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Realizing Health Reform's Potential:

Jobs Without Benefits: The Health Insurance Crisis Faced by Small Businesses and Their Workers

EMBARGOED
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Abstract: The share of U.S. workers in small firms who were offered, eligible for, and covered by health insurance through their jobs has declined over the past decade. Less than half of workers in companies with fewer than 50 employees were both offered and eligible for health insurance through their jobs in 2010, down from 58 percent in 2003. In contrast, about 90 percent of workers in companies with 100 or more employees were offered and eligible for their employer's health plans in both 2003 and 2010. Workers in the smallest firms—and those with the lowest wages—continue to be less likely to get coverage from their employers and more likely to be uninsured than workers in larger firms or with higher wages. The Affordable Care Act includes new subsidies that will lower the cost of health insurance for small businesses and workers who must purchase coverage on their own.

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OVERVIEW

Employer-based health insurance is the primary source of health care coverage in the United States, covering 160 million workers and their families.[1] However, over the past 10 years—between 2001 and 2011—the share of the individuals under age 65 who are covered by employer plans has fallen from 68 percent to 57 percent.[2] Nearly all of the erosion has occurred among small firms.[3] The reason is clear: on average, small businesses pay more for the same benefits than do large firms. According to a 2006 analysis, small businesses pay nearly 18 percent more, on average.[4] These higher rates are the result of a number of factors: the ability of insurance carriers in many states to charge small firms higher premiums based on the health, age, and gender of their workforces, as well as the kind of business it is, and because of higher per-employee administrative costs, including broker commissions.[5]

New provisions already in effect under the Affordable Care Act have sought to alleviate the financial burden insurance creates for small employers. Small businesses with fewer than 25 employees and average wages of less than $50,000 can claim tax credits of up to 35 percent against the cost of their premium contributions. About 360,000 small businesses covering an estimated 2 million workers are projected to have claimed the credits in 2011.[6] In addition,

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insurance carriers selling policies in the small-group market are required to spend at least 80 percent of their premium dollars on medical costs, as opposed to profits and overhead, or pay rebates to subscribers. An estimated 3.3 million employees of small firms and their families received $321.1 million in rebates this year.[7] Another set of insurance market reforms will roll out in January 2014 that will ban all insurance carriers from denying or limiting coverage based on employees' health or gender or the industry they work in. They will also provide new health plan choices and premium subsidies for both small employers and their employees.

A new analysis of the Commonwealth Fund's Biennial Health Insurance Survey of 2010 shows how crucial these new health reforms are for small firms and their workers. Among workers in businesses with fewer than 50 employees, the share of workers who worked for a firm that offered coverage, were eligible for coverage when it was offered, and who ultimately enrolled in their employers' plans fell significantly between 2003 and 2010. Fewer than half (49%) of workers in small firms were offered and eligible for coverage through their jobs in 2010, down from 58 percent in 2003. Only one-third actually enrolled in employer plans in 2010, compared with 42 percent in 2003. In contrast, about 90 percent of workers in firms of 100 or more workers were offered and eligible for benefits through their jobs in 2003 and 2010 and around seven of 10 were covered by their companies' health plan in both years. Consequently, workers in small firms were far more likely to be uninsured than those in large firms: 40 percent of workers in firms with fewer than 50 workers were uninsured at some point in 2010, more than twice the rate of those working in firms with 50 workers or more (15%).

The study finds a substantial income divide in small and large firms. Workers who earn low wages in small firms are the least likely to be offered health benefits by their employers, to be eligible for benefits in companies that do offer them, and to be covered by their companies' health plans. Among workers in firms with fewer than 50 employees, only one-third (34%) of those earning less than $15 an hour were offered and eligible for health benefits at their job in 2010 and only 18 percent were covered by their companies' health plans. In contrast, 70 percent of workers in small firms who earn $15 or more per hour were offered and eligible for health benefits and half (53%) were enrolled in health plans. While low-wage workers in large firms fared better than those in small firms, these workers were also much less likely to be offered, eligible for, and covered by health benefits from their employer than higher-wage workers in large firms. Consequently, low-wage workers in small and large firms were far more likely to be uninsured than were higher-wage earners in both small and large firms. Among workers earning less than $15 an hour, more than half (54%) of those in small firms and one-third in large firms were uninsured at some point in 2010. In contrast, among workers earning $15 or more an hour, 19 percent of workers in small firms and 7 percent in large firms were uninsured in 2010.

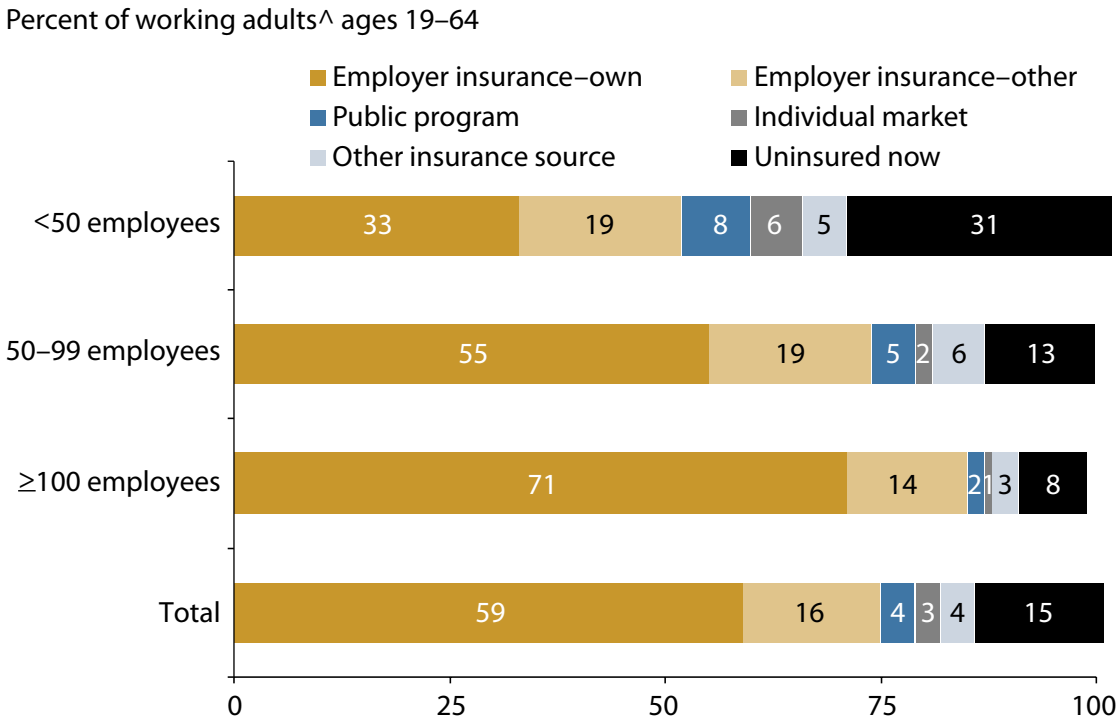
Workers in small firms are also less likely to have a choice of plans and to have health plans that leave them more exposed to costs. Only 36 percent of small-firm workers with health benefits from their employer were offered a choice of plans, compared with two-thirds (66%) of those in firms with 50 or more workers. In addition, 31 percent of small-firm workers faced an annual deductible of $1,000 or more compared with 21 percent of those in large firms. Fifteen percent of small-firm employees did not have prescription drug coverage included in their benefits packages, compared with 4 percent of larger-firm employees.

