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## CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance

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## CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance

### Abstract

[Excerpt] This document responds to questions that the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have received regarding their estimates of the effects of the Affordable Care Act (ACA). In their original analysis of the impact of the legislation, CBO and JCT estimated that, on balance, the number of people obtaining coverage through their employer would be about 3 million lower in 2019 under the legislation than under prior law. As reflected in CBO's latest baseline projections, the two agencies now anticipate that, because of the ACA, about 3 million to 5 million fewer people, on net, will obtain coverage through their employer each year from 2019 through 2022 than would have been the case under prior law.

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The analysis presented here explains two of the key assumptions about employers' behavior that affect CBO and JCT's estimates of the effects of the ACA and presents a range of estimates of sources of insurance coverage and federal budgetary outcomes that would result from the ACA under certain alternative assumptions. The analysis also shows how CBO and JCT's estimates might differ if firms were able to, and ultimately decided to, undertake more widespread restructuring of their workforces than is reflected in the baseline projections—through strategies such as shifting more of their lower-wage workers into separate firms, contracting for the services of more such workers from other companies, or shifting their workforces toward part-time workers instead of fulltime workers.

### Keywords

Congressional Budget Office, CBO, Joint Committee on Taxation, JCT, Affordable Care Act, ACA, health benefits

### Comments

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## **CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance**

This document responds to questions that the Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) have received regarding their estimates of the effects of the Affordable Care Act (ACA).<sup>1</sup> In their original analysis of the impact of the legislation, CBO and JCT estimated that, on balance, the number of people obtaining coverage through their employer would be about 3 million lower in 2019 under the legislation than under prior law.<sup>2</sup> As reflected in CBO's latest baseline projections, the two agencies now anticipate that, because of the ACA, about 3 million to 5 million fewer people, on net, will obtain coverage through their employer each year from 2019 through 2022 than would have been the case under prior law.<sup>3</sup>

Some observers have expressed surprise that CBO and JCT have not expected a much larger reduction in the number of people receiving employment-based health insurance in light of the expanded availability of subsidized health insurance coverage that will result from the ACA. CBO and JCT's estimates take account of that expansion, but they also recognize that the legislation leaves in place some financial incentives and also creates new financial incentives for firms to offer and for many people to obtain health insurance coverage through their employers. CBO and JCT have estimated that many workers and their families will not be eligible for Medicaid, the Children's Health Insurance Program (CHIP), or substantial subsidies for the purchase of health insurance through the exchanges and that most employers will continue to have an economic incentive to offer health insurance to their employees. This analysis provides some

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<sup>1</sup> The Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

<sup>2</sup> See Congressional Budget Office, *cost estimate for H.R. 4872, the Reconciliation Act of 2010* (March 20, 2010).

<sup>3</sup> See Congressional Budget Office, *Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act* (March 2012). As specified in law, and to provide a benchmark against which potential legislation can be measured, CBO constructs its baseline estimates under the assumption that current laws generally remain unchanged.

illustrative examples of the incentives for firms to offer health insurance under the ACA.

Other analysts who have carefully modeled the nation's existing health insurance system and the changes in incentives for employers to offer insurance coverage created by the ACA have reached conclusions similar to those of CBO and JCT or have predicted smaller declines (or even gains) in employment-based coverage owing to the law. Surveys of employers regarding their plans for offering health insurance coverage in the future have uncertain value and offer conflicting findings. One piece of evidence that may be relevant is the experience in Massachusetts, where employment-based health insurance coverage appears to have increased since that state's reforms, which are similar but not identical to those in the ACA, were implemented.

Despite the care and effort that CBO and JCT have devoted to modeling the health insurance system and the provisions of the ACA, there is clearly a tremendous amount of uncertainty about how employers and employees will respond to the set of opportunities and incentives under that legislation. Assessing the effects of broad changes in the nation's health insurance system requires assumptions and projections about a wide array of technical, behavioral, and economic factors. In addition to the uncertainty surrounding employers' and employees' decisionmaking, there is uncertainty regarding many other factors, including the future growth rate of private insurance premiums and the number of individuals and families who will have income in the eligibility ranges for Medicaid, CHIP, and exchange subsidies. Moreover, models of the health insurance system, including those developed and used by CBO and JCT, are generally based on observed changes in behavior in response to modest changes in incentives, but the legislation enacted in 2010 is sweeping in its nature. Given the high degree of uncertainty, some Members of Congress have asked how CBO and JCT's estimates of the effects of the ACA on health insurance coverage would differ under alternative assumptions about the behavior of employers. The analysis presented in this report is illustrative of a wide range of possible outcomes regarding employers' behavior but does not reflect all of the dimensions of uncertainty inherent in CBO and JCT's projections of insurance coverage.

The analysis presented here explains two of the key assumptions about employers' behavior that affect CBO and JCT's estimates of the effects of the ACA and presents a range of estimates of sources of insurance coverage and federal budgetary outcomes that would result from the ACA under certain alternative assumptions. The analysis also shows how CBO and JCT's estimates might differ if firms were able to, and ultimately decided to, undertake more widespread restructuring of their workforces than is reflected in the baseline projections—through strategies such as shifting more of their lower-wage workers into separate firms, contracting for the services of more such workers from other companies, or shifting their workforces toward part-time workers instead of full-time workers.

In the four alternative scenarios discussed below, the ACA changes the number of people who will obtain health insurance coverage through their employer in 2019

by an amount that ranges from a reduction of 20 million to a gain of 3 million relative to what would have occurred otherwise. Compared with the March 2012 baseline projections for that year, the estimates under those alternative scenarios range from an additional decline of 14 million to a gain of 8 million people with employment-based coverage. In the scenario with the greatest additional reduction in employment-based coverage owing to the ACA (14 million), the number of enrollees who purchase health insurance through insurance exchanges is 9 million higher, the number of enrollees in Medicaid and CHIP is 2 million higher, and the number of uninsured is 2 million higher, than in the baseline projections.

The differences in the estimated number of people receiving health insurance coverage through various sources lead to differences in the estimated budgetary impact of the insurance coverage provisions of the ACA. If a firm chose not to offer insurance coverage under the ACA, some of its workers and their families might enroll in Medicaid or CHIP or be eligible to receive subsidies through the insurance exchanges; as a result, the cost of those programs would increase. At the same time, the reduction in that firm's compensation to workers that was provided in the form of health benefits would generally be offset by an increase in the compensation it provided in the form of wages and salaries. Because health benefits are generally not taxed but wages and salaries are, that shift in the composition of compensation would raise federal revenues. In addition, the federal government would generally receive penalty payments from the employer and from any employees who ended up without health insurance.

With those cross currents, the net effect of a larger reduction in employment-based insurance coverage on the budgetary impact of the ACA depends crucially on the share of the workers and their families losing such coverage who are eligible for Medicaid, CHIP, or exchange subsidies and on the tax rates those workers pay. If an additional firm with a large share of low-income workers chose not to offer insurance coverage, the net effect would tend to be an increase in the federal budgetary cost of the ACA's coverage provisions; if an additional firm with a small share of low-income workers chose not to offer insurance coverage, the net effect would tend to be a decrease in the federal budgetary cost of the ACA's coverage provisions.

In the March 2012 baseline projections, the insurance coverage provisions of the ACA have an estimated net cost to the federal government of \$1,252 billion over the eleven-year period from 2012 through 2022. Under the four alternative scenarios examined here, that projected net cost ranges from \$1,170 billion to \$1,297 billion, representing differences relative to the baseline projections that range from a decrease of \$82 billion (or 7 percent) to an increase of \$45 billion (or 4 percent). The scenarios with the larger estimated costs are the ones in which additional reductions in employment-based coverage relative to the baseline projections are concentrated among low-income workers. In contrast, the scenario with the largest reduction in employment-based coverage actually *lowers* the cost of the ACA to the federal government relative to the baseline projections because the extra costs for Medicaid and exchange subsidies are more than offset by the increased revenues resulting from higher taxable compensation among workers who receive higher wages in lieu of health benefits.

In sum, CBO and JCT continue to expect that the Affordable Care Act will lead to a small reduction in employment-based health insurance. That projection arises from the agencies' modeling of the many changes in opportunities and incentives facing employers and employees under the ACA, and it is consistent with the findings of other analysts who have carefully modeled the nation's health insurance system. Significant changes in some of the key assumptions underlying the estimates lead to somewhat higher or lower projections of the change in employment-based health insurance and the budgetary impact of the ACA. However, differences in the projected change in employment-based health insurance tend to have limited effects on the projected budgetary impact of the law because changes in the availability and take-up of such insurance affect the federal budget through several channels that are partly offsetting. Indeed, one scenario examined here shows that larger reductions in employment-based health insurance than expected by CBO and JCT might lower rather than raise the cost of the insurance coverage provisions of the ACA. Accordingly, in CBO and JCT's judgment, a sharp decline in employment-based health insurance as a result of the ACA is unlikely and, if it occurred, would not dramatically increase the cost of the ACA.

### **CBO and JCT's Current Estimates of the Effects of the ACA on Employment-Based Health Insurance Coverage**

CBO and JCT now estimate that, because of the ACA, about 3 million to 5 million fewer people, on net, will obtain coverage through their employer each year from 2019 through 2022 than would have been the case under prior law.<sup>4</sup> (That estimate is reflected in CBO's latest baseline projections.) That projected change in the number of people with employment-based insurance is the net result of several shifts in coverage, which can be illustrated using the estimates for 2019. For that year, CBO and JCT estimate a net decline of 5 million in the number of people obtaining coverage through their employer, as a result of the following changes:

- About 11 million people who would have had an offer of employment-based coverage under prior law will not have an offer under the ACA. That estimate represents about 7 percent of the roughly 161 million people projected to have employment-based coverage under prior law.<sup>5</sup> The businesses that choose not to offer coverage as a result of the ACA will tend to be smaller employers and employers with predominantly lower-wage workers; those workers and their families are more likely to be eligible for Medicaid, CHIP, or subsidies through the health insurance exchanges.

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<sup>4</sup> Throughout this report, estimates of the number of people who will be covered by employment-based insurance in 2014 and later years reflect both enrollees in traditional employment-based insurance arrangements and enrollees covered in the Small Business Health Options Programs to be established under the ACA.

