The Implications of the Affordable Care Act for Employers

Statement of
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Mr. Chairman, ranking member Pallone, and members of the committee, I appreciate the opportunity to testify before you today on the impact of the Affordable Care Act (ACA) on American businesses and workers. The views that I express are my own and should not be attributed to the Urban Institute or its sponsors. I am a senior fellow at the Urban Institute with more than two decades of experience analyzing the impact of policy on insurance coverage and costs. My testimony draws on my own and my colleagues' analyses of the ACA,[1] much of it relying on the Urban Institute's Health Insurance Policy Simulation Model (HIPSM)—a microsimulation model that relies on the best economic behavioral research to estimate individual and employer responses to the specific provisions of the law.

Our analysis shows that, if the ACA had been fully implemented in 2012,

- Employer-sponsored coverage would have increased by over 4 million people. In small, mid-sized, and large firms alike, more workers and their families would have private health insurance.
- This 2.7 percent increase in individuals covered by employer plans costs employers the equivalent of .0003 percent of total wages.
- For businesses in general, employer premium spending per person insured would not be affected by the law, remaining constant at about $3,650. But for small employers, premium spending per person insured would decline by about 4 percent.
- Aggregate employer spending on health, taking into account the increase in the number of covered lives and new assessments, would increase by roughly 2 percent.

In short, contrary to concerns that the ACA will increase costs and reduce employer-sponsored coverage, the law will have a negligible impact on total employer-sponsored coverage and costs and makes small businesses—for whom coverage expands the most—financially better off.

What are ACA's requirements for employer-sponsored insurance coverage?

Few of the ACA's requirements affect all employers, regardless of size. Those that do are primarily provisions prohibiting or constraining current limits on health insurance coverage—like dollar limits on annual or lifetime benefits, rescissions of coverage, and waiting periods (or delays in the start of coverage) of more than 90 days. Additional provisions have been implemented to expand access to group (as well as nongroup) coverage—specifically by extending dependent coverage to adult children up to age 26, eliminating pre-existing condition exclusions for children, and requiring coverage of specified preventive services without cost sharing. Most of these have already been implemented without incident and without an impact on the share of people covered by employer-sponsored insurance (ESI).

The ACA does not require any employers to provide their workers coverage, and, for employers with more than 100 employees, the law establishes no requirements beyond those just mentioned if they choose to offer benefits. But beginning in 2013, employers with 50 or

[1] The results presented here are more fully developed in Linda J. Blumberg et al., "Implications for the Affordable Care Act for American Business," Urban Institute, October 2012, available at http://www.urban.org/publications/412675.html.

more employees will face penalties, whether or not they offer coverage, if at least one of their full-time employees receives a subsidy for the purchase of nongroup coverage in a health insurance exchange. In general, individuals are eligible for subsides if their incomes fall between 138 percent and 400 percent of the federal poverty level and if the employee's share of the lowest cost premium for individual coverage exceeds 9.5 percent of income or if, on average, the plan reimburses less than 60 percent of covered expenses—conditions designed to protect most employers offering coverage from facing any penalties.

The ACA exempts employers with fewer than 50 workers from any penalties associated with offering insurance coverage and, as of 2014, for a period of two years offers employers with 25 or fewer employees and average pay of $50,000 or less tax credits toward premiums for coverage if they choose to provide it. According to the IRS, the ACA offers 4 million businesses the opportunity to receive a substantial tax reduction.

Alongside the tax credits, for those small employers (defined as having 50 or fewer workers in 2014 and 2015, and 100 or fewer after 2015) who opt to provide coverage, the law will

- require coverage of "essential health benefits,"
- provide access to new insurance markets through "exchanges," and
- limit premium variation across firms to geographic area, age, and tobacco use.

Regulations issued by the Department of Health and Human Services leave it to states to define essential health benefits from a set of options, including each state's most enrolled small employer plans—therefore making the essential health benefits unlikely to impose new costs on small businesses. The impact of rating requirements will vary across states, based on each state's current rules and levels of coverage. In general, less healthy groups in the market will see premium savings. New markets or exchanges will reduce administrative costs for the smallest groups and will promote transparency and competition likely to benefit all small groups (as well as individuals in the nongroup market). The law's requirements for state and federal premium monitoring or rate review and minimum medical loss ratios will reinforce these market effects and help constrain premiums in markets less amenable to competition.