FINDINGS

The Majority of U.S. Workers Get Health Insurance from an Employer

Most U.S. workers have health insurance through an employer, either their own or a family member's. In 2010, three of five (59%) adults ages 19–64 who were working full- or part-time and who were not self-employed had health insurance from their own employer; an additional 16 percent were covered through a family member's employer (Appendix Table 1, Exhibit 1).[8] One of every four (26%) workers was not covered by an

Exhibit 1. Only One of Three Small-Firm Workers Was Insured Through Their Employer in 2010



^ Includes both part-time and full-time workers who are not self-employed.
Note: Subgroups may not sum to 100 percent because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

employer plan: 4 percent had public coverage (Medicaid or Medicare), 3 percent purchased their own plan in the individual market, 4 percent reported coverage from another source, and 15 percent were uninsured.

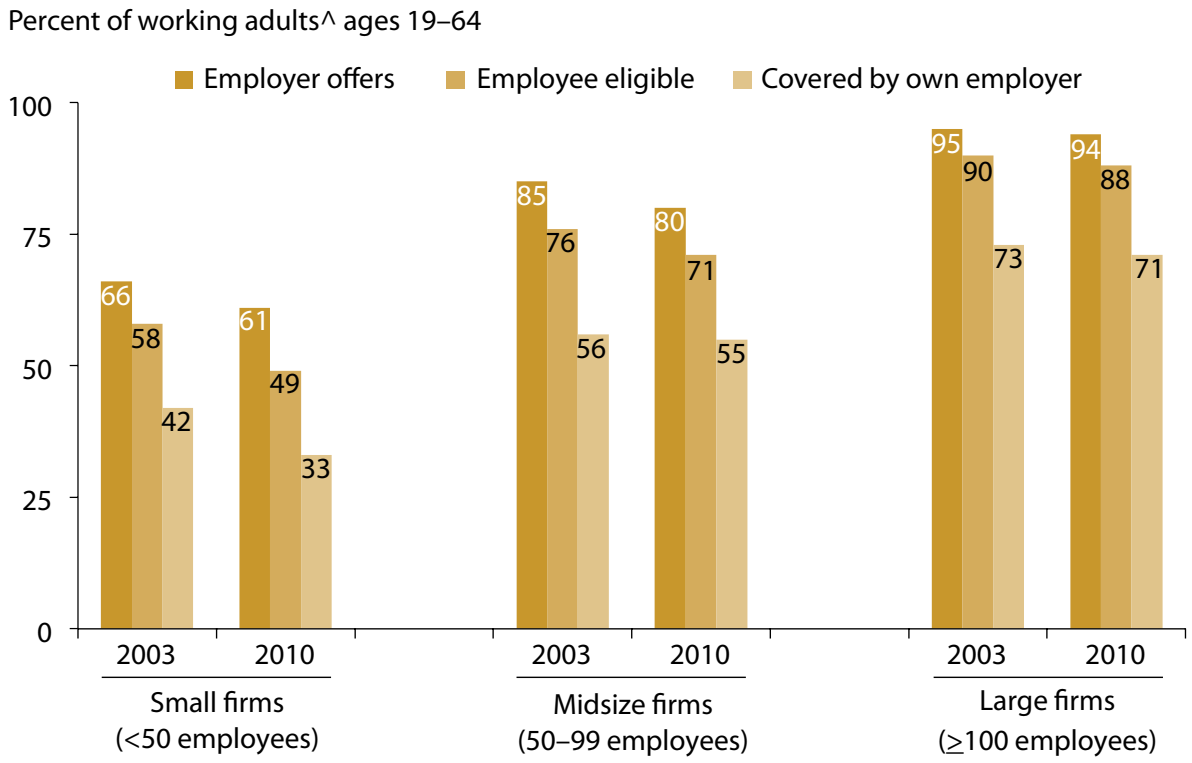
Employees in small firms were the least likely of all workers to have health benefits through their jobs. One of three (33%) workers in firms with fewer than 50 employees said they had health benefits through their own employer in 2010 (Exhibit 1). In comparison, more than half (55%) of workers in midsize firms with 50 to 99 employees were covered by their own employers' plans, as were more than seven of 10 (71%) workers in firms with 100 or more employees.

About one-third of employees in small firms reported coverage through other sources at the time of the survey, including other employer plans, public insurance programs, and the individual market, but nearly one-third (31%) were uninsured. This is more than twice the share of employees in midsize firms who were uninsured (13%) and nearly four times the share of uninsured employees in large firms (8%).

Share of Small-Firm Employees Who Were Offered, Eligible, and Enrolled in Employer's Health Plan Declined

Over the past decade, fewer workers in small firms were offered health insurance, fewer were eligible to enroll in their company's health plans, and fewer enrolled. In 2010, slightly under half (49%) of workers in small firms were both offered and eligible for coverage through their jobs, down from 58 percent in 2003 (Exhibit 2). Only one-third had benefits through their jobs, compared with 42 percent in 2003. In contrast, 71 percent of workers in midsize firms with 50 to 99 employees were both offered and eligible for coverage through their employers in 2010, statistically unchanged from 2003. Fifty-five percent enrolled in their employers' plans, about the same rate as in 2003. About 90 percent of workers in large firms of 100 or more workers were both offered and eligible for their employers' plans in both 2003 and 2010 and about 70 percent enrolled in the plans.

Exhibit 2. Declining Share of Small-Firm Employees Offered, Eligible for, and Covered by Own Employer Health Benefits, 2003–2010



^ Workers include both part-time and full-time workers who are not self-employed.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2010).

The reasons workers may not be eligible for health benefits include not working a sufficient number of hours or being in a waiting period for coverage.[9] This disproportionately affects workers in small firms who are more likely to work part time. In the survey, more than one of four (29%) workers in firms with fewer than 50 employees worked part-time, compared with half that rate (14%) among workers in larger firms (data not shown).

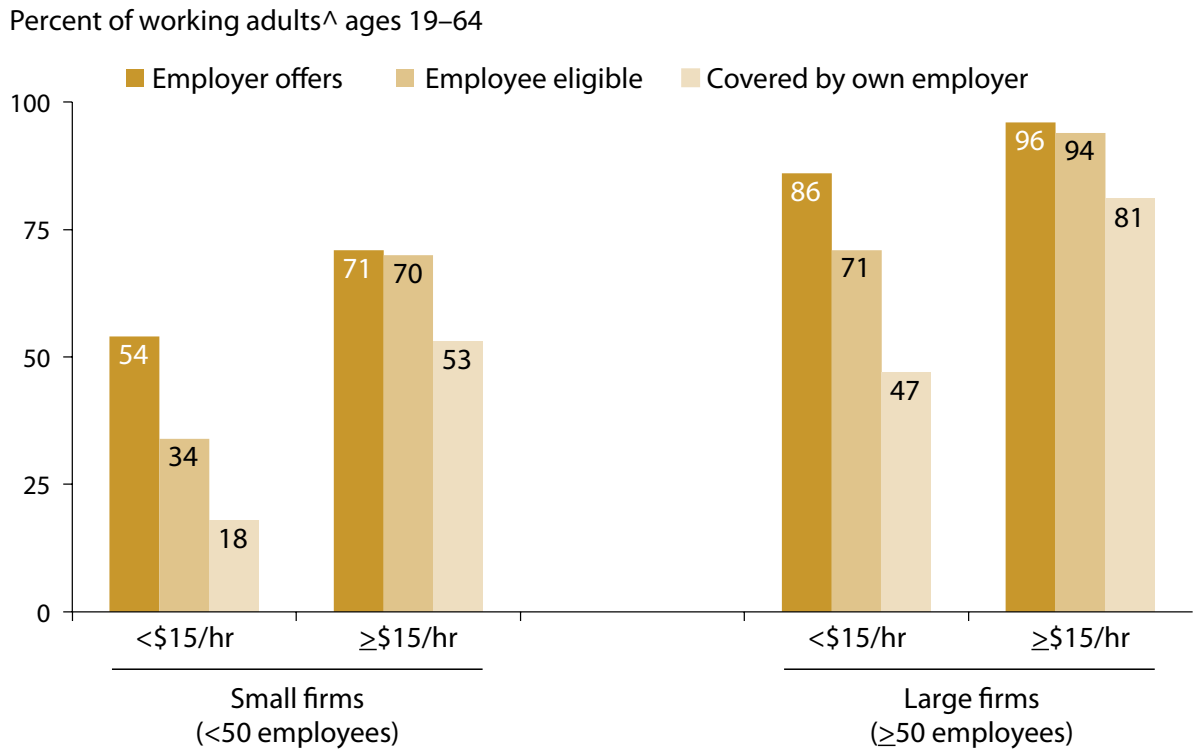
Low-Wage Workers in Small Firms Have Lowest Rates of Employer Based Health Coverage