<sup>5</sup> That estimate of 161 million people with employment-based coverage under prior law excludes some people who would have such coverage but would also be enrolled in Medicare.

- Another 3 million people who would have had employment-based insurance under prior law and will still have an offer of such coverage under the ACA will instead choose to obtain coverage from another source. Under the legislation, workers with an offer of employment-based coverage will generally be ineligible for exchange subsidies, but that “firewall” will presumably be enforced imperfectly, and an explicit exception to it will be made for workers whose offer of employment-based coverage is deemed unaffordable.
- About 9 million people who would not have been covered by an employment-based plan under prior law will have that coverage under the ACA. That change reflects the combined impact of the insurance mandate, the penalties that will be imposed on employers who do not offer insurance, and the tax credits for certain small employers who provide insurance for their workers—which will lead some employers who would not have offered coverage in the absence of the ACA to offer it and will lead some people who would not have taken up their employer’s offer of insurance to do so.

Those estimates reflect CBO and JCT’s assessment of employers’ and employees’ responses to the set of opportunities and incentives under the ACA. In particular, they reflect the view that workers generally want to obtain health insurance coverage at the lowest possible cost—taking into account both the price charged and any tax effects or government subsidies that apply—adjusted for differences in the scope of coverage, out-of-pocket payments, access to health care providers, and other features of insurance coverage.

On the basis of both economic theory and empirical evidence, CBO and JCT also think that employers generally construct compensation packages to attract the best available workers at the lowest possible cost.<sup>6</sup> That is, firms attempt to offer the mix of wages and nonwage benefits—such as vacation time, retirement benefits, and health insurance—that will be most attractive to their current and potential employees while having the lowest cost. The attractiveness and cost of different mixes of compensation depend on the relative price and availability of services (such as health insurance) when provided by firms or purchased separately by workers. That relative price and availability depend partly on features of private markets and partly on the structure of government programs and the tax rules applying to firms and workers.

The fact that many firms currently offer health insurance coverage to their workers despite the high cost of premiums and rapid growth in those premiums for many years shows that many firms continue to find health insurance coverage to be a worthwhile element of their compensation packages.<sup>7</sup> If firms could have

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<sup>6</sup> See Janet Currie and Brigitte C. Madrian, “Health, Health Insurance, and the Labor Market,” in Orley C. Ashenfelter and David Card, eds., *Handbook of Labor Economics*, vol. 3 (Elsevier, 1999), pp. 3309–3416. See also Sherwin Rosen, “The Theory of Equalizing Differences,” in Orley C. Ashenfelter and Richard Layard, eds., *Handbook of Labor Economics*, vol. 1 (Elsevier, 1999), pp. 641–692.

<sup>7</sup> See Marc Roemer, *The Number of Health Insurance Plans Sponsored by Private Sector Employers in 2000 and 2010*. Statistical Brief No. 344 (Rockville, Md.: Agency for Healthcare

attracted employees more cheaply by dropping health benefits and adding wages or other benefits that cost less, then they would have done so. One reason that the provision of health insurance by firms remains cost-effective is that the price of health insurance with a given scope and comprehensiveness of benefits is often higher in the individual (nongroup) market than in the employer (group) market, owing to higher administrative costs for individual policies. A second reason that firms continue to provide health insurance is that wages received by workers are subject to both individual income taxes and payroll taxes, whereas health insurance benefits received by workers are generally not taxed. Finally, individual market coverage may not be viewed by employees as a good substitute for employment-based coverage because of the possibility of coverage exclusions or premium surcharges due to specific health conditions of a family member.

The ACA will change the opportunities and incentives for employers and employees in fundamental ways. The key considerations include these:

- Beginning in 2014, individuals and families will be able to purchase health insurance through new exchanges at prices that will not depend on their health status. Currently, the nongroup health insurance market in most states does not offer such “community-rated, guaranteed-issue” insurance coverage.<sup>8</sup>
- Beginning in 2014, workers and their families who have family income below 138 percent of the federal poverty level (projected to be about \$33,000 for a family of four in 2014) will be eligible for coverage through Medicaid. In addition, workers who have family income above that level but below roughly 200 percent of the federal poverty level will be eligible for significant subsidies through the insurance exchanges if their employer does not offer health insurance. In contrast, workers with family income between roughly 200 percent and 400 percent of the federal poverty level will be eligible for smaller subsidies through the exchanges if their employer does not offer coverage, and workers with higher family income will not be eligible for any subsidies for insurance purchased through exchanges.<sup>9</sup>
- Most large firms—which are the predominant source of employment-based health insurance now—have a mix of higher-income and lower-income workers, so not all of their employees and their dependents would be eligible for Medicaid, CHIP, or exchange subsidies if those employers decided not to offer coverage. And nondiscrimination provisions in the Internal Revenue Code and the Public Health Service Act discourage firms from offering health

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Research and Quality, October 2011), [www.meps.ahrq.gov/mepsweb/data\\_files/publications/st344/stat344.shtml](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st344/stat344.shtml).

<sup>8</sup> Community-rated premiums do not vary by individuals’ health characteristics; guaranteed-issue policies are available regardless of an individual’s health characteristics.

<sup>9</sup> Although workers with family income between 200 percent and 250 percent of the federal poverty level will be eligible for cost-sharing subsidies if they are enrolled in an exchange plan, those subsidies in particular are quite small compared with the cost-sharing subsidies for families with income below 200 percent of the federal poverty level.



insurance benefits to more highly paid employees while not offering them to lower-paid employees.<sup>10</sup>

- Employment-based health insurance will continue to receive a significant subsidy through the tax exclusion for employer-paid premiums and tax provisions that allow a large portion of employees' shares of premiums to be paid out of pretax income. Those tax preferences will provide an ongoing incentive for employers to offer coverage, even after certain high-premium plans face an excise tax beginning in 2018. The value of the tax exclusion for workers who obtain health insurance through their employer is usually proportional to their combined marginal tax rates for payroll taxes and for federal and state income taxes. For higher-income workers, that tax subsidy typically amounts to more than 25 percent of the cost of premiums. The tax subsidy will not be available to workers whose employers drop coverage and who end up purchasing insurance through exchanges.
- The administrative costs involved in operating and managing health insurance plans will be higher in the exchanges than they will be for large employers, principally because administering plans (including handling enrollment and collecting premiums) for many individual policyholders is more expensive than administering them for a single employer. (However, the administrative costs for health insurance plans offered in the exchanges under the ACA will be lower than the administrative costs in the nongroup market without the ACA.)
- The requirement that individuals obtain health insurance coverage and the penalties that will apply to many individuals if they do not obtain it will lead more workers to seek health insurance coverage. Because employers design benefit packages to appeal to their current and potential workers, greater demand for health insurance will increase the incentive for employers to offer insurance as well as for employees to take up insurance offered by employers.
- The ACA applies both "sticks" and "carrots" to employers to encourage them to offer health insurance to their employees. Starting in 2014, firms with more than 50 employees that do not offer insurance and have at least one employee who receives an exchange subsidy will be subject to a penalty; that penalty will initially be as much as \$2,000 per full-time worker (beyond the first 30 such workers) and in subsequent years is set to increase at the rate of growth in per capita health insurance premiums. Firms with up to 25 full-time-equivalent employees and with average annual wages of less than \$50,000 may be eligible for a tax subsidy that covers a percentage of their contributions to health insurance premiums. To be eligible, employers must contribute at least 50 percent of the cost of premiums for single coverage for their employees. The maximum credit is available to employers with 10 or fewer full-time-equivalent employees and average annual wages of up to \$25,000, and it phases out as average wages and the number of employees rise. Before 2014, the maximum credit covers up to 35 percent of an

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<sup>10</sup> Section 105(h) of the Internal Revenue Code and section 2716 of the Public Health Service Act.

employer's payments for premiums; for 2014 and later, the credit will cover up to 50 percent of an employer's payments but only for two years. (The average wage limits will be adjusted for inflation starting in 2014, and the rules for the tax credit include some additional details as well.)

- Employers who drop coverage, leaving their employees to purchase insurance on their own, will generally have to raise the cash compensation of their employees to compete with employers who continue to offer health insurance. Evidence of such substitution has been found in studies that examine the wages of workers with differing job-related insurance benefits.<sup>11</sup> Further evidence of such substitution can be seen at the aggregate level: Despite rapidly rising costs of health benefits during the past few decades, slow growth of wages and salaries has caused the share of national income devoted to total compensation to decline slightly.

### **Other Evidence About the Effects of the ACA on Employment-Based Health Insurance Coverage**

Other analysts who have carefully modeled the nation's existing health insurance system and the changes in incentives for employers to offer insurance coverage created by the ACA have reached conclusions similar to those of CBO and JCT or have predicted smaller declines (or even gains) in employment-based coverage owing to the law. For example, the Office of the Actuary at the Centers for Medicare and Medicaid Services concluded that, on net, about 1 million fewer people would have employment-based coverage under the ACA in 2019 than under prior law.<sup>12</sup> Analysts at the Urban Institute estimated that such coverage would have diminished by about half a million people, on net, if the legislation had been fully implemented in 2010.<sup>13</sup> Analysts at The Lewin Group predicted a net reduction in employment-based coverage of about 3 million people, assuming full implementation in 2011.<sup>14</sup> And analysts at RAND estimated that about 4 million *more* individuals would be covered by employment-based coverage (as

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<sup>11</sup> See Jonathan Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review*, vol. 4, no. 3 (1994), pp. 622–641; Jonathan Gruber and Alan B. Krueger, "The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers' Compensation Insurance," in David Bradford, ed., *Tax Policy and the Economy*, vol. 5 (Cambridge, Mass.: National Bureau of Economic Research, 1991), pp. 111–144; and Craig Olson, "Do Workers Accept Lower Wages in Exchange for Health Benefits?" *Journal of Labor Economics*, vol. 20, no. S2 (2002), pp. S91–S114.

<sup>12</sup> See Richard S. Foster, "Estimated Financial Effects of the Patient Protection and Affordable Care Act, as Amended" (Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, April 22, 2010), [www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf).