What impact will the ACA's requirements have on employer health insurance costs and coverage?

The Urban Institute's Health Insurance Policy Simulation Model allows us to simulate the impact of these ACA provisions on business costs and employer-sponsored coverage. HIPSM simulates the decisions of individuals and businesses in response to policy changes and estimates changes in coverage and spending by employers, individuals, and the government resulting from specific reforms. To assess the ACA's impact on cost and coverage, we simulated the main coverage provisions of the law, including, if applicable, penalties or tax credits, as if they had been fully implemented in 2012.

Our findings are as follows:

- Employer-sponsored coverage would have increased by 2.7 percent (from 151.5 to 155.6 million people) and employer spending by 2.2 percent (from $553.4 to $565.8

billion). The largest relative coverage increase (6.3 percent) would have occurred among workers in small firms with 100 or fewer employees.

- For small businesses with fewer than 50 workers, which are exempt from penalties and may be eligible for premium tax credits, along with other employers with 100 or fewer workers, the law reduces the costs of coverage in aggregate. Our analysis shows that, on average, these employers, if they choose to offer coverage, would find average costs per person insured reduced by 7.3 percent and spending for the group as a whole reduced by 1.4 percent. The reductions reflect efficiencies in the insurance market and tax credits that offset premium costs for the smallest employers with low-wage workers.

- The law leaves the cost per person insured virtually unchanged for large businesses (with more than 1,000 employees). Our analysis shows these employers already cover the vast majority of their employees, will continue to do so, and will retain the flexibility to define their own benefits. Coverage increases (largely due to somewhat higher employee enrollment rates) would increase total spending by large businesses by 4.3 percent.

- Only mid-sized businesses (with 101 to 1,000 employees), as a group, experience an increase in costs per person insured, reflecting penalties on as many as 5 percent of these employers who are not currently providing coverage. Expanded enrollment, however, is the primary factor contributing to an increase in overall spending of 9.5 percent for these employers.

The ACA and employer health insurance offer decisions

Although most analyses (including those by the Congressional Budget Office and the RAND Corporation) have—like ours—concluded that the law will leave employer-sponsored health insurance largely intact, critics of the ACA, armed with reports from business consultants, nevertheless make the argument that CBO and others have seriously misjudged employers' incentives and significantly underestimated subsidy costs under the ACA. But the key to the ACA's actual impact on ESI will be whether most workers' employers continue to see their employees as valuing employer-provided health insurance over the alternative created by the ACA. And, under the terms of the ACA and the pressure of a competitive marketplace, our analysis shows they overwhelmingly will. Most workers' firms will be dominated by workers who will receive better benefits and, through the tax system, better subsidies through employer-provided coverage than through newly created insurance exchanges.[2]

That some workers now benefiting from ESI would be better off in exchanges is a fact. But a leap from that fact to the conclusion that employers have a powerful incentive to drop coverage runs counter to standard economic theory. ***First, over time, a competitive labor***

[2] For a complete discussion of the issues related to employer decisions to offer health insurance under the ACA, see Blumberg, et al., "Why Employers Will Continue to Provide Health Insurance: The Impact of the Affordable Care Act," *Inquiry* 49, no. 2 (2012): 116–26.

market will not allow employers to save money by dropping employer-sponsored coverage. Employers pay workers a combination of wages and benefits at a level equal to the employee's value to the firm. The market will keep compensation at that level, whether employers pay a worker's value only in wages or in some combination of wages and benefits. If, in total, an employer compensates workers less than their value, that employer will lose those workers to competitors who offer them more. If, alternatively, an employer pays workers more than their value, the firm will lose money. That means, plain and simple, that in a competitive market, employers cannot "come out ahead" by dropping coverage and at the same time reducing compensation.