Low-wage workers in small firms were the least likely to be eligible for employment-based health benefits and had the lowest rates of employer coverage. Slightly over half (54%) of small-firm employees who earned less than $15 an hour worked for companies who offered health insurance in 2010; only one-third (34%) were eligible for health benefits (Exhibit 3). In contrast, 71 percent of small-firm employees with higher wages worked for companies that offered insurance, almost all of whom were eligible for their employer's health plan. In larger firms, offer rates were higher for both low-wage (86%) and higher-wage (96%) workers. However, eligibility rates were lower for large-firm workers who had wages under $15 an hour (71%) compared with those with higher wages (94%).

Low-wage workers in small and large firms were the least likely of all employees to have health benefits through their jobs. Only 18 percent of small-firm workers who earned less than $15 an hour were covered by their own employers' health plans in 2010, compared with more than half (53%) of higher-wage workers in small firms (Exhibit 3). In larger firms, only 47 percent of workers with wages under $15 an hour had health benefits through their jobs, compared with 81 percent of those with higher wages.

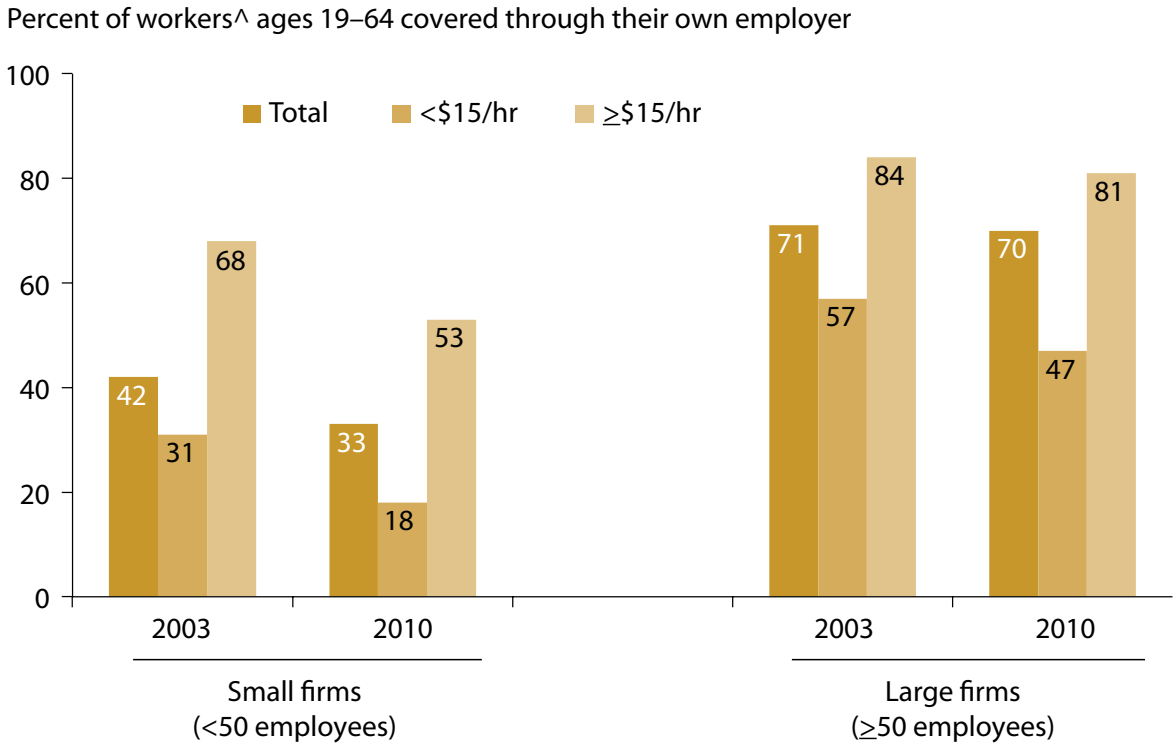
Between 2003 and 2010, the share of workers with coverage through their employers declined for both low-wage and high-wage workers in small firms and among low-wage workers in large firms (Exhibit 4).

Exhibit 3. Fewer Than One of Five Low-Wage Employees in Small Firms Has a Health Plan Through Their Employer



^ Workers include both part-time and full-time workers who are not self-employed.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Exhibit 4. Employer Coverage Rates in Small Firms Declined for Low- and Higher-Wage Workers, 2003–2010



^ Workers include both part-time and full-time workers who are not self-employed.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2010).

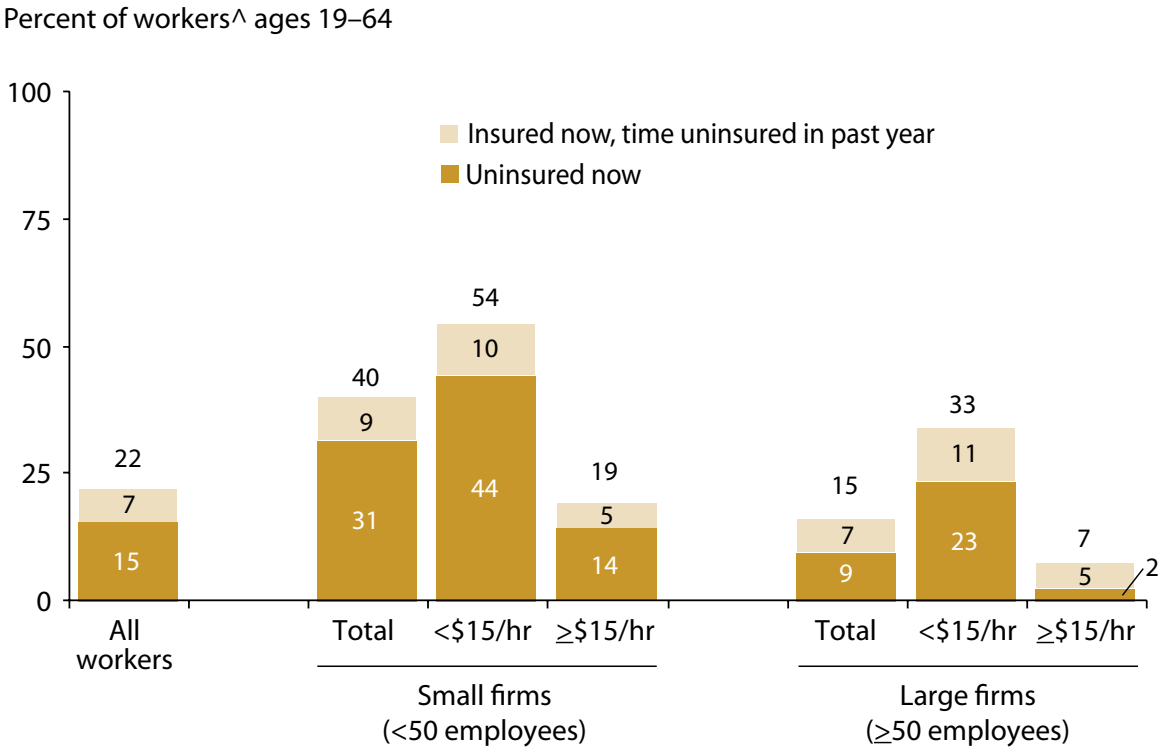
The percentage of workers in small firms with health benefits through their jobs dropped from 31 percent among low-wage workers in 2003 to 18 percent in 2010 and from 68 percent among high-wage workers to 53 percent over the same time period. Own-employer coverage rates among low-wage workers in large firms fell by 10 percentage points over the same period, from 57 percent to 47 percent. These decreases in own-employer coverage in small and large firms occurred among full-time employees—not among those working part-time hours (data not shown). The only group of workers who did not report a drop in coverage through their own jobs were high-wage workers in large firms. For these workers, the share covered by their own employers' plan remained at around eight of 10 in 2003 and 2010.