<sup>13</sup> See Matthew Buettgens, Bowen Garrett, and John Holahan, *America Under the Affordable Care Act* (Washington, D.C.: Urban Institute, December 2010), [www.urban.org/uploadedpdf/412267-america-under-aca.pdf](http://www.urban.org/uploadedpdf/412267-america-under-aca.pdf).

<sup>14</sup> See The Lewin Group, *Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers*, Staff Working Paper No. 11 (Falls Church, Va: The Lewin Group, June 2010), <http://www.lewin.com/publications/publication/409>.

CBO and JCT classify such coverage) in 2016 under the ACA than under prior law.<sup>15,16</sup>

Some observers have argued that employers' decisions about whether to offer health insurance coverage under the ACA will not be based on the kind of rigorous assessment of costs and benefits—to themselves and their employees—that are captured by the models used by CBO and JCT and by the other analysts just mentioned. Instead, some have argued, firms will choose not to offer coverage based simply on the following observations: All of their workers can purchase coverage through the new exchanges, which will be better in important respects than the current individual insurance market; some of those workers will receive subsidies if they buy insurance through the exchanges; the penalties facing firms that do not offer coverage are much smaller than the costs of insurance; and not offering insurance allows firms to avoid some complexity and uncertainty.

As discussed above, those observations form a very incomplete picture of the consequences of an employer's decision not to offer health insurance. In particular, many employees will not be eligible for significant exchange subsidies under the ACA (a point that is quantified later in this report), and the employers who do not offer insurance will ultimately not realize significant savings because they will generally need to pay higher cash compensation to attract the same workforce. Still, is it possible that some firms will choose not to offer health insurance, regardless of the full consequences for themselves or their workers? Certainly, not all firms will behave as the calculations underlying CBO and JCT's models would predict. However, just as some employers may base a decision not to offer coverage on nonfinancial reasons or may not take into account all of the factors that CBO and JCT think are relevant, other employers may decide to keep offering coverage because they and their employees are accustomed to their doing so. And given the importance of health insurance to people and the cost of obtaining that insurance, it seems likely that most firms will ultimately make considered and informed decisions. Therefore, CBO and JCT expect that, once all of the key provisions in the ACA have taken effect, most firms will analyze carefully the opportunities and incentives that they and their workers will have.

Surveys of employers regarding their plans for offering health insurance coverage in the future offer conflicting findings. For example, Mercer (a leading human resources consulting firm) conducted a survey in the late summer of 2011 and

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<sup>15</sup> See Christine Eibner and Carter C. Price, *The Effect of the Affordable Care Act on Enrollment and Premiums, With and Without the Individual Mandate* (Santa Monica, Calif: RAND Corporation, 2012), [http://www.rand.org/pubs/technical\\_reports/TR1221](http://www.rand.org/pubs/technical_reports/TR1221).

<sup>16</sup> Other analysts have looked at the incentives for employers not to offer insurance coverage to individual employees on a case-by-case basis, rather than estimating how employers will respond to the incentives that will apply to their workforces as a whole. See Douglas Holtz-Eakin and Cameron Smith, *Labor Markets and Health Care Reform: New Results* (Washington, D.C.: American Action Forum, May 2010), [http://americanactionforum.org/sites/default/files/OHC\\_LabMktsHCR.pdf](http://americanactionforum.org/sites/default/files/OHC_LabMktsHCR.pdf). Holtz-Eakin and Smith conclude that the ACA provides incentives for employers to drop employment-based insurance for as many as 35 million Americans. A later section of this report presents illustrative examples of the sort reported by Holtz-Eakin and Smith.

found that about 9 percent of all surveyed employers with 500 or more employees said they were likely to stop offering health insurance coverage to their workers after 2014.<sup>17</sup> Much higher levels of employers' dropping of health benefits were predicted in a survey conducted by McKinsey & Company (a leading international management consulting firm). In June 2011, McKinsey reported that about 30 percent of employers said they would "definitely or probably" stop offering health insurance coverage to their employees after 2014, and more than 50 percent of employers with a high awareness of the ACA's provisions stated that they would "definitely or probably" drop coverage.<sup>18</sup> In contrast, another survey conducted in May 2011 by the International Foundation of Employee Benefit Plans found that between 1 percent and 3 percent of employers plan to eliminate health benefits for active employees, new workers that they will hire, workers' dependents, or retirees.<sup>19</sup> And yet another survey conducted in May 2011 found that nearly 19 percent of employers said they would consider eliminating health insurance coverage in 2014.<sup>20</sup>

Beyond the conflicting findings of these surveys, it is doubtful that any survey conducted today could provide very accurate predictions of employers' future decisions. Responses to such surveys have no consequences for the responders, do not require careful analysis or extensive deliberations, and are necessarily based on limited information about the various ways that the ACA will affect the market for health insurance. In contrast, firms' future decisions about offering health insurance will have significant consequences for both employers and their employees. Those decisions will reflect the development of the exchanges, changes in the price of insurance, employees' heightened desire for health insurance in order to satisfy the ACA mandate, evolving market forces, and other factors that employers cannot fully anticipate today.

One piece of evidence about how employers may respond to the ACA is the behavior of firms in Massachusetts following the implementation of that state's major health care reform. That reform included many provisions that are similar to those of the ACA, including the creation of an insurance exchange, the provision of subsidies for lower-income individuals, a mandate for individuals to purchase insurance, and penalties for employers who do not offer health insurance coverage. Yet the Massachusetts reform also differed from the ACA in a number of ways. Some aspects of the Massachusetts law provide a stronger incentive for firms to offer coverage than will occur under the ACA: For example, workers in

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<sup>17</sup> See Mercer, "Employers Accelerate Efforts to Bring Health Care Costs Under Control," (press release, New York, November 16, 2011), [www.mercer.com/press-releases/1434885](http://www.mercer.com/press-releases/1434885).

<sup>18</sup> See Shubhan Singhal, Jeris Stueland, and Drew Ungerman, "How U.S. Health Care Reform Will Affect Employee Benefits," *McKinsey Quarterly* (June 2011), [www.mckinsey.com/~media/mckinsey/dotcom/US%20employer%20healthcare%20survey/us\\_health\\_benefits.aspx](http://www.mckinsey.com/~media/mckinsey/dotcom/US%20employer%20healthcare%20survey/us_health_benefits.aspx).

<sup>19</sup> See International Foundation of Employee Benefit Plans, "New Survey Examines Employer Reactions to Health Care Reform One Year Later" (press release, Brookfield, Wis., June 2011), [http://www.ifebp.org/AboutUs/PressRoom/Releases/pr\\_060811.htm](http://www.ifebp.org/AboutUs/PressRoom/Releases/pr_060811.htm).

<sup>20</sup> See Lockton, "Health Reform Challenges Employers' Ability to Control Costs, Maintain Robust Plans, Survey Show," (presentation, June 2011), [www.lockton.com/Resource\\_/PageResource/MKT/Employer%20Health%20Reform%20Survey%20Results%202011--FINAL.pdf](http://www.lockton.com/Resource_/PageResource/MKT/Employer%20Health%20Reform%20Survey%20Results%202011--FINAL.pdf).

Massachusetts who had employment-based coverage need to wait six months after losing coverage before becoming eligible for subsidies through the state exchange. In addition, firms in Massachusetts with 11 or more full-time-equivalent employees face penalties if they do not offer coverage; under the ACA, by contrast, firms with fewer than 50 full-time-equivalent employees will not incur such penalties. Moreover, firms that previously offered health coverage to their employees in both Massachusetts and other states may not want to offer different compensation packages in different states. However, other aspects of the Massachusetts law provide a weaker incentive for firms to offer coverage than will occur under the ACA: For example, at a given income level, individuals in Massachusetts who obtain coverage through the exchange receive more generous subsidies than under the ACA, and firms with at least 50 full-time-equivalent employees face smaller penalties for each worker who is not offered minimum health benefits.

CBO and JCT have not modeled the Massachusetts system, so the estimated net impact of those differences in provisions is not clear. Still, it is noteworthy that employment-based health insurance coverage appears to have increased in Massachusetts since that state's reforms were implemented.<sup>21</sup>

### **How Characteristics of the Workforce Will Affect Incentives for Firms to Offer Health Insurance Under the ACA**

Because employers seek to offer compensation packages that are most attractive to current and potential employees at the lowest possible cost, their decisions about offering employment-based health insurance under the ACA will be influenced heavily by the subsidies available to some people through insurance exchanges, Medicaid, and CHIP and by the tax treatment of employment-based insurance. As discussed in more detail below, if firms offer health insurance to some of their workers, they are generally required to offer it to all or most of their workers. Therefore, CBO and JCT (and many other analysts) expect that firms will generally make decisions about offering or not offering health insurance for their workers as a group. Accordingly, CBO and JCT anticipate that, when employers decide whether to offer coverage or not, they will weigh the value of the tax exclusion for employment-based insurance that is available to *all* of their employees if the firm offers coverage against the value of Medicaid and CHIP benefits and the exchange subsidies that will be available to *some* of their employees and their dependents if the firm does not offer coverage. As a result, the proportion of an employer's workers and their families eligible for Medicaid, CHIP, or exchange subsidies, and the amounts of those benefits relative to the amounts of the tax subsidies for the employer's workforce as a whole, will be central to that employer's decision about offering health insurance.

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<sup>21</sup> See Sharon K. Long and Karen Stockley, "Sustaining Health Reform in a Recession: An Update on Massachusetts as of Fall 2009," *Health Affairs*, vol. 29, no. 6 (2010), pp. 1234–1241; and Genevieve M. Kenney, Sharon K. Long, and Adela Luque, "Health Reform in Massachusetts Cuts the Uninsurance Rate for Children in Half," *Health Affairs*, vol. 29, no. 6 (2010), pp. 1242–1247.