An array of additional factors also decrease the likelihood of employers currently offering insurance to their workers to change that decision due to the provision of the ACA. ***In general, better-paid workers remain better off with employer-sponsored coverage.*** Regardless of their perspective on dropping, analysts agree that it is only at or below an income of 250 percent of the federal poverty level that the ACA's combination of premium and cost-sharing subsidies make exchange coverage, on average, as good as or better than tax-subsidized employer-sponsored coverage. Nondiscrimination rules impede employers' ability to simply decide not to offer coverage to workers who have access to subsidies in the exchange while offering it to workers who do not. To deny coverage for those eligible for subsidies, they would have to drop it for everybody and therefore face a penalty. In addition to paying the penalty, keeping all workers "whole" would require that employers pay additional wages both to cover extra unsubsidized premium and benefit costs (for workers eligible and ineligible for subsidies) and to offset the fact that any premium payments would now be paid by employees out of after-tax, not pre-tax, dollars. Doing so would result in an overall increase in the firm's compensation costs, which would make firms worse, not better, off.

Within firms, "losers" from dropping far outnumber "winners," on average. Taking all this together, employers would only be likely to drop coverage if most of their workers would benefit from the exchange—in which case they could substitute extra wages for benefit reductions. But, because offsetting payments would increase their compensation costs, employers are not likely to drop coverage if most of their workers would not benefit from the exchange. When an employer contemplates a decision to drop coverage, it is the distribution of income among the firm's employees that matters. We know that only about one in five workers with their own ESI coverage has income below 250 percent of the federal poverty level. Given this, the share of workers in a particular firm who would benefit from dropping—based on income and subsidy calculations alone—will likely be far smaller than the share of workers who will not. If the firm dropped coverage, compensating all workers for lost benefits would increase employers' total compensation costs. These employers, therefore, will have a disincentive to drop coverage.

Complexities in assessing "winners" and "losers" increase reluctance to drop. Further reducing the likelihood that employers will drop coverage is the difficulty in a mixed-wage firm of assessing predominant coverage preferences among employees. Assessing preferences will be complicated by workers' particular circumstances—factors not taken into account by those who claim that dropping will be widespread. These factors include age, smoking status, alternative family coverage options, health status and related preferences, willingness to take risk, and

relative preferences for particular benefits. Given the complexity of employees' preferences, which an employer would be hard-pressed to assess or to synthesize, a decision to drop coverage exposes an employer to the risk of undermining worker loyalty, increasing worker turnover, and disrupting rather than enhancing employees' benefit expectations. Deciding whether and when to take that risk is far more complicated—and less likely—than a simple subsidy calculus might suggest.

Pre-ACA trends in employer-sponsored health insurance coverage

That the ACA leaves the future scope of employer-sponsored health insurance coverage largely unchanged does not mean that employer-sponsored insurance will necessarily expand to cover a growing proportion of Americans. On the contrary, the share of the population covered has been and is likely to continue to drop. The future of employer-sponsored coverage is overwhelmingly determined by the state of the economy and by the growth in health care costs. As long as health care costs grow faster than inflation, the proportion of the population ESI covers will continue to drop. That trend should not be confused with or attributed to the impact of the ACA.

That said, however, the ACA includes cost-containment measures that, if successful, have the potential to slow the growth in health expenditures. Health care costs have historically risen considerably faster than the economy, but overall spending growth has slowed significantly in recent years, partly because of the recession. This slowdown (for both private and public payers) actually began as early as 2004—before the recession—and may also reflect changes in the structure of insurance (in particular, a shift toward high-deductible plans) and provider payment and delivery changes (in particular, the evolution of value-based purchasing aimed at reducing unnecessary hospitalizations and promoting clinically integrated care).

The cost-containment measures in the ACA could sustain and extend the slowdown in health care cost growth. The law's provisions to slow growth in rates Medicare pays hospitals have already contributed to a substantial slowdown in the projections of Medicare per beneficiary cost growth. Arguments that these payment constraints undermine hospitals' economic viability or lead hospitals to shift costs to private purchasers are not supported by the evidence. Medicare payment constraints produce greater hospital efficiency in hospitals that are largely dependent on Medicare revenues and in markets with competition among private insurers that have no dominant hospital system. In these markets, employers committed to cost containment have the opportunity to adopt effective Medicare payment reform initiatives, slowing growth in their own health care spending.

The ACA's initiatives for payment and delivery reform are equally important in slowing cost growth over the long term. These initiatives—including pay-for-performance, accountable care organizations, and bundling—aim to move private as well as public insurance away from payment per service, which drives up volume, and toward payment for value, or rewards to integrated care. In piloting these initiatives, Medicare not only sets an example for employer-sponsored insurance, it also explicitly offers the opportunity for collaboration across public and private payers. If these initiatives are successful, future growth in health care costs will be slower than is projected, employer spending growth will slow, and employer-sponsored health

insurance will be more extensive than is now projected.