More Than Half of Low-Wage Workers in Small Firms Were Uninsured at Some Point During 2010

Limited access to employer-based health benefits and a lack of affordable alternatives leave many workers in small firms without health insurance. Two of five (40%) workers in firms with fewer than 50 employees reported being uninsured at some point in 2010 (Exhibit 5). Thirty-one percent were uninsured at the time of the survey and 9 percent were insured but had spent some time without health insurance in the past year. Fifteen percent of workers in larger firms were uninsured during the year.

Workers in small and large firms with low wages were most likely to lack health insurance. More than half (54%) of workers in firms with fewer than 50 employees who earned less than $15 an hour reported being uninsured during 2010—nearly three times the rate (19%) among higher-wage workers in small firms.

Exhibit 5. More Than Half of Low-Wage Workers in Small Firms Were Uninsured During 2010



^ Includes both part-time and full-time workers who are not self-employed.
Note: Subtotals may not sum to total because of rounding.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

One-third of low-wage workers in large firms were uninsured in 2010, compared with 7 percent of higher-wage workers in large firms.

When offered and eligible for health insurance, all workers in small firms are less likely to take up coverage than those working in larger firms. In 2010, the take-up rate of job-based health insurance among eligible workers in firms with fewer than 50 employees was 66 percent, compared with 81 percent among eligible workers in larger firms (Appendix Table 1). Take-up rates were lower among lower-wage workers than higher-wage workers in both large and small firms (data not shown). Moreover, most higher-wage workers in both small and large firms who did not take up coverage through their jobs had health insurance through another source, most frequently another employer. In contrast, larger shares of workers with low wages in small and large firms who were eligible for coverage through their jobs but did not enroll were uninsured.

Over the past decade, with fewer lower-wage workers in small firms receiving health benefits through their jobs, the share who were uninsured ballooned by nearly 10 percentage points from 45 percent in 2003 to 54 percent in 2010 (data not shown). In contrast, while the share of higher-wage workers in small firms with employer-based health benefits also declined, most found coverage through another source. The share of uninsured workers in this group did not change.

The Individual Insurance Market Is Not an Affordable Option, Particularly for Low-Wage Workers

For workers who are unable to gain health insurance through an employer or public program, the individual insurance market is generally their only option for coverage. Fifteen percent of full-time and part-time workers, including those who are self-employed, reported they had looked for health insurance in the individual insurance market in the past three years (Exhibit 6). However, high premiums, limited benefit packages, and denials or benefit exclusions because of preexisting health conditions make the market a considerable challenge for those shopping for a health plan.

Of those workers who had shopped for coverage in the individual market, one of three (34%) found it very difficult or impossible to find the type of coverage they needed and more than half (55%) found it very difficult or impossible to find coverage they could afford. More than one of four (28%) reported they were

Exhibit 6. The Individual Insurance Market Is Not an Affordable Option for Workers and the Self-Employed

Working adults^ ages 19–64:	Total	<50 employees	≥50 employees	<$15/hr	≥$15/hr
Have individual coverage or tried to buy it in past three years	15%	19%	13%	19%	12%
Found it very difficult or impossible to find coverage they needed	34	34	33	40	31
Found it very difficult or impossible to find affordable coverage	55	53	56	65	48
Were turned down, charged a higher price, or had condition excluded because of a preexisting condition	28	26	28	32	26
Any of the above	65	66	64	75	58
Never bought a plan*	47	44	48	55	40

^ Includes both part-time and full-time workers.
* Among those who tried to buy a plan.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

turned down, charged a higher price, or had a health condition excluded from coverage because of a pre-existing condition. In all, nearly two-thirds (65%) of workers who had searched for health insurance in the individual market in the past three years experienced at least one of these three problems. Consequently, nearly half (47%) of those who looked never ended up buying a plan.

Similar rates of workers in small and large firms reported problems finding individual market insurance. However, low-wage workers found it particularly difficult to find a plan. Three-quarters (75%) of workers in firms of all sizes with wages of less than $15 an hour who shopped in the individual market in the past three years experienced one of three problems the survey asked about, compared with 58 percent of those with wages of $15 an hour or higher. More than half (55%) of workers with low wages never ended up buying a plan compared with 40 percent of workers with higher wages who said they had never enrolled.

Workers in Small Businesses Have Fewer Choices, Less-Adequate Benefits Packages

Workers in small business who get coverage through their employers have less choice of health plans than workers covered by large firms. Among small-firm workers with health benefits through their jobs, 36 percent reported that they were offered a choice of plans compared with two-thirds of large-firm workers (Appendix Table 2).

Health plans offered by small employers also generally include greater cost-sharing responsibilities and less-generous benefit packages than plans offered by larger firms. Nearly one-third (31%) of employees covered through firms with fewer than 50 employees reported their coverage included a deductible of $1,000 or more in 2010, compared with 21 percent of those covered through larger firms. Fifteen percent of small-firm workers who were covered by their company's health plan did not have prescription-drug coverage, almost four times the rate (4%) of large-firm employees.

Overall, small-firm employees were less satisfied with their health plans. More than one-quarter (29%) rated their insurance as fair or poor, compared with 16 percent of those in larger businesses. Workers who earned less than $15 an hour in firms of all sizes were also more likely to rate their plan as fair or poor (27%) compared with those earning $20 or more an hour (14%) (Appendix Table 2).