### Proportion of the Workforce Eligible for Medicaid, CHIP, or Exchange Subsidies Under the ACA

A substantial proportion of workers and their families who would have employment-based health insurance in the absence of the ACA will not be eligible for Medicaid, CHIP, or significant exchange subsidies. That fact may seem surprising, because median household income in the United States in 2010 was about \$49,000, and the ACA provides some exchange subsidies for families with income of up to 400 percent of the federal poverty level, which was about \$88,000 in 2010 for a family of four. Three factors help to explain why most workers and their families who would have employment-based health insurance in the absence of the ACA will not be eligible for Medicaid, CHIP, or significant exchange subsidies under that law:

- First, families with workers tend to have higher income than families without workers, and thus higher income than families on average.
- Second, CBO and JCT expect that family income will generally rise faster than the federal poverty level, which is indexed to the Department of Labor's consumer price index for all urban consumers.
- Third, higher-income workers are more likely than lower-income workers to work for a firm that offers such coverage and are more likely to take up such coverage when offered. The Medical Expenditure Panel Survey (Household Component) shows that, of the 5 million full-time, full-year workers who had family income at or below 125 percent of the federal poverty level in 2008, only 41 percent were covered by private (mostly employment-based) insurance. The survey also shows that, of the 10 million such workers who had family income between 125 percent and 200 percent of the federal poverty level, only 65 percent were covered by private insurance. In contrast, of the 84 million full-time, full-year workers who had family income above 200 percent of the federal poverty level, 90 percent were covered by private insurance.<sup>22</sup>

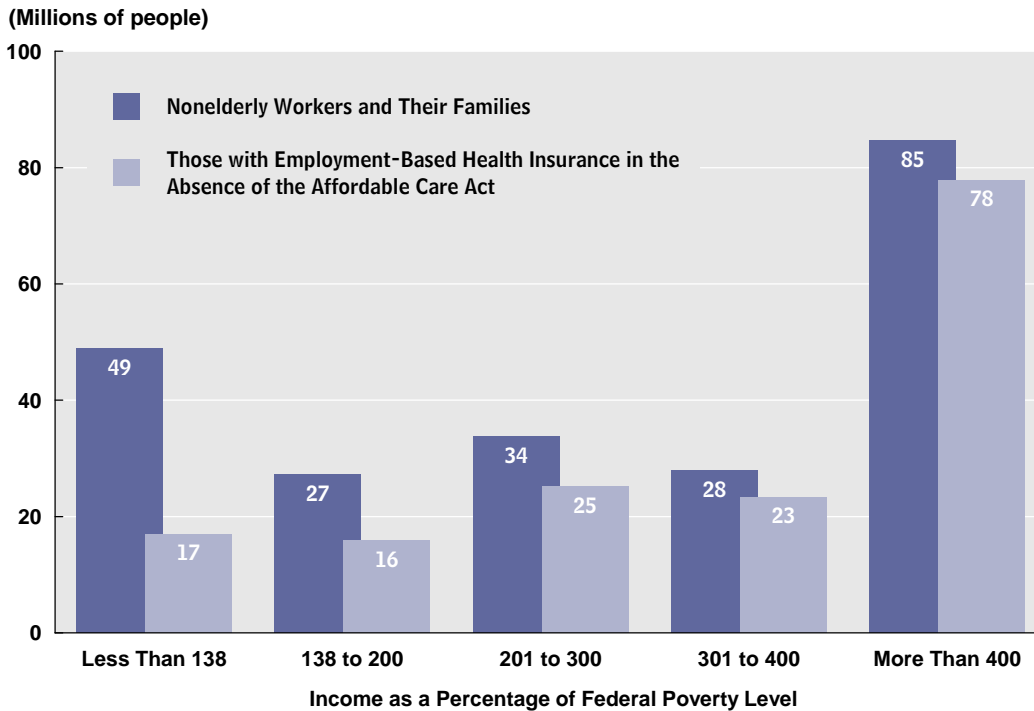
Owing to those factors, CBO and JCT project that, of the 159 million nonelderly workers and their families who the agencies project would receive employment-based insurance coverage in 2016 *in the absence of the ACA*:

- Forty-nine percent (or 78 million people) are projected not to be eligible for Medicaid, CHIP, or any subsidies in the exchanges under the ACA because their income will be above 400 percent of the federal poverty level (see Figure 1). (The percentage of *all* nonelderly workers and their families in that category is smaller—38 percent.)

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<sup>22</sup> For more details, see William A. Carroll and G. Edward Miller, *Health Insurance Status of Full-Time Workers by Demographic and Employer Characteristics, 2008*, Statistical Brief No. 317 (Rockville, Md.: Agency for Healthcare Research and Quality, March 2011), [http://www.meps.ahrq.gov/mepsweb/data\\_files/publications/st317/stat317.pdf](http://www.meps.ahrq.gov/mepsweb/data_files/publications/st317/stat317.pdf).

**Figure 1.**  
**The Distribution of Nonelderly Workers and Their Families, by Family Income Relative to the Federal Poverty Level, 2016**



Source: Congressional Budget Office.

- Only 11 percent (or 17 million people) are projected to be eligible for Medicaid under the ACA because their income will be below 138 percent of the federal poverty level. (By comparison, 22 percent of *all* nonelderly workers and their families are projected to have income below 138 percent of the federal poverty level.)
- Only 10 percent (or 16 million people) are projected to have income between 138 percent and 200 percent of the federal poverty level and therefore to be eligible for substantial subsidies in the exchanges under the ACA. Specifically, those people would pay between 3.4 percent and 6.5 percent of their income to obtain the benchmark insurance plan—the plan to which subsidies will be tied, which will be the second-lowest-cost “silver” plan—and would receive cost-sharing subsidies as well.<sup>23</sup>

<sup>23</sup> Silver plans are those with an actuarial value of 70 percent; the actuarial value of a health insurance plan is the share of spending on covered benefits that is paid by insurance, with the remainder paid out-of-pocket by enrollees. The percentage of income that will be paid in the exchange to obtain the benchmark plan is indexed over time under the ACA; its future value depends on changes in wages and health insurance premiums. See Congressional Budget Office, *Additional Information About CBO’s Baseline Projections of Federal Subsidies for Health Insurance Provided Through Exchanges* (May 2011).



- About 30 percent (or 48 million people) are projected to have income between 201 percent and 400 percent of the federal poverty level. Those individuals will be eligible for subsidies in the exchanges under the ACA such that they would pay between 6.5 percent and 9.8 percent of their income for the premiums for the benchmark plan.

### **Illustrative Examples of the Magnitude of the Exchange Subsidies Relative to the Tax Exclusion**

In addition to considering the share of its workers and their families who will be eligible for Medicaid, CHIP, or exchange subsidies under the ACA, a firm will also weigh the cost to its workers of obtaining insurance through exchanges (after accounting for any subsidies) against the cost of obtaining insurance through the firm (after accounting for the tax exclusion).<sup>24</sup> From the workers' perspective, the latter cost includes the entire amount of the premiums (because the cost to firms of providing health insurance is ultimately reflected in lower wages and salaries paid to their employees), less the savings workers realize in taxes because the compensation they receive in the form of health benefits is generally not taxed. The difference in the net cost of health insurance to workers from those two sources will depend on differences in the price of health insurance obtained through the exchanges or through the firm and on the relative amount of support provided by exchange subsidies and the tax exclusion, which depends in turn on workers' income.

CBO and JCT project that a typical family health insurance policy purchased through an employer will cost about \$20,000 in 2016 and that the typical premiums for the second-lowest-cost silver plan available through the exchanges for that family will be about \$15,400. The difference in projected cost for the two policies reflects various factors: First, employment-based plans are expected to have an actuarial value of 85 percent (roughly comparable with the average for employment-based plans today), and silver plans will have an actuarial value of 70 percent.<sup>25</sup> Second, administrative costs are expected to be much higher for exchange plans than for plans offered by large employers, principally because of the higher cost of handling enrollment and collecting premiums. Third, the premiums for the second-lowest-cost silver plan are expected to be below the average premiums for silver plans.

Exchange subsidies will be most beneficial for families with the lowest income. Consider a family of four whose income in 2016 is about 200 percent of the federal poverty level, which CBO and JCT estimate will imply modified adjusted gross income of about \$50,000 (see Table 1):<sup>26</sup>

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<sup>24</sup> Firms will also weigh the costs and benefits for their workers of receiving subsidized health care through Medicaid and CHIP. That comparison plays a role in CBO and JCT's modeling, but for simplicity, the following discussion focuses on the choice between employment-based coverage and exchange coverage.

<sup>25</sup> Insurance plans that have small deductibles and copayments have higher actuarial values than plans with large deductibles and copayments.

<sup>26</sup> Modified adjusted gross income (MAGI) equals adjusted gross income (AGI), untaxed Social



- If the family obtained insurance coverage through an employer, then the combination of federal and state income and payroll taxes means that the average family with that income would receive a tax subsidy of 29 percent of the \$20,000 premium, or about \$5,900.<sup>27</sup> The after-tax cost of the premium ( $\$20,000 - \$5,900 = \$14,100$ ) plus out-of-pocket costs for medical services (which would be about \$3,200 for such a policy) would total about \$17,300.
- If, instead, the family obtained insurance coverage through an exchange and purchased the second-lowest-cost silver plan, it would pay no more than 6.5 percent of its income, or about \$3,200, so it would receive a subsidy of its premiums of about \$12,200.<sup>28</sup> The family would also be eligible for cost-sharing subsidies of up to about \$3,600 to reduce out-of-pocket costs for medical services. The after-subsidy cost of the premium ( $\$15,400 - \$12,200 = \$3,200$ ) plus the remaining out-of-pocket costs (which would be about \$2,800 for such a policy) would total about \$6,000.<sup>29</sup>
- Therefore, for this family, receiving coverage through an exchange would save \$11,300 ( $\$17,300 - \$6,000$ ) per year relative to receiving coverage through an employer.

For families with higher income, however, the advantage of obtaining insurance through an exchange is smaller because such families would receive smaller exchange subsidies (owing to the sliding scale under the ACA) and would lose larger tax subsidies for insurance obtained through their employers (owing to their higher income tax brackets).

Consider, then, a family of four whose income in 2016 equals 300 percent of the federal poverty level, which CBO and JCT estimate will imply modified adjusted gross income of about \$74,000. If the family obtained insurance coverage through an employer, it would receive, on average, a tax subsidy of 33 percent of the \$20,000 premium, or about \$6,600. If, instead, the family purchased the second-

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Security benefits, foreign earned income that is excluded from AGI, tax-exempt interest, and income of dependent filers.

