The Effects of the Affordable Care Act on Workers’ Health Insurance Coverage

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Employer-sponsored health insurance is the cornerstone of the U.S. health insurance system. David Blumenthal, among others, has described this system as an “accident of history,” and he quotes Uwe Reinhardt, a leading authority on health care economics, as asserting that “If we had to do it over again, no policy analyst would recommend this model.” Nonetheless, the Patient Protection and Affordable Care Act of 2010 (the ACA) builds on, rather than eliminates, employer-sponsored insurance. However, because the ACA makes substantial changes to the employer-based system, some wonder whether the employers’ role in providing insurance will diminish or disappear over time.

The ACA builds on the employer-based health insurance system by developing exchanges through which small employers can offer coverage and by penalizing large employers that do not offer coverage. The exchanges, which will be open to both small employers and individuals, could alleviate some of the difficulties faced by small firms that want to offer insurance. Currently, small firms’ capacity to offer coverage is limited by high administrative costs, low bargaining power to negotiate benefit design and premiums, and a small number of enrollees for risk pooling. By aggregating employees of small firms into a single risk pool, exchanges will reduce year-to-year variance in premiums and may increase bargaining power and reduce administrative spending per enrollee. However, because the ACA also expands Medicaid eligibility and provides subsidies for low-income individuals without employer coverage, some have raised concerns that the new law may cause employers to stop offering health insurance. Workers’ preferences regarding insurance coverage will also change with the introduction of new options for subsidized coverage through the exchanges and financial penalties for being uninsured.

Our team at the RAND Corporation has simulated the effects of the ACA to predict how and why health insurance markets are likely to change after implementation. RAND’s Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model predicts individuals’ decisions about health insurance enroll-
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EFFECTS OF THE ACA ON WORKERS’ COVERAGE

Effect of the Affordable Care Act on Workers’ Health Insurance Options.

Although the model allows employers to drop coverage in response to the reform, we estimate that the law will result in a large net increase in employer-sponsored insurance offers (see graph). We predict that the number of workers offered coverage will increase from 115.1 million (84.6% of the approximately 136.0 million U.S. workers) to 128.7 million (94.6%) after the reform. This increase is not driven by penalties levied on employers with more than 50 workers. In fact, the probability of being offered coverage increases proportionately more for workers at small firms than for workers at large firms, even though small firms are not subject to penalties. Currently, only 60.4% of workers at businesses with 50 or fewer employees have an offer of coverage; the proportion is projected to increase to 85.9% after the reform. The large increase in offers provided by small businesses is driven primarily by two factors: greater demand for coverage by workers due to individual penalties for being uninsured and the availability of new, often lower-cost insurance options (because of administrative savings, for example) for small businesses that offer coverage on the exchanges. After the reform, we predict that nearly three of four workers offered coverage by small businesses will receive that offer through the exchanges. The ACA will have a lesser effect on large employers, since most already offer insurance coverage to their workers. Of the 13.6 million workers newly offered coverage, only 3.2 million will be employed by firms large enough to be subject to employer penalties.

MENT by comparing the benefits of an option (e.g., reduced out-of-pocket expenditures, lower risk, increased consumption of medical services) with the costs (e.g., higher premiums). In this model, firms decide whether to offer insurance and what type to offer on the basis of a “group choice” algorithm, whereby they consider their workers’ preferences and the costs of providing coverage. The decision-making process followed by an employer accounts for the possibility that some workers may be eligible for Medicaid, subsidized coverage through the exchanges, or inclusion in a spouse’s insurance policy. These factors reduce the firm’s incentive to offer insurance. The model also accounts for penalties that may be levied on firms with 50 or more workers that do not offer coverage and for the fact that firms with 100 or fewer workers now have the option of offering coverage through the exchanges. (A full description of the model’s methods can be found in the report by Eibner and colleagues.)

We modeled an ACA-based scenario that includes the individual mandate, penalties for firms with more than 50 workers that do not offer coverage, a Medicaid expansion to include persons with incomes as high as 133% of the federal poverty level, and the creation of state health insurance exchanges open to individuals and firms with 100 or fewer workers. Individuals who obtain coverage through the exchanges are eligible for government subsidies if their incomes are between 100 and 400% of the federal poverty level and they do not have a quali-
The exchanges will be run by the states, which will have latitude over many design options. State decisions will most likely have substantial effects on how many firms actually decide to offer coverage through the exchange. For example, states have the option to allow firms with more than 100 workers to offer coverage through the exchange, although this is not required. If large employers are allowed to participate in exchanges, we predict that many — both current and new insurance offerers — will elect to do so. Implementation of the exchanges could also have effects that would change our model’s predictions. We assume that the exchanges will lead to administrative savings relative to traditional small-group coverage. Although the possibility of administrative savings has been discussed as a potential benefit of the exchanges, it is not clear how long it will take to achieve these savings (or whether they will occur at all). In addition, the perceived quality of coverage through the exchanges could influence firms’ decisions. There is likely to be a degree of bias toward the status quo after reform, and perceived problems with the functioning of the exchanges could work toward maintaining the status quo. The market will also be affected by the degree to which plans currently offered to small businesses can maintain grandfathered status, which will exempt them from the ACA’s rating regulations.

Although these caveats will influence the proportion of workers who are offered exchange-based versus traditional employer-sponsored insurance, our prediction that employer-sponsored insurance will remain an important source of coverage is very robust to variations in modeling assumptions. This is partly driven by an increase in workers’ demand for health insurance. After the ACA is implemented, firms making decisions on the basis of costs and benefits of their insurance options, including new subsidies and penalties, will frequently choose to offer insurance rather than to drop coverage and allow their workers to buy individual coverage. This prediction is consistent with evidence from Massachusetts, where the rate of insurance offers by employers increased after the 2006 state health care reform. The tax-advantaged treatment of employer-sponsored coverage helps to sustain the employer-based system. However, the nature of employer-sponsored coverage may change substantially after implementation of the ACA, with an increase in the number of workers offered coverage through the health insurance exchanges. Many employers will find that offering coverage through the exchanges is an attractive option, owing to wider risk pooling, lower administrative costs, and expanded choices.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

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