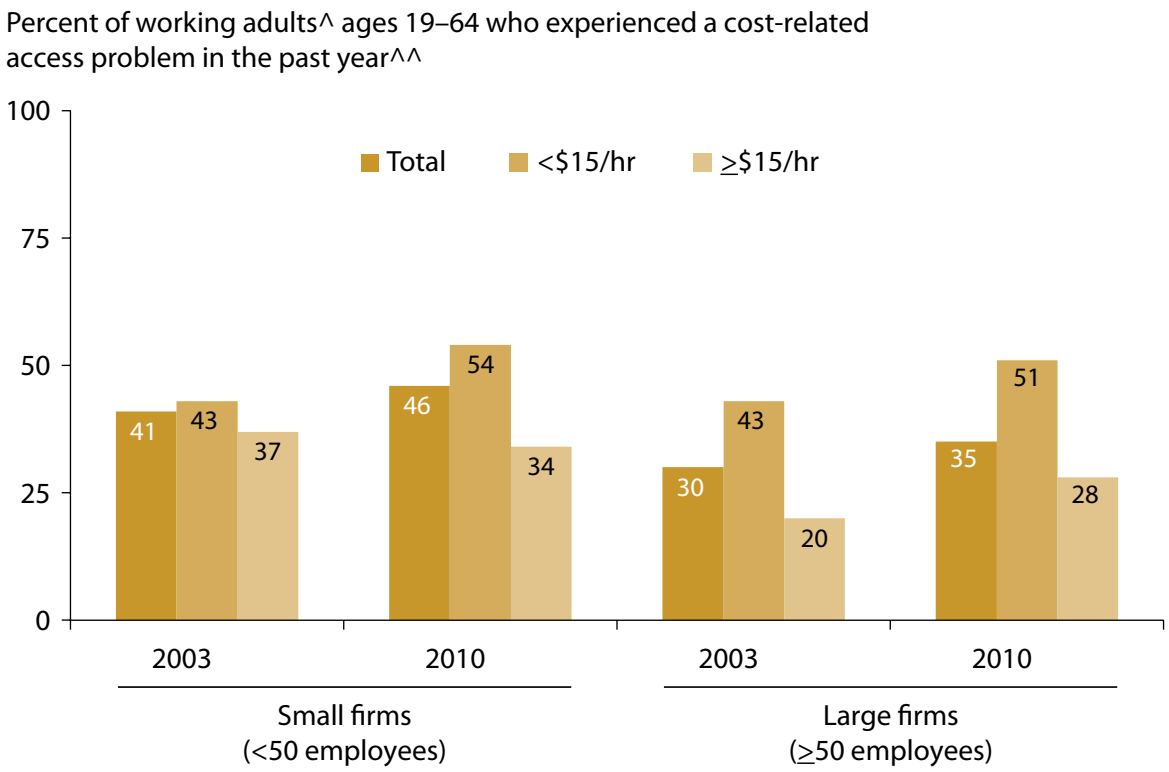
Low-Income Employees Most Likely to Report Cost-Related Problems Getting Needed Care

Workers in small firms were more likely than those in large firms to report they did not get needed care because of cost. Nearly half (46%) of workers in small businesses reported in 2010 that they had cost-related problems getting needed care in the past year compared with one of three (35%) workers in firms with 50 or more employees (Exhibit 7, Appendix Table 3). These problems included: not getting needed care from a doctor or clinic; not filling a prescription; skipping a recommended test, treatment, or follow-up; or not getting needed specialist care—all because of cost.

Across businesses of all sizes, workers with low wages report the highest rates of cost-related problems getting needed care. Fifty-four percent of small-firm workers earning less than $15 an hour reported problems getting needed care in 2010 compared with 34 percent of higher-wage workers in small firms. Low-wage workers in larger firms also reported going without needed care at high rates: 51 percent reported a cost-related access problem in 2010, nearly double the rate (28%) of higher-wage, large-firm employees and similar to the rate of low-wage employees in small firms.

Between 2003 and 2010, the share of low-wage workers who reported going without needed care because of cost increased in firms of all sizes. Among workers earning less than $15 an hour, the percentage who reported going without needed care because of cost climbed from 43 percent in 2003 to 54 percent among those employed in small firms and from 43

Exhibit 7. Cost-Related Problems in Getting Needed Care Increased for Low-Wage Workers, 2003–2010



^ Workers include both part-time and full-time workers who are not self-employed.
^^ Any of the following because of cost: had a medical problem; did not visit doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get needed specialist care.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2003 and 2010).

percent to 51 percent among those working in large companies.

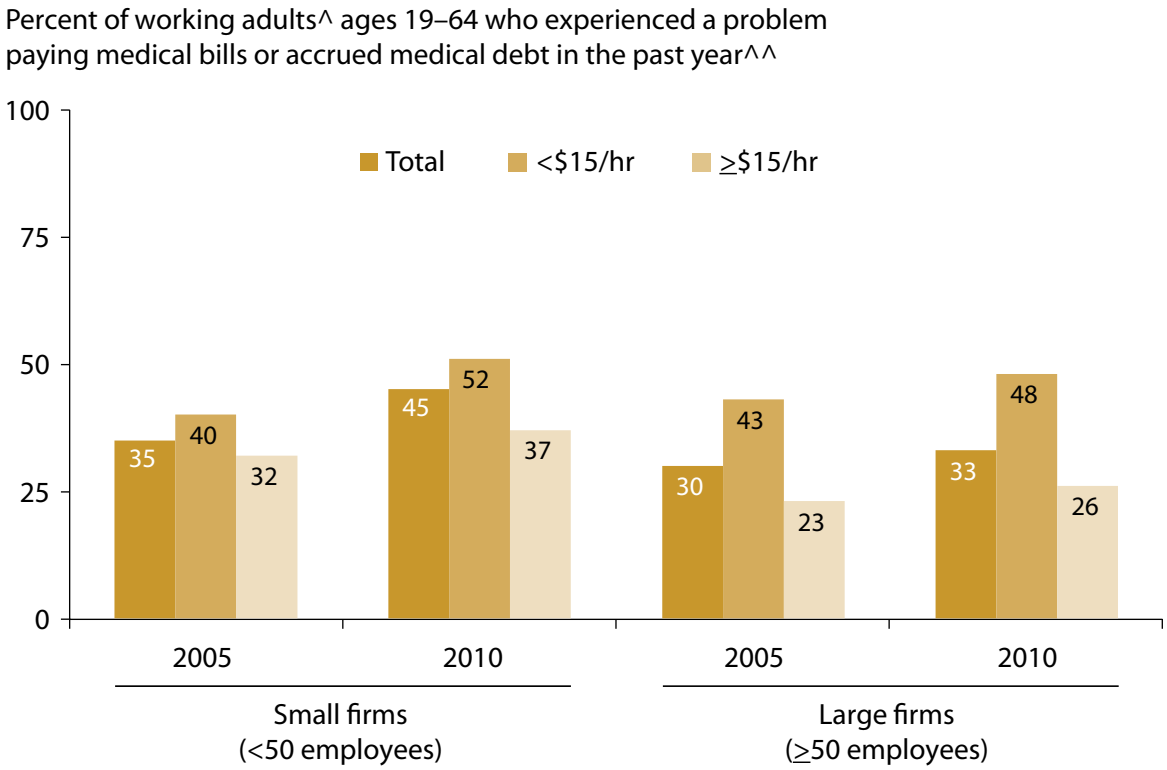
Low-Wage, Small-Firm Workers Report Highest Rates of Problems Paying Medical Bills and Medical Debt

Workers in small firms also reported problems paying medical bills at higher rates than those in larger firms. More than two of five (45%) workers in small firms said they had problems with medical bills compared with one of three (33%) of those in larger firms (Exhibit 8, Appendix Table 3). This included having problems paying or being unable to pay medical bills, being contacted by a collection agency for unpaid medical bills, having to change their way of life to pay bills, or paying off medical bills over time.

Again, low-wage employees across firms of all sizes reported problems paying medical bills at the highest rates. In 2010, slightly over half (52%) of small-firm workers earning less than $15 an hour reported problems with medical bills or medical debt, compared with 37 percent of small-firm workers with higher wages (Exhibit 8). Similarly, 48 percent of low-wage workers in large firms reported medical bill and debt problems in 2010, 22 percentage points higher than the rate among higher-wage, large-firm employees and similar to the rate among low-wage, small-firm employees.