<sup>27</sup> That calculation and subsequent ones are based on current federal law, under which provisions of the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P.L. 111-312) that limited the reach of the alternative minimum tax and extended the tax cuts originally enacted in 2001, 2003, and 2009 have already expired or are set to expire at the end of 2012. State taxes are calculated as the average among similar families in all states.

<sup>28</sup> That example and subsequent ones reflect the assumption that families choose second-lowest-cost silver plans; if they choose more expensive plans, they will bear the extra cost of premiums without additional government support. CBO and JCT's estimates of the effects of the ACA incorporate an additional complication that, for simplicity, is not shown in the example: When employers stop offering coverage, the increase in employees' taxable compensation moves their income to a slightly higher percentage of the federal poverty level, which slightly reduces their exchange subsidy.

<sup>29</sup> Out-of-pocket costs are larger for the silver plan, projected to average about \$6,400 per year for the family in this example, before taking account of the government subsidies, than for the employment-based plan, projected to average about \$3,200 per year for the family in this example, because the silver plan has a lower actuarial value, as discussed above.

lowest-cost silver plan through an exchange, it would spend about 9.8 percent of its income, or about \$7,200, so it would receive a subsidy of its premium of about \$8,200. The family would typically face much higher out-of-pocket costs under the silver plan than under its employment-based plan. On balance, however, receiving coverage through an exchange would save this family about \$3,000 per year relative to receiving coverage through an employer.

Now consider a family of four whose income in 2016 is just under 400 percent of the federal poverty level, which CBO and JCT estimate will imply modified adjusted gross income of about \$99,000. If the family obtained insurance coverage through an employer, it would receive, on average, a tax subsidy of 39 percent of the premium, or about \$7,800. If, instead, the family purchased the second-lowest-cost silver plan through an exchange, it would pay about 9.8 percent of its income, or about \$9,700, so it would receive a subsidy of its premium of about \$5,700. Again, the family would typically face much higher out-of-pocket costs under the silver plan than under its employment-based plan. For this family, receiving coverage through an exchange would cost \$700 per year *more* than receiving coverage through an employer.

Families with income above 400 percent of the federal poverty level will not be eligible for any subsidies in the exchanges and will receive a significant tax benefit from obtaining insurance through an employment-based plan. For example, a family of four whose income in 2016 equals 500 percent of the federal poverty level, which CBO and JCT estimate will imply modified adjusted gross income of about \$124,000, would pay about \$6,300 more to receive coverage through an exchange than through an employer.

For every firm, the advantages and disadvantages of offering health insurance coverage will depend on the effects of that decision on its workers as a group—which will critically depend, as demonstrated by the preceding examples, on the composition of that firm's workforce. For example, if 25 percent of a firm's workers have income equal to 200 percent of the federal poverty level, another 25 percent have income equal to 300 of the poverty level, and the remaining 50 percent have income equal to 500 percent of the poverty level, calculations like those shown for the illustrative families indicate that the firm's workers as a group would have a higher cost for coverage through exchanges than through the employer. In addition, firms that chose not to offer coverage would generally pay penalties for doing so, or if they were sufficiently small, they might forgo tax credits for offering coverage. Moreover, because of the penalty that most people would face under the ACA if they do not have insurance coverage, few individuals will want to go without coverage altogether.

### **Some Alternative Assumptions About Employers' Behavior**

In the judgment of CBO and JCT, their estimates of the effects of the insurance coverage provisions of the ACA on sources of coverage and the federal budget are in the middle of the distribution of possible outcomes. However, assessing the effects of broad changes in the nation's health insurance system requires

assumptions and projections about a wide array of technical, behavioral, and economic factors. As a result, any projections of those effects are clearly quite uncertain. To illustrate that uncertainty, CBO and JCT have estimated the sources of insurance coverage and federal budgetary outcomes that would result from the ACA under certain alternative assumptions.

Three aspects of CBO and JCT's modeling that are especially important in estimating employers' responses to the insurance coverage provisions of the ACA, and that are varied in the analysis in this report, are the following:

- The responsiveness of employers to the difference between the cost of health insurance to their employees if provided by the employers or if obtained from other sources (incorporating the impact of subsidies and the tax exclusion),
- The weight that employers place on their employees' additional demand for health insurance coverage because of the ACA's mandate for individuals to obtain insurance coverage, and
- The extent to which firms will restructure their workforces so that their low-income workers and their families can take advantage of the exchange subsidies and expanded availability of Medicaid and CHIP.

Regarding the first of those issues, increasing the estimated degree of responsiveness of employers to the difference in cost of obtaining coverage from different sources increases the number of people whose employers are projected to stop offering insurance coverage in response to the ACA. Correspondingly, decreasing the degree of responsiveness reduces the number of people whose employers are projected to stop offering coverage. CBO and JCT's baseline estimates of the effects of the ACA reflect a degree of responsiveness by firms that is consistent with research on this topic.<sup>30</sup> In the alternative scenarios presented below, CBO and JCT increase those assumed sensitivities in two scenarios (in two different ways) and decrease them in one scenario.

Regarding the second of the issues listed above, decreasing the weight that employers place on employees' additional demand for health insurance because of the individual mandate increases the number of people whose employers are projected to stop offering insurance coverage in response to the ACA. Correspondingly, increasing the weight that employers place on employees' additional demand for health insurance decreases the number of people whose

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<sup>30</sup> Specifically, the price elasticity for firms of offering health insurance coverage is assumed to be -0.07 for very large firms (those with 1,000 employees or more), -0.15 for large firms (those with 100 to 999 employees), -0.38 for medium-sized firms (those with 25 to 99 employees), and -1.14 for small firms (those with fewer than 25 employees). Those figures imply, for example, that if the price of employer-provided health insurance increased by 1 percent, a large firm would be 0.15 percent less likely to offer coverage. For further discussion, see Congressional Budget Office, *Health Insurance Simulation Model: A Technical Description*, Background Paper (October 2007), p. 18. Since the publication of that paper, CBO has changed its assumption regarding the price elasticity for very large firms so that it is now assumed to be -0.07 rather than zero, as indicated in that paper.

employers are projected to stop offering coverage. In their baseline estimates of the effects of the ACA, CBO and JCT incorporate an impact on firms' decisions to offer coverage that will arise from the penalty that the ACA will impose on people who do not satisfy the individual mandate. The magnitude of that impact is consistent with the agencies' assessment of the available evidence on this topic.<sup>31</sup> In the alternative scenarios presented below, CBO and JCT decrease that assumed impact in two scenarios and increase it in one scenario.

The genesis of the third issue is that most firms have a mix of higher-income and lower-income workers, so not all workers and their dependents in any given firm would be eligible for Medicaid, CHIP, or exchange subsidies if those firms decided not to offer health insurance coverage. As a result, some firms might wish to provide health insurance only to those workers and dependents who would not be eligible for those programs, while allowing lower-income workers and dependents to obtain insurance through one of those channels. For example, some firms might want to design their health insurance plans so that the terms of the plans explicitly covered only higher-paid workers. Or some firms might want to reduce work hours for lower-paid workers so that they became part-time workers and were thus ineligible for all of the benefits provided to full-time workers. Alternatively, some firms might want to lay off their lower-paid workers and either contract for similar services through an unrelated business entity or hire individual workers as independent contractors.

But there are significant legal and economic obstacles to successfully pursuing such restructuring of either insurance plans or workforces. First, both the Internal Revenue Code and the Public Health Service Act contain nondiscrimination provisions (expanded under the ACA) that impede firms from offering health insurance coverage to higher-paid employees while excluding lower-paid employees.<sup>32</sup> Second, a well-developed body of law addresses the question of who is an employee: Both case law and employment, labor, and tax statutes make it difficult for a firm to claim that an individual working under its direction is not an employee.<sup>33</sup> Importantly, an employer would bear the burden of proof in

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<sup>31</sup> See David Auerbach and others, *Will Health Insurance Mandates Increase Coverage? Synthesizing Perspectives from the Literature in Health Economics, Tax Compliance, and Behavioral Economics*, Congressional Budget Office Working Paper 2010-05 (August 2010).

<sup>32</sup> See section 105(h) of the Internal Revenue Code and section 2716 of the Public Health Service Act.

<sup>33</sup> Under both state and federal law, the tests for defining a worker's status look to the individual circumstances of any particular relationship in question. Courts consider whether an individual is an employee or an independent contractor (and thus self-employed) in determining cases under, for example, title VII of the Civil Rights Act, the Age Discrimination in Employment Act, and the Americans with Disabilities Act. Whether an individual is an employee or an independent contractor also has ramifications under the Internal Revenue Code (including a firm's responsibility for paying employment taxes, and the tax treatment of employee benefits and plans), the Employee Retirement Income Security Act of 1974 (setting minimum standards for employee retirement plans), the Family and Medical Leave Act (whether a firm is obligated to allow a worker to take unpaid leave under certain health-related circumstances), the Fair Labor Standards Act (whether a firm is obligated to pay the minimum wage), and the Worker Adjustment and Retraining Act (relating to advance notice in the event of plant closings and mass layoffs).

certain types of employment-related litigation. Although firms sometimes improperly classify workers, firms that do not comply with relevant worker classification laws are subject to serious legal and economic consequences, including possible loss of tax advantages, interest and penalties on unpaid taxes, and punitive damages.

Under the ACA, most firms with predominantly lower-income workers will have less incentive than before to provide health insurance because of the expanded availability of subsidized insurance through Medicaid, CHIP, and insurance exchanges. Under pre-ACA law, though, there were already significant economic incentives for firms to structure their workforces so as to minimize the number of workers who were classified as employees; those incentives include the rules regarding nondiscrimination in providing pension and health insurance benefits, employers' payroll tax liabilities, and minimum-wage requirements. Yet many firms retain a mixture of lower-paid and higher-paid employees, apparently finding that they can operate more efficiently by mixing workers with different skills and wages.

In one of the alternative scenarios presented below, CBO and JCT assume substantially more restructuring by employers than is assumed in the baseline estimates of the effects of the ACA. In that scenario, CBO and JCT assume that more lower-paid employees lose their employment-based coverage while higher-paid employees in their firms do not. Such an outcome would be consistent with a widespread reorganization of firms' workforces or benefits that somehow circumvented or overcame the legal and economic obstacles just described.

