to taxable wages. If, instead, employers simply dropped coverage or provided other tax-favored benefits (such as higher matching for 401(k) plans), the offsetting revenues might not materialize.

People have been predicting the collapse of America's employer-based coverage system for many years. At this point, even the best designed simulations of how the ACA will affect employers' and employees' behavior are still simulations. Until the complex new matrix of rules and incentives created by the ACA takes full effect, it is impossible to predict whether the law will help shore up ESI or hasten its demise. What can be said with some confidence is that major health care legislation has rarely produced exactly the results projected by experts, and policymakers are likely to be tinkering with the ACA's rules for a long time to come.



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Mark Merlis is an independent health policy consultant.

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