Between 2005 and 2010, the share of small-firm workers who reported problems paying their medical bills increased by 10 percentage points, from 35 percent to 45 percent.[10] Low-wage workers in small firms were the most affected, with reported rates climbing by more than 10 percentage points from 40 percent to 52 percent.

Exhibit 8. Problems Paying Medical Bills Increased for Workers in Small Firms, 2005–2010



^ Workers include both part-time and full-time workers who are not self-employed.
^^ Had problems paying or unable to pay medical bills; contacted by collection agency for unpaid medical bills; had to change way of life to pay bills; medical bills being paid off over time.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2010).

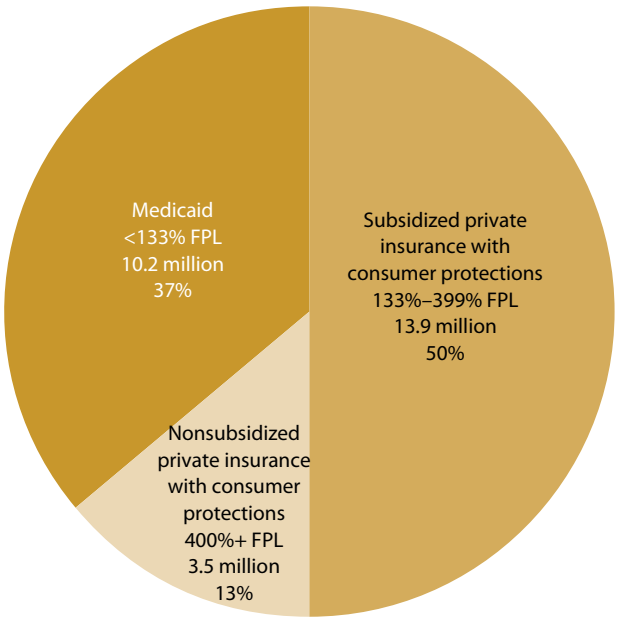
THE AFFORDABLE CARE ACT: PROVISIONS FOR SMALL EMPLOYERS AND THEIR EMPLOYEES

Provisions in the Affordable Care Act, some already in place, are targeted to improve the affordability, comprehensiveness, and choice of health plans for small businesses and their employees.[11] The provision of new affordable coverage options beginning in 2014 in particular will address the needs of the rising numbers of low-wage workers in both small and large firms who are uninsured. Most of the 27.6 million workers in small and large firms who were uninsured in 2011 would be eligible for subsidized private insurance or Medicaid starting in 2014 (Exhibit 9). Workers with higher incomes will benefit from new consumer protections and a simpler, more structured choice of health plans.

Limits on Administrative Costs and Premium Review

Certain practices and features of the insurance industry have driven growth in administrative costs in recent years. These include the practice of charging people different premiums based on factors such as their health status or gender, a lack of economies of scale in the individual and small-group insurance markets, broker fees, and marketing. Such elements have increased per-capita administrative costs by 85 percent over the past decade, compared with a 66 percent increase in overall health spending.[12] The Commonwealth Fund Commission on a High Performance Health System estimates that if the United States reduced insurance administrative costs to the average level of other industrialized countries with similar mixed private and public health care systems—such as Germany, the Netherlands, and Switzerland—the country could save $55 billion annually.[13]

Exhibit 9. Uninsured Workers with Low and Moderate Incomes Will Be Eligible for Subsidized Insurance in 2014



27.6 million uninsured workers, 2011

Notes: FPL refers to federal poverty level. Workers are full- and part-time workers.
Source: Analysis of the March 2012 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

To help lower the rate of growth in administrative costs, the Affordable Care Act began requiring insurers to report the share of premiums they spend on medical care and quality improvement activities in 2011 (known as a "medical loss ratio"), as opposed to the share spent on profits, overhead, marketing, and other administrative activities.[14] Starting in August 2012, insurance carriers in the small-group and individual markets who spent less than 80 percent of their premiums on medical costs and quality improvement and insurers in the large-group market who spent less than 85 percent were required to pay rebates to subscribers for the difference. In 2012, insurers who did not meet the medical loss ratio requirement paid out $1.1 billion in rebates to 12.8 million Americans.[15] More than 3 million people who were insured through small employers received $321.1 million in rebates, an average of $174 per family.

Since 2011, the law also has required any insurer that increases premiums by 10 percent or more in the individual or small-employer group markets to justify the increase to state officials and the U.S. Department of Health and Human Services (HHS).[16] According to HHS, this premium review saved consumers an estimated $1 billion in 2012.[17] Starting in 2014, states can recommend that health plans be excluded from participation in the insurance exchanges if they have demonstrated a pattern of excessive or unjustified premium increases.

Small-Business Tax Credits

The health reform law provides tax credits that reduce the cost of premiums for small businesses that offer health insurance to their employees.[18] From 2010 to 2014, small businesses with fewer than 25 employees and average wages below $50,000 can claim a tax credit for up to 35 percent of an employer's premium contribution—25 percent if they are nonprofit—which must be at least 50 percent of the premium. From 2014 to 2016, small businesses may claim a credit of up to 50 percent of the employer's premium contribution—35 percent for nonprofits—for health plans purchased through the new health insurance exchanges. In the 2010 tax year, 170,300 small businesses claimed tax

credits worth $468 million.[19] For the 2011 tax year, the Obama administration estimates the number of businesses claiming the credit will rise to 360,000, benefitting 2 million workers.[20] The administration has also proposed expanding eligibility for credits to employers with up to 50 employees.[21]

Insurance Market Protections for Individuals and Small Businesses

The Affordable Care Act initiated a set of sweeping reforms of the individual and small-group insurance markets that began to take effect in 2010 and will continue to be implemented through 2014. Nearly all states have taken legislative or regulatory steps to implement the Patient's Bill of Rights, which went into effect in 2010, and prevents carriers from retroactively cancelling insurance policies or placing lifetime limits on what they will pay, among other provisions.[22] Beginning in 2014, the law bans insurers from denying or restricting coverage based on preexisting health conditions and charging higher premiums based on health status or gender. Insurance carriers can increase premiums for older people, but by no more than three times what is charged a younger person for a similar plan. These protections are particularly important to small firms with older or sicker workforces or ones with a high proportion of women. They will also benefit employers in higher-risk businesses, such as limousine services.

State Health Insurance Exchanges and Affordable Coverage Options for Individuals and Small Businesses

Starting in 2014, small businesses and people without an offer of affordable insurance through their jobs will be able to go to new insurance marketplaces—or exchanges—either online or in person to select a health plan and find out whether they are eligible for subsidies. The exchanges will operate in each state and will provide a menu of health plan choices that include information on premiums and cost-sharing, benefits covered, participating providers, and ratings of plan quality and enrollee satisfaction. All plans offered through the exchanges, as well as plans in the individual and small-group markets, will include a comprehensive package of essential benefits sold at four different tiers: bronze, silver, gold, and platinum.[23] Plans offered within each tier will cover the same share of a person's medical costs on average, ranging from 60 percent in the bronze tier to 90 percent in the platinum tier. For all plans, annual out-of-pocket costs will be limited to $5,950 for individual policies and $11,900 for family policies. Annual deductibles for plans sold to small employers can be no greater than $2,000 for an individual policy or $4,000 for a family policy.