### **The Estimated Impact of the ACA Under Alternative Assumptions About Employers' Behavior**

CBO and JCT's baseline estimates of the effects of the insurance coverage provisions of the ACA indicate that 3 million to 5 million fewer people, on net, will obtain coverage through their employer each year from 2019 through 2022 than would have been the case under prior law (see Table 2). Those estimates also indicate that, under the ACA, the number of people without health insurance will fall from between 57 million and 60 million in those years to about 26 million or 27 million. Roughly 22 million to 23 million people are estimated to receive insurance coverage through the new insurance exchanges in those years, and 16 million to 17 million additional people are estimated to be enrolled in Medicaid and CHIP.

The baseline estimates include a net cost to the federal government of the coverage provisions of the ACA of \$1,252 billion over the 11-year period from 2012 to 2022 (see Table 3). That amount represents a gross cost to the federal government of \$1,762 billion for Medicaid, CHIP, tax credits and other subsidies for the purchase of health insurance through the newly established exchanges and related costs, and tax credits for small employers. That gross cost is offset in part by \$510 billion in receipts from penalty payments, the new excise tax on high-premium insurance plans, and other budgetary effects (mostly increases in tax revenues).

Under alternative assumptions about employers' behavior, the effects of the ACA on both insurance coverage and the federal budget differ from those in the baseline.<sup>34</sup> Because CBO and JCT view the baseline as representing the middle of the distribution of possible outcomes, the four scenarios examined here include both larger and smaller reductions in employment-based insurance.

**Scenario 1: Greater Responsiveness by Employers to the Difference in the Cost of Obtaining Insurance from Different Sources and Lesser Responsiveness to Additional Demand for Insurance Arising from the Individual Mandate**

In the first scenario, CBO and JCT incorporated three changes in their assumptions about employers' behavior that *increase* the projected number of employers deciding not to offer coverage:

- First, the assumed responsiveness of all firms to differences in the cost of obtaining insurance coverage was doubled relative to the responsiveness underlying the March 2012 baseline.<sup>35</sup> For small firms in particular, the resulting degree of responsiveness is quite high relative to most estimates seen in the research literature.
- Second, the responsiveness to differences in cost for medium-sized and large firms was increased further, effectively placing additional weight on the eligibility for Medicaid, CHIP, and significant exchange subsidies for those workers and their families. Specifically, the increase in a firm's responsiveness was assumed to be proportional to the share of workers at that firm with income below 250 percent of the federal poverty level.<sup>36</sup> Taking both of those increases in responsiveness together, a large firm with all of its workforce composed of workers having income below 250 percent of the federal poverty level would have a degree of responsiveness that was four times its baseline value, while a large firm with all of its workforce composed of workers with income above 250 percent of the federal poverty level and a small firm with a workforce composed of workers with any amounts of income would have degrees of responsiveness that were twice their baseline values.
- Third, the effect on employers' decisions of the increase in demand for insurance arising from the penalty for not satisfying the individual mandate was reduced by 90 percent from its baseline value.

With those assumptions about employers' behavior, CBO and JCT estimate that the ACA would reduce employment-based insurance coverage in 2019 by

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<sup>34</sup> Because the ACA does not contain major changes to employers' incentives to offer insurance coverage before 2014, the alternative assumptions in the scenarios begin in 2014.

<sup>35</sup> As a result, in this scenario, firms' price elasticities for offering coverage ranged from -0.14 for very large firms to -2.28 for small firms.

<sup>36</sup> Since many small firms employ primarily lower-income workers, and the first change already made such firms very sensitive to differences in cost, no further changes to their responsiveness was made in this second step.

12 million people, compared with 5 million in the baseline projections (see Table 4). Enrollment in the exchanges is estimated to be 27 million in that year, 4 million more than in the baseline; and enrollment in Medicaid and CHIP is estimated to rise by 18 million, 2 million more than in the baseline. The number of uninsured is estimated to be 30 million less than the number under prior law, leaving 27 million people uninsured in 2019.

Under those assumptions, CBO and JCT estimate that the coverage provisions of the ACA would have a net cost to the federal government of \$1,297 billion over the 11-year period from 2012 to 2022, an additional cost of \$45 billion relative to the baseline projections. With more people receiving insurance through the exchanges, Medicaid, and CHIP than in the baseline, exchange subsidies would be \$165 billion higher, and federal Medicaid and CHIP outlays \$53 billion higher. However, those extra costs would be offset in large part by higher tax revenues stemming from an increase in taxable compensation that would occur as firms reduced their nontaxed payments for employment-based health insurance. That increase in revenues would amount to \$153 billion, offsetting about 70 percent of the additional exchange subsidies and Medicaid and CHIP outlays. In addition, revenues from penalties collected from uninsured individuals and employers who do not provide minimum health benefits would be larger in this scenario than in the baseline.

### **Scenario 2: Lesser Responsiveness by Employers to the Difference in the Cost of Obtaining Insurance from Different Sources and Greater Responsiveness to Additional Demand for Insurance Arising from the Individual Mandate**

The second scenario is meant to be the opposite of the first scenario. In this scenario, CBO and JCT incorporated three changes in their assumptions about employers' behavior that *decrease* the number of employers deciding not to offer coverage:

- First, the responsiveness of all firms to differences in the cost of obtaining insurance coverage was cut in half relative to the responsiveness underlying the March 2012 baseline.
- Second, the responsiveness of medium-sized and large firms was decreased further, effectively placing additional weight on the preferences of higher-paid workers who may be more influential in setting a firm's benefits policies. Specifically, the decrease in a firm's responsiveness to lower-paid workers was proportional to the share of workers at a firm with income below 250 percent of the federal poverty level. Taking both of those changes together, a large firm with all of its workforce composed of workers having income below 250 percent of the federal poverty level would have a degree of responsiveness that was one-quarter of its baseline value, while a large firm with all of its workforce composed of workers having income above 250 percent of the federal poverty level and a small firm with a workforce composed of workers with any amounts of income would have degrees of responsiveness that were one-half their baseline values.

- Third, the effect on employers' decisions of the increase in demand for insurance arising from the penalty for not satisfying the individual mandate was increased by 90 percent from its baseline value.

With those assumptions about employers' behavior, CBO and JCT estimate that the ACA would *increase* employment-based insurance coverage in 2019 by 3 million people, compared with a decline of 5 million in the baseline projections. Under that scenario, enrollment in the exchanges is estimated to be 18 million in that year, 4 million fewer than in the baseline, and enrollment in Medicaid and CHIP is estimated to rise by 15 million, 1 million fewer than in the baseline. The number of uninsured is estimated to be 33 million less than the number under prior law, leaving 24 million people uninsured in 2019.

Under those assumptions, CBO and JCT estimate that the coverage provisions of the ACA would have a net cost to the federal government of \$1,170 billion over the 11-year period from 2012 to 2022, a savings of \$82 billion relative to the baseline projections. With fewer people receiving insurance through the exchanges, Medicaid, and CHIP than in the baseline, exchange subsidies would be \$179 billion lower, and federal Medicaid and CHIP outlays \$43 billion lower. However, those savings would be offset in large part by lower tax revenues stemming from a decrease in taxable compensation that would occur as firms increased their nontaxed payments for employment-based health insurance. That decline in revenues would amount to \$119 billion, which would offset about half of the additional exchange subsidies and Medicaid and CHIP outlays. In addition, revenues from penalties collected from uninsured individuals and employers who do not provide minimum health benefits would be less in this scenario than in the baseline.

### **Scenario 3: A Variation on Scenario 1's Greater Responsiveness by Employers to Differences in the Cost of Obtaining Insurance**

In the first scenario, CBO and JCT incorporated three changes in their assumptions about employers' behavior that increased the number of employers deciding not to offer coverage. In this third scenario, CBO and JCT made somewhat different changes in their assumptions that also increase the number of employers deciding not to offer coverage but lead to different sorts of workers not having employment-based insurance—which leads to different estimated budgetary effects of the ACA. In this scenario:

- First, the responsiveness of all firms to differences in the cost of obtaining insurance coverage was increased substantially relative to the baseline values. Specifically, the degree of responsiveness for very large, large, and medium-sized firms was twice as high as the responsiveness of small employers in the baseline estimates, and the degree of responsiveness for small firms was four times its baseline level.<sup>37</sup> The resulting elasticities represent extremely high degrees of responsiveness that have only rarely been reported in the research literature, and even then only for the behavior of small firms.<sup>38</sup> Those

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<sup>37</sup> The resulting price elasticities were -2.30 and -4.60.

<sup>38</sup> A price elasticity in this range was reported by Roger Feldman and others, "The Effect of



increases in the degree of firms' responsiveness apply regardless of the proportion of a firm's workforce represented by lower-paid or higher-paid workers—in contrast with the increases in firms' responsiveness in the first scenario, which were concentrated in firms with larger proportions of lower-paid workers.

- Second, and matching the first scenario, the effect on employers' decisions of the increase in demand for insurance arising from the penalty for not satisfying the individual mandate was reduced by 90 percent from its baseline value.

With those assumptions about employers' behavior, CBO and JCT estimate that the ACA would reduce employment-based insurance coverage in 2019 by 20 million people, compared with 5 million in the baseline projections. Enrollment in the exchanges is estimated to be 31 million in that year, 9 million more than in the baseline, and enrollment in Medicaid and CHIP is estimated to rise by 18 million, 2 million more than in the baseline. The number of uninsured is estimated to be 29 million less than the number under prior law, leaving 28 million people uninsured in 2019.

Those estimated differences in insurance coverage relative to the baseline are similar in direction to those in the first scenario but generally of greater magnitude. However, the estimated net budgetary effect is a *decrease* in the cost of the ACA, rather than an increase, as in the first scenario.

