

# Health Care Spending Under Reform: Less Uncompensated Care and Lower Costs to Small Employers

## Timely Analysis of Immediate Health Policy Issues

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### Summary

The impact on spending by government and employers has been a major issue in the current health reform debate. In this brief, we estimate the cost and coverage implications of the key provisions of the bill passed by the House of Representatives in November 2009.

Currently, the medical needs of uninsured people put significant strain on the health care system because, even without insurance coverage, they receive billions of dollars worth of “uncompensated” care—medical care that is either freely donated by providers or results in an unpaid bill. Under the House reform bill, we estimate that 34 million fewer people would be uninsured. The cost of uncompensated care provided to the uninsured in a single year would decrease from \$61 billion to \$25 billion. Assuming that about three-quarters of uncompensated care is financed by federal, state and local governments (through Medicare and Medicaid Disproportionate Share Hospital payments and other provisions), we estimate that the \$89 billion increase in government costs in a single year (due to the expansion of Medicaid and subsidies to employers and individuals) could be significantly offset, by perhaps as much as \$27 billion due to decreased spending on uncompensated care.

We estimate that the change in employer’s net costs under the House reform bill would be relatively modest—an increase of just 2.9 percent over the current system. Moreover, spending differs by firm size, with higher

spending among larger firms and lower spending among smaller firms. The increase in costs for larger firms primarily reflects increased enrollment in existing employer coverage that will occur because of the individual mandate. Among small employers, we estimate that net costs would *decrease* due to a combination of factors, including employer subsidies, the introduction of health insurance exchanges as a more efficient vehicle for small group coverage, the expansion of Medicaid coverage to some low-income employees, and exemptions from penalties for not offering health insurance coverage. Thus, the House bill would reduce the disadvantages that small firms currently face in providing health insurance to their employees, a key objective of reform.

The Senate bill passed in December 2009 has many similarities to the House bill. However employers who do not offer coverage would be subject to lower assessments, and the expansion of Medicaid and premium and cost-sharing subsidies for lower income exchange enrollees are both lower compared to the House bill. On net, the costs of large and small employers and of government would be lower under the Senate bill, while costs for lower income families would be higher due to less coverage and lower subsidies. And while the Senate bill appears to allow for greater reductions in DSH allotments, more uninsured are likely to remain compared to the House bill, which could mean a greater burden of uncompensated care.

### Introduction

During the debate over health care reform, the cost of health insurance for smaller employers has been a particular concern, since they are currently at a significant disadvantage in purchasing coverage for employees compared to larger firms.<sup>1</sup> Compared to larger firms, smaller firms face higher administrative

loads on small-group insurance products, have a much greater variance in health insurance premiums, and tend to have lower wage workers who benefit less, on average, from the exclusion of employer-sponsored insurance premiums from taxable wages. As a result, smaller employers are currently much less likely to purchase insurance

on behalf of their employees, and their employees are more likely to be uninsured. A key objective of the House bill is to reduce the disadvantages that small employers currently face in providing health insurance to their employees.

The United States now spends considerable sums on the medical



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needs of the uninsured. This spending puts significant strain on the health care system because the uninsured receive billions of dollars worth of “uncompensated