Exchanges for small businesses. Also known as the Small Business Health Options Program (SHOP), the small business exchanges will be open to firms with up to 100 employees, although states can choose to limit participation to firms with up to 50 employees until 2016, when firms with up to 100 workers will be eligible.[24] States also have the option, beginning in 2017, to open the exchanges to firms with 100 or more workers. Today, small-business employees are less likely to be offered a choice of plans in part because small firms have limited time and resources to administer multiple plans and in part because many insurers require firms to enroll their entire workforce in one product.[25] The SHOP exchanges will greatly expand choice to small businesses and their employees. Each SHOP exchange must allow employers to elect a level of coverage—whether bronze, silver, gold, or platinum—and then let their employees choose qualified plans within that level. But in its final rule on the exchanges this year, HHS provided states with some additional flexibility: state SHOP exchanges may allow employers to let employees choose any plan sold through the exchange across multiple benefit levels or from a set of selected levels (such as silver or gold). Or, conversely, employers might be allowed to offer a more narrow choice of qualified plans within or across benefit levels. Or employers might choose just one plan for their employees. To reduce administrative costs for participating employers, the SHOP exchanges will provide employers with a single monthly premium bill, which will also include the employee contribution, for all plans in which their

employees are enrolled. The SHOP exchanges would then arrange for the employer and employee payments to be made to the health plans.

Exchanges for individuals. The state individual exchanges will be the central portal for people who do not have health insurance through a job to select plans and find out whether they are eligible for premium tax credits or Medicaid. These new marketplaces will be critical venues for workers, particularly low-wage workers, who do not have access to affordable coverage through their jobs to enroll in a health plan. Premium tax credits will reduce the cost of insurance bought through the exchanges for people with incomes between 100 percent and 400 percent of the federal poverty level—or between $23,050 and $92,200 for a family of four. The tax credits will be available in advance and will cap what people spend on premiums on a sliding scale from 2 percent of their income, at 100 percent of poverty, to 9.5 percent of income at 300 percent to 400 percent of poverty. In addition, cost-sharing subsidies will increase the financial protection of plans for workers with incomes up to 250 percent of poverty ($57,625 for a family of four). Out-of-pocket limits will reduce costs for people with incomes less than 400 percent of poverty. By 2022, an estimated 20 million people under age 65 will receive premium tax credits.[26]

Expanded eligibility for Medicaid. People with incomes up to 133 percent of the federal poverty level—$14,856 for an individual and $30,657 for a family of four—will generally be eligible for Medicaid.[27] The Supreme Court ruling in June 2012 allows states to choose whether to participate in the Medicaid expansion under the law and some states have expressed reservations about joining.[28] But because the federal government will cover 100 percent of the costs for most states through 2016, before gradually reducing its contribution to 90 percent for all states by 2020, it is expected that most states will eventually participate in the program.[29]

Individual and Large-Employer Responsibilities to Maintain and Offer Coverage

The Affordable Care Act includes provisions to ensure global participation in insurance markets by both individuals and employers. First and foremost, as discussed previously, the law is aimed at improving the affordability of health insurance for individuals without an offer of coverage through an employer and small businesses that want to provide health benefits to their employees. But the law also includes a new requirement for individuals to maintain coverage. And while it does not require any employer to offer coverage, if employees of large companies of 50 or more workers become eligible for subsidized coverage through the exchanges, their employers are assessed a penalty designed to offset the federal cost of their subsidy.

Individual requirement to have health insurance. The individual requirement to maintain coverage is a central provision in the law for decreasing the risk and effects of adverse selection—that is, when people wait to enroll in a health plan until they get sick and are then consequently very costly to cover—in insurance markets. Beginning in 2014, everyone is required to indicate on their tax forms whether they have health insurance that meets minimal essential benefit standards, with penalties—in certain circumstances—if people do not have insurance. The penalty is equal to the greater of $95 or 1 percent of taxable income in 2014, $325 or 2 percent of taxable income in 2015, and $695 or 2.5 percent of taxable income in 2016. The dollar amount of the penalty is capped at $2,085 per family; no one would pay more in penalties than the national average premium for the bronze plan sold through the exchanges. Nor will anyone be prosecuted if they do not have health insurance. There are numerous exemptions to the penalty, including: individuals who could not find a health plan that costs less than 8 percent of their income, net of subsidies and employer contributions; people with incomes below the tax-filing threshold ($9,750 for an individual, $19,500 for a married couple, $27,100 for a married couple with two children); people who have been without insurance

for less than three months; and certain other circumstances. In fact, the exemptions to the penalties are so extensive that the Urban Institute estimates that if the mandate had been implemented in 2011, only 7 percent of the nonelderly U.S. population would have had to pay a penalty if they had opted not to newly purchase a health plan.[30]

Employer shared responsibility for businesses with 50 or more employees. The law includes shared responsibility payments for employers with 50 or more workers whose employees become eligible for premium tax credits through the insurance exchanges either because the employer does not offer health insurance or the coverage fails to meet minimum affordability or comprehensiveness standards. Specifically, employers with 50 or more full-time workers who do not offer health insurance will make $2,000 payments per full-time employee if at least one employee becomes eligible for premium tax credits through an exchange. Each company's first 30 full-time workers are not considered in the penalty calculation. Among large firms that offer health insurance, if a full-time worker is eligible for a tax credit through the exchanges—either because his or her premium contribution exceeds 9.5 percent of income for a single plan or the plan covers less than 60 percent on average of an enrollee's costs—the company will pay the lesser of $3,000 for each full-time worker who receives a premium tax credit or $2,000 for each full-time worker, with first 30 workers excluded.

CONCLUSION

The majority of Americans receive health insurance through employers, however, analysis of the Commonwealth Fund Biennial Health Insurance Survey of 2010 shows that workers in small firms—particularly those with low wages—are less likely to be offered and eligible for health insurance through their jobs and much more likely to be uninsured than workers in larger firms. In addition, employees of small businesses often report that their coverage is less generous compared with workers in large firms. Consequently, larger numbers of workers in small firms, and particularly those with lower incomes, are going without needed care because of cost. They are also more likely to report problems paying their medical bills.

The Affordable Care Act will improve the affordability and comprehensiveness of coverage for both small businesses who want to offer coverage and for workers in small businesses who are not offered and eligible for coverage through their jobs. This will be accomplished through features and provisions in the law, which include: state health insurance exchanges for small businesses and individuals, tax credits for small businesses, premium subsidies and expanded eligibility for Medicaid for families with incomes under 400 percent of poverty, new insurance market protections for small businesses and individuals, and a new essential health benefit standard that will ensure everyone buying health insurance will have a comprehensive health plan. Currently, small businesses and their employees are already benefitting from tax credits that reduce the cost of coverage and requirements that insurers spend less of their premiums on administration and profits and more on health care. Taken together, these provisions will dramatically reduce the number of employees—at firms of all sizes—who are uninsured and ensure that all workers, regardless of their wages or the number of hours they work, will have access to timely, affordable health care, without the risk of expensive medical bills.

Notes

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Methodology

Data for this study were drawn from the 2010 Commonwealth Fund Biennial Health Insurance Survey, a nationally representative telephone survey conducted by Princeton Survey Research Associates International between July and November 2010. The survey consisted of 25-minute telephone interviews in either English or Spanish with a random, national sample of 4,005 adults, age 19 and older, living in the continental United States. Because relying on landline-only samples leads to under-coverage of American households, a combination of landline and cell phone random-digit dial samples was used to reach people, regardless of the type of telephones they use.