Even if that is not the case, the ACA's establishment of a viable nongroup insurance marketplace—with subsidies—not only benefits individuals whose employers do not offer coverage. It also benefits small employers of low-wage workers. These firms are unable to offset the costs of health insurance with reduced wages, as large employers employing a mix of low- and higher-wage workers are able to do. In addition, large firms have greater economies of scale in purchasing insurance, allowing them to obtain greater value for their health care dollar than small employers. Accordingly, the small low-wage employers are very unlikely to offer insurance coverage to their workers and often find themselves at a disadvantage in competing with large employers for workers. The ACA will create a much more level playing field for these small employers, owing to the law's market reforms, exchanges, and subsidies that will allow their workers to purchase affordable, adequate coverage directly.

Overall, the evidence simply does not support critics' arguments that the ACA will burden employers and undermine employer-sponsored health insurance. On the contrary, except for a cost increase to mid-sized employers due largely to enrollment increases, the ACA benefits rather than burdens small employers who want to provide health insurance, leaves the overall costs of employer-sponsored health insurance largely unchanged, and offers the potential, through cost containment, of slowing the growth in health care costs, benefiting private along with public purchasers of health insurance.

Will the ACA decrease employment?

All of this information taken together indicates that the incremental costs to employers of increased employer-sponsored insurance coverage and employer penalties are very small relative to current compensation – with the 2.7 percent increase in employer-sponsored coverage coming at a costs equal to .0003 percent of total wages. A change that small in relative terms could simply not have large implications for the overall level of employment. Also, as Holahan and Garrett[3] show, new revenues needed to pay for the entire health reform over the 2014 and 2019 period would amount to only .4 percent of GDP, and therefore be unlikely to have significant effects on employment. Plus, the increase in health care spending under reform will expand employment in the health sectors, largely if not completely offsetting any small employment effects in other sectors.

In addition, Dubay and colleagues,[4] consistent with analysis by Kolstad and Kowalski,[5] find that there is no evidence that the similar, comprehensive reforms implemented in Massachusetts in 2006 had a negative effect on employment in that state. In fact, Dubay et al.'s finding of no employment effects holds up even when looking specifically at the most

[3] Holahan J and Garrett B. "How Will the Affordable Care Act Affect Jobs" Washington, DC: Urban Institute, 2011.
[4] Dubay L, Holahan J, Long S, and Lawton E. "Will the Affordable Care Act Be a Job Killer?" Washington, DC: Urban Institute, 2011.
[5] Kolstad JT and Kowalski AE. "Mandate-Based Health Reform and the Labor Market: Evidence from the Massachusetts Reform." NBER Working Paper No. w17933. Cambridge, MA: National Bureau of Economic Research, March 2012.

vulnerable employers, the smallest firms and those in the retail trade and accommodation and food services industries.

Concerns have also been raised about the ACA's definition of part-time being set at 30 hours per week, as opposed to the frequent practice today of considering fewer than 35 hours per week as part-time. Often large employers will offer insurance coverage to full-time workers, but not to part-time workers (e.g., 96 percent of employers with 50 or more workers offer health insurance to at least some of their workers, as does 99.5 percent of employers with 1000 or more workers, according the 2011 Medical Expenditure Panel Survey-Insurance Component). Some employers contend that they would lower the hours worked per week for workers in this 30 to 34 hours per week wedge to 29 hours or fewer, in order to avoid the possibility of penalties being assessed if some of those workers obtain subsidized coverage in the nongroup exchange. However, there are many factors that go into employers deciding the number of hours employees will work. These include the administrative costs of employing more workers to do the same work, competition for hiring workers that want to be employed with more hours and can find more hours elsewhere, potential costs of higher turnover, just to name a few. Keeping the potential magnitude of this issue in perspective is important as well. Only about 4 percent of the national workforce is typically employed 30 to 34 hours per week, and of this group, only about 1/3 or a little over 1 percent of the workforce have incomes that would make them potentially eligible for nongroup subsidies that could trigger employer penalties. Thus again, it is safe to assume that any employment effects related to this provision in the ACA would have to be quite small.

Again, the strong, consistent empirical evidence is that employment effects related to the ACA will not be large on net.