In this third scenario, CBO and JCT estimate that the coverage provisions of the ACA would have a net cost to the federal government of \$1,239 billion over the 11-year period from 2012 to 2022, a *savings* of \$13 billion relative to the baseline projections. With substantially more people receiving insurance through the exchanges, Medicaid, and CHIP than in the baseline, exchange subsidies would be \$310 billion higher, and federal Medicaid and CHIP outlays \$65 billion higher, than in the baseline. However, in this scenario, those extra costs would be almost entirely offset by higher tax revenues stemming from an increase in taxable wages and salaries that would occur as firms reduced their nontaxed payments for employment-based health insurance. That increase in revenues would amount to \$351 billion. In addition, revenues from penalties collected from uninsured individuals and especially employers who do not provide minimum health benefits would be higher in this scenario than in the baseline.

The budgetary effects in this scenario differ from those in the first scenario because the workers who lose employment-based coverage in this scenario are different. Increasing the responsiveness of all firms to differences in the cost of obtaining insurance from different sources leads to projections of a substantial number of workers with both lower income and higher income losing their employment-based coverage. The loss of employment-based coverage by lower-

income workers tends to increase the deficit under the ACA because those workers and their dependents will generally be eligible for Medicaid, CHIP, or significant exchange subsidies. However, the loss of employment-based coverage by higher-income workers tends to reduce the deficit under the ACA because those workers and their dependents would not generally be eligible for Medicaid, CHIP, or significant exchange subsidies, and they would pay more in taxes as a result of losing the tax exclusion.

Thus, the scenario with the largest estimated cost of the ACA is not the one with the largest estimated reduction in employment-based health insurance coverage (Scenario 3), but rather the one in which the additional reduction in such coverage relative to the baseline projections is concentrated among low-income workers (Scenario 1). Because such workers and their dependents usually face low tax rates and are generally eligible for Medicaid, CHIP, or substantial exchange subsidies, their shift out of employment-based coverage tends to be costly to the federal government.

#### **Scenario 4: Substantially More Restructuring by Employers**

In the fourth scenario, CBO and JCT incorporated a substantial restructuring by employers in which more of their lower-paid employees lose their employment-based coverage while their higher-paid employees do not. As discussed above, CBO and JCT's baseline estimates of the effects of the ACA incorporate less restructuring than in this scenario because there are significant legal and economic obstacles to successfully pursuing such a tactic for either insurance plans or workforces. In this scenario, CBO and JCT assume that the effects on workers with income equal to 250 percent or more of the federal poverty level are the same as in the baseline, but that 20 percent of workers with income less than 250 percent of the federal poverty level lose their employment-based coverage.

With that assumption about employers' behavior, the estimated effects on insurance coverage and the federal budget are similar to those under the first scenario. In this scenario, the ACA is estimated to reduce employment-based insurance coverage in 2019 by 10 million people, compared with 5 million in the baseline projections. Enrollment in the exchanges is estimated to be 26 million in that year, 3 million more than in the baseline, and enrollment in Medicaid and CHIP is estimated to rise by 17 million, 1 million more than in the baseline. The number of uninsured is estimated to be 30 million less than the number under prior law, leaving 27 million people uninsured in 2019.

In this scenario, CBO and JCT estimate that the coverage provisions of the ACA would have a net cost to the federal government of \$1,289 billion over the 11-year period from 2012 to 2022, which represents an additional \$36 billion cost relative to the baseline projections. With more people receiving insurance through the exchanges, Medicaid, and CHIP than in the baseline, exchange subsidies would be \$146 billion higher, and federal Medicaid and CHIP outlays would be \$27 billion higher. However, those extra costs would be offset in large part by higher tax revenues stemming from an increase in taxable compensation that would occur as firms reduced their nontaxed payments for employment-based health insurance. That increase in revenues would amount to \$118 billion,

offsetting about two-thirds of the additional exchange subsidies and Medicaid and CHIP outlays. In addition, revenues from penalties collected from uninsured individuals and employers who do not provide minimum health benefits would be higher in this scenario than in the baseline.

Jessica Banthin and Paul Jacobs of CBO's Health and Human Resources Division prepared this report under the supervision of Linda Bilheimer. The estimates described here were the work of many analysts at CBO and on the staff of the Joint Committee on Taxation; the CBO analysts who played especially important roles were Sarah Anders, James Baumgardner, Holly Harvey, Jean Hearne, Alexandra Minicozzi, Kirstin Nelson, Allison Percy, and Robert Stewart. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations. It and other CBO publications are available on the agency's Web site ([www.cbo.gov](http://www.cbo.gov)).

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**TABLE 1.**

**Illustrative Comparison of Costs of Employment-Based and Exchange Coverage by Family Income, 2016**

|   | Percentage of Federal Poverty Level |          |          |           |
|---|-------------------------------------|----------|----------|-----------|
|   | 200%                                | 300%     | 399%     | 500%      |
| Modified Adjusted Gross Income  | \$50,000                            | \$74,000 | \$99,000 | \$124,000 |
| <b>Employment-Based Coverage</b> (Premium: \$20,000; average out-of-pocket costs for medical services: \$3,200) |                                     |          |          |           |
| Average marginal tax rate (Including federal and state income taxes and payroll taxes) <sup>a</sup>             | 29.4%                               | 32.8%    | 38.8%    | 38.7%     |
| Average federal and state tax subsidies for a typical employer-based plan                                       | \$5,900                             | \$6,600  | \$7,800  | \$7,700   |
| Total cost (Including after-tax premium and out-of-pocket costs for medical services)                           | \$17,300                            | \$16,600 | \$15,400 | \$15,500  |
| <b>Exchange Coverage</b> (Premium: \$15,400; average out-of-pocket costs for medical services: \$6,400)         |                                     |          |          |           |
| Percentage of income required to purchase second-lowest-cost silver plan  | 6.5%                                | 9.8%     | 9.8%     | n.a.      |
| Premium subsidy   | \$12,200                            | \$8,200  | \$5,700  | \$0       |
| Cost-sharing subsidies  | \$3,600                             | \$0      | \$0      | \$0       |
| Total cost (Including after-subsidy premium and out-of-pocket costs for medical services)                       | \$6,000                             | \$13,600 | \$16,100 | \$21,800  |
| <b>Cost for Exchange Coverage Versus Employment-Based Coverage</b>  |                                     |          |          |           |
| Difference between cost of exchange coverage and cost of employment-based coverage                              | -\$11,300                           | -\$3,000 | \$700    | \$6,300   |
| Percentage difference between cost of exchange coverage and cost of employment-based coverage                   | -65%                                | -18%     | 5%       | 41%       |

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Note: The analysis presents average expected costs in 2016 for a family of four with two adults and two children. Serving as an illustration, the analysis includes simplifying assumptions and therefore does not incorporate all features of the ACA nor all of the differences between employment-based and exchange coverage.

a. Marginal state income tax rates are calculated as the average across similar families in all states.

**TABLE 2.**  
**March 2012 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage**

| <b>EFFECTS ON INSURANCE COVERAGE<sup>a</sup></b>  |   | 2012       | 2013       | 2014       | 2015       | 2016       | 2017       | 2018       | 2019       | 2020       | 2021       | 2022       |
|---|---|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|
| (Millions of nonelderly people, by calendar year) |   |            |            |            |            |            |            |            |            |            |            |            |
| Prior-Law Coverage <sup>b</sup>                   | Medicaid and CHIP   | 34         | 34         | 35         | 34         | 32         | 32         | 31         | 32         | 32         | 32         | 32         |
|   | Employer  | 154        | 156        | 157        | 157        | 159        | 160        | 160        | 161        | 161        | 160        | 161        |
|   | Nongroup and Other <sup>c</sup>                           | 25         | 25         | 25         | 27         | 28         | 28         | 31         | 30         | 30         | 31         | 31         |
|   | Uninsured <sup>d</sup>                                    | <u>55</u>  | <u>56</u>  | <u>56</u>  | <u>56</u>  | <u>56</u>  | <u>57</u>  | <u>58</u>  | <u>57</u>  | <u>59</u>  | <u>60</u>  | <u>60</u>  |
|   | <b>TOTAL</b>  | <b>269</b> | <b>271</b> | <b>272</b> | <b>274</b> | <b>275</b> | <b>277</b> | <b>280</b> | <b>280</b> | <b>282</b> | <b>283</b> | <b>284</b> |
| Change  | Medicaid and CHIP   | *          | 1          | 13         | 15         | 17         | 16         | 16         | 16         | 17         | 17         | 17         |
|   | Employer <sup>e</sup>                                     | 1          | 1          | -2         | -2         | -4         | -5         | -5         | -5         | -4         | -3         | -3         |
|   | Nongroup and Other <sup>c</sup>                           | 1          | *          | -1         | -1         | -2         | -2         | -3         | -3         | -3         | -3         | -3         |
|   | Exchanges   | 0          | 0          | 8          | 12         | 20         | 22         | 23         | 23         | 22         | 23         | 22         |
|   | Uninsured <sup>d</sup>                                    | -2         | -2         | -18        | -24        | -30        | -31        | -31        | -31        | -32        | -33        | -33        |
| <u>Uninsured Population Under the ACA</u>         |   |            |            |            |            |            |            |            |            |            |            |            |
|   | Number of Uninsured Nonelderly People <sup>d</sup>        | 53         | 53         | 38         | 32         | 26         | 26         | 26         | 26         | 26         | 27         | 27         |
|   | Insured Share of the Nonelderly Population <sup>a</sup>   |            |            |            |            |            |            |            |            |            |            |            |
|   | Including All Residents                                   | 80%        | 80%        | 86%        | 88%        | 91%        | 91%        | 91%        | 91%        | 91%        | 90%        | 90%        |
|   | Excluding Unauthorized Immigrants                         | 82%        | 82%        | 88%        | 91%        | 93%        | 93%        | 93%        | 93%        | 93%        | 93%        | 93%        |
| <u>Memo: Exchange Enrollees and Subsidies</u>     |   |            |            |            |            |            |            |            |            |            |            |            |
|   | Number with Unaffordable Offer from Employer <sup>f</sup> |            |            | *          | *          | 1          | 1          | 1          | 1          | 1          | 1          | 1          |
|   | Number of Unsubsidized Exchange Enrollees                 |            |            | 1          | 2          | 4          | 4          | 4          | 5          | 5          | 5          | 5          |
|   | Average Exchange Subsidy per Subsidized Enrollee          |            |            | \$4,780    | \$5,040    | \$5,210    | \$5,300    | \$5,780    | \$6,170    | \$6,490    | \$6,940    | \$7,270    |

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act (ACA) is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

CHIP = Children's Health Insurance Program; \* = between 0.5 million and -0.5 million.

a. Figures for the nonelderly population include only residents of the 50 states and the District of Columbia.

b. Figures reflect average annual enrollment; individuals reporting multiple sources of coverage are assigned a primary source. To illustrate the effects of the ACA, which is now current law, changes in coverage are shown compared with coverage projections in the absence of that legislation, or "prior law."

c. Other includes Medicare; the effects of the ACA are almost entirely on nongroup coverage.

d. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.

e. The change in employment-based coverage is the net result of changes in offers of health insurance from employers and enrollment by workers and their families. For example, in 2019, an estimated 11 million people who would have had an offer of employment-based coverage under prior law will lose their offer under current law, and another 3 million people will have an offer of employment-based coverage but will enroll in health insurance from another source instead. These flows out of employment-based coverage will be partially offset by an estimated 9 million people who will newly enroll in employment-based coverage under the ACA.

f. Workers who would have to pay more than a specified share of their income (9.5 percent in 2014) for employment-based coverage could receive subsidies via an exchange.

**TABLE 3.**  
**March 2012 Estimate of the Budgetary Effects of the Insurance Coverage Provisions Contained in the Affordable Care Act**

| <b>EFFECTS ON THE FEDERAL DEFICIT<sup>a,b</sup></b>     | 2012     | 2013      | 2014      | 2015       | 2016       | 2017       | 2018       | 2019       | 2020       | 2021       | 2022       | 11-Year Total,<br>2012-2022 |
|---|----------|-----------|-----------|------------|------------|------------|------------|------------|------------|------------|------------|-----------------------------|
| (Billions of dollars, by fiscal year)                   |          |           |           |            |            |            |            |            |            |            |            |                             |
| Medicaid and CHIP Outlays <sup>c</sup>                  | -1       | 1         | 48        | 81         | 98         | 103        | 107        | 113        | 118        | 127        | 136        | 931                         |
| Exchange Subsidies and Related Spending <sup>d,e</sup>  | 2        | 4         | 16        | 46         | 74         | 92         | 102        | 109        | 114        | 121        | 127        | 808                         |
| Small Employer Tax Credits <sup>f</sup>                 | <u>1</u> | <u>2</u>  | <u>3</u>  | <u>4</u>   | <u>2</u>   | <u>1</u>   | <u>2</u>   | <u>2</u>   | <u>2</u>   | <u>2</u>   | <u>2</u>   | <u>23</u>                   |
| Gross Cost of Coverage Provisions                       | 3        | 6         | 66        | 130        | 175        | 197        | 210        | 224        | 234        | 250        | 265        | 1,762                       |
| Penalty Payments by Uninsured Individuals               | 0        | 0         | 0         | -3         | -6         | -7         | -7         | -7         | -8         | -8         | -9         | -54                         |
| Penalty Payments by Employers <sup>f</sup>              | 0        | 0         | -4        | -9         | -10        | -12        | -13        | -15        | -16        | -16        | -17        | -113                        |
| Excise Tax on High-Premium Insurance Plans <sup>f</sup> | 0        | 0         | 0         | 0          | 0          | 0          | -11        | -18        | -22        | -27        | -32        | -111                        |
| Other Effects on Tax Revenues and Outlays <sup>g</sup>  | <u>0</u> | <u>-1</u> | <u>-4</u> | <u>-8</u>  | <u>-16</u> | <u>-24</u> | <u>-30</u> | <u>-35</u> | <u>-38</u> | <u>-37</u> | <u>-38</u> | <u>-231</u>                 |
| <b>NET COST OF COVERAGE PROVISIONS</b>                  | <b>3</b> | <b>5</b>  | <b>58</b> | <b>110</b> | <b>143</b> | <b>154</b> | <b>150</b> | <b>149</b> | <b>151</b> | <b>161</b> | <b>169</b> | <b>1,252</b>                |

Sources: Congressional Budget Office and the staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program

a. Does not include federal administrative costs that are subject to appropriation.

b. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

c. Under current law, states have the flexibility to make programmatic and other budgetary changes to Medicaid and CHIP. CBO estimates that state spending on Medicaid and CHIP in the 2012-2022 period would increase by about \$73 billion as a result of the coverage provisions.

d. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.

e. Figures may not equal the amounts shown in the table entitled "Health Insurance Exchanges: CBO's March 2012 Baseline" (posted on CBO's Web site) because different related items are included in the two tables.

f. The effects on the deficit of this provision include the associated effects on tax revenues of changes in taxable compensation.

g. The effects are almost entirely on tax revenues. CBO estimates that outlays for Social Security benefits would increase by about \$7 billion over the 2012-2022 period, and that the coverage provisions would have negligible effects on outlays for other federal programs.

TABLE 4.

## Changes in the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance with Varying Assumptions About Employers' Responses

|  | March 2012   |              |              |              |              | Change Compared with Baseline |            |             |             |
|--|--------------|--------------|--------------|--------------|--------------|-------------------------------|------------|-------------|-------------|
|  | Baseline     | Scenario 1   | Scenario 2   | Scenario 3   | Scenario 4   | Scenario 1                    | Scenario 2 | Scenario 3  | Scenario 4  |
| <b>CHANGE IN COVERAGE IN 2019, RELATIVE TO PRIOR LAW</b>               |              |              |              |              |              |                               |            |             |             |
| (Millions of nonelderly people, by calendar year)                      |              |              |              |              |              |                               |            |             |             |
| Medicaid and CHIP  | 16           | 18           | 15           | 18           | 17           | 2                             | -1         | 2           | 1           |
| Employer <sup>a</sup>  | -5           | -12          | 3            | -20          | -10          | -7                            | 8          | -14         | -5          |
| Nongroup and Other <sup>b</sup>  | -3           | -2           | -4           | -1           | -3           | *                             | -1         | 1           | *           |
| Exchanges  | 23           | 27           | 18           | 31           | 26           | 4                             | -4         | 9           | 3           |
| Uninsured <sup>c</sup>   | -31          | -30          | -33          | -29          | -30          | 1                             | -2         | 2           | 1           |
| <b>11-YEAR EFFECTS ON THE FEDERAL DEFICIT, 2012-2022<sup>d,e</sup></b> |              |              |              |              |              |                               |            |             |             |
| (Billions of dollars, by fiscal year)                                  |              |              |              |              |              |                               |            |             |             |
| Medicaid and CHIP Outlays  | 931          | 984          | 887          | 996          | 958          | 53                            | -43        | 65          | 27          |
| Exchange Subsidies and Related Spending <sup>†</sup>                   | 808          | 973          | 628          | 1,118        | 954          | 165                           | -179       | 310         | 146         |
| Small Employer Tax Credits <sup>g</sup>                                | <u>23</u>    | <u>21</u>    | <u>25</u>    | <u>20</u>    | <u>22</u>    | <u>-2</u>                     | <u>2</u>   | <u>-3</u>   | <u>-1</u>   |
| Gross Cost of Coverage Provisions                                      | 1,762        | 1,978        | 1,541        | 2,134        | 1,934        | 216                           | -221       | 372         | 172         |
| Penalty Payments by Uninsured Individuals                              | -54          | -59          | -49          | -63          | -56          | -5                            | 5          | -9          | -1          |
| Penalty Payments by Employers <sup>g</sup>                             | -113         | -130         | -88          | -158         | -131         | -17                           | 25         | -45         | -18         |
| Excise Tax on High-Premium Insurance Plans <sup>g</sup>                | -111         | -108         | -121         | -93          | -110         | 3                             | -10        | 19          | 1           |
| Other Effects on Tax Revenues and Outlays <sup>h</sup>                 | <u>-231</u>  | <u>-384</u>  | <u>-112</u>  | <u>-582</u>  | <u>-349</u>  | <u>-153</u>                   | <u>119</u> | <u>-351</u> | <u>-118</u> |
| <b>NET COST OF COVERAGE PROVISIONS</b>                                 | <b>1,252</b> | <b>1,297</b> | <b>1,170</b> | <b>1,239</b> | <b>1,289</b> | <b>45</b>                     | <b>-82</b> | <b>-13</b>  | <b>36</b>   |

Sources: Congressional Budget Office and staff of the Joint Committee on Taxation.

Notes: The Affordable Care Act is comprised of the Patient Protection and Affordable Care Act (P.L. 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

The assumptions for the scenarios are as follows:

Scenario 1: Elasticities doubled for all firms, doubled again for medium-sized and large firms by proportion of workers with income below 250 percent of the poverty level; additional demand from individual mandate reduced by 90 percent relative to baseline assumptions.

Scenario 2: Elasticities halved for all firms, halved again for medium-sized and large firms by proportion of workers with income below 250 percent of the poverty level; additional demand from individual mandate increased by 90 percent relative to baseline assumptions.

Scenario 3: Elasticities for large and medium-sized firms increased to be twice as sensitive as that for small firms in the baseline, elasticities for small firms multiplied by four; and additional demand from individual mandate reduced by 90 percent relative to baseline assumptions.

Scenario 4: Effects on workers with income equal to 250 percent or more of the federal poverty level are the same as in the baseline, and 20 percent of workers with income below 250 percent of the poverty level lose employment-based coverage.

Numbers may not add up to totals because of rounding.

CHIP = Children's Health Insurance Program; \* = less than 0.5 million.

- a. The change in employment-based coverage is the net result of increases in and losses of offers of health insurance from employers and changes in enrollment by workers and their families.
  - b. Other includes Medicare; the effects of the Affordable Care Act are almost entirely on nongroup coverage.
  - c. The count of uninsured people includes unauthorized immigrants as well as people who are eligible for, but not enrolled in, Medicaid.
  - d. Does not include federal administrative costs that are subject to appropriation.
  - e. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.
  - f. Includes spending for high-risk pools, premium review activities, loans to co-op plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance.
  - g. The effects on the deficit of this provision include the associated effects on tax revenues of changes in taxable compensation.
  - h. The effects are almost entirely on tax revenues.
-