This issue brief is based on the responses of 1,609 adults, ages 19 to 64, who reported working full or part time and were not self-employed. Data are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The landline portion of the survey achieved a 29 percent response rate and the cellular phone component achieved a 25 percent response rate. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level.

We also report data from the 2003 and 2005 Commonwealth Fund Biennial Health Insurance Surveys, which used the same stratified sampling strategy as was used in 2010, except they did not include a cellular phone random-digit dial sample. The 2003 survey was conducted from September 2003 to January 2004 and included 1,963 adults, ages 19 to 64, who reported being employed full or part time and are not self-employed. The 2005 survey was conducted from August 2005 to January 2006 and included 1,953 adult workers, ages 19 to 64, who were not self-employed.

Appendix Table 1. Availability of and Workers' Eligibility for Employer Insurance by Hourly Wage and Employer Size (Base: workers ages 19–64 who are not self-employed)

	Total (workers ages 19–64)	Hourly wage*			Employer size*					
		<$15	$15–<$20	≥$20	<25	25–49	50–99	100 or more	<50	≥50
Unweighted n	1609	584	266	631	275	125	106	1053	400	1159
Total (millions)	103.9	41.0	17.1	37.8	18.4	8.9	6.9	66.8	27.3	73.7
Percent distribution	100%	39%	16%	36%	18%	9%	7%	64%	26%	71%
Availability and eligibility of employer insurance										
Employer offers insurance	83	73	86	94	53	76	80	94	61	93
Employee eligible for insurance	75	55	83	92	46	57	71	88	49	87
Take-up of employer insurance when offered and eligible**	78	63	81	87	64	70^	78^	81	66	81
Current source of insurance coverage										
Covered through own employer	59	35	67	80	29	39	55	71	33	70
Covered through someone else's employer	16	18	19	12	20	17	19	14	19	14
Covered through public program	4	7	1	1	10	3	5	2	8	2
Covered through individual market	3	3	2	2	8	2	2	1	6	1
Covered through other source	4	6	3	3	3	7	6	3	5	4
Uninsured	15	31	8	3	30	32	13	8	31	9

Note: Workers include both full-time and part-time workers who are not self-employed.
* Undesignated wage/employer size are included in the distribution but not shown in the table.
** Base: workers who are offered and eligible for health insurance from their employer.
^ Small sample size of less than 100.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Appendix Table 2. Annual Insurance Premiums, Deductibles, Out-of-Pocket Costs, and Benefit Design by Hourly Wage and Employer Size (Base: workers ages 19–64 who are not self-employed, insured through their own employer)

		Hourly wage*			Employer size*			
	Total	<$15	$15–<$20	≥$20	<50 employees	≥50 employees	<100 employees	≥100 employees
Unweighted n	986	199	182	518	138	833	197	774
Total (millions)	61.1	14.3	11.5	30.3	8.9	51.3	12.7	47.6
Percent distribution	100%	23%	19%	50%	15%	84%	21%	78%
Annual premium costs (all plans)								
None	18	19	17	17	34	15	28	15
$1-$499	10	15	9	8	8	10	10	10
$500-$1,499	20	24	25	16	14	21	16	21
$1,500-$2,999	21	20	20	23	11	23	12	24
$3,000 or more	23	13	21	30	22	23	24	22
*Premium is 5% or more of income***	29	38	28	24	30	28	32	27
Annual deductible per person***								
No deductible	31	29	26	32	28	31	24	32
$1–$499	32	37	31	30	31	31	38	30
$500–$999	16	12	18	16	10	17	12	17
$1,000 or more	22	21	25	22	31	21	27	21
Deductible is 5% or more of income	6	8	14	3	9	6	7	6
Total household out-of-pocket medical expenses, including premiums								
None	3	4	2	2	2	3	1	3
$1–$999	17	23	18	14	26	16	22	16
$1,000–$4,999	55	59	54	53	44	57	51	56
$5,000 or more	24	14	25	31	26	24	25	24
*Spent annually 5% or more of income****	47	66	53	37	46	46	50	45
*Spent annually 10% or more of income****	25	34	26	22	26	25	27	25
Insurance benefits								
No prescription drug coverage	5	8	6	4	15	4	13	3
No dental coverage	14	19	12	12	38	10	31	10
Neither prescription drug nor dental coverage	2	4	2	1	10	1	9	0
How would you rate current health insurance coverage?								
Excellent	22	17	17	25	19	22	24	21
Very good	30	18	35	35	25	31	25	31
Good	29	37	25	25	27	29	25	30
Fair/poor	18	27	22	14	29	16	26	16

Appendix Table 2. Annual Insurance Premiums, Deductibles, Out-of-Pocket Costs, and Benefit Design by Hourly Wage and Employer Size (Base: workers ages 19–64 who are not self-employed, insured through their own employer) (continued)

		Hourly wage*			Employer size*			
	Total	<$15	$15–<$20	≥$20	<50 employees	≥50 employees	<100 employees	≥100 employees
Employer offers a choice of health plans								
Yes, choice of two or more plans	62	55	55	68	36	66	37	68
No, only one plan	38	45	44	32	61	33	60	31

Note: Workers include both full-time and part-time workers who are not self-employed.
* Undesignated wage/employer size are included in the distribution but not shown in the table.
** Base: Those who designated income and premiums.
*** Base: Those who provided information about their deductible.
**** Base: Those who specified their income and premiums/out-of-pocket costs for combined individual/family medical expenses.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Appendix Table 3. Insurance Coverage Continuity, Cost-Related Access Problems and Medical Bill Problems by Hourly Wage and Employer Size (Base: workers ages 19–64 who are not self-employed)

	Total (workers ages 19–64)	Hourly wage*			Employer size*					
		<$15	$15–<$20	≥$20	<25	25–49	50–99	≥100	<50 employees	≥50 employees
Unweighted n	1,609	584	266	631	275	125	106	1,053	400	1,159
Total (millions)	103.9	41.0	17.1	37.8	18.4	8.9	6.9	66.8	27.3	73.7
Percent distribution	100%	39%	16%	36%	18%	9%	7%	64%	26%	71%
Insurance coverage continuity										
Insured all year	78	59	83	94	59	63	80	85	60	85
Insured now, time uninsured during the year	7	10	9	3	11	5	6	7	9	7
Uninsured now	15	31	8	3	30	32	13	8	31	9
Uninsured any time during the year**	22	41	17	6	41	37	20	15	40	15
Access problems in past year										
Went without needed care in past year because of cost:										
Did not fill prescription	23	32	21	14	28	28	27	20	28	21
Skipped recommended test, treatment, or follow-up	23	31	19	16	28	26	21	21	27	21
Had a medical problem, did not visit doctor or clinic	25	38	21	13	35	29	21	22	33	22
Did not get needed specialist care	15	23	15	8	21	15	17	14	19	14
At least one of four access problems because of cost	38	51	36	26	47	44	40	34	46	35
Medical bill problems in past year										
Had problems paying or unable to pay medical bills	24	36	24	12	28	33	25	21	30	21
Contacted by collection agency for unpaid medical bills	13	21	13	6	17	17	13	12	17	12
Had to change way of life to pay bills	14	22	12	7	16	21	19	12	17	12
Any of the above bill problems	28	43	27	14	35	43	30	24	38	24
Medical bills/debt being paid off over time	23	29	25	18	24	29	32	22	25	23
Any bill problem or medical debt	36	49	38	23	43	50	41	32	45	33

Note: Workers include both full-time and part-time workers who are not self-employed.
* Undesignated wage/employer size are included in the distribution but not shown in the table.
** Combines "Insured now, time uninsured during the year" and "Uninsured now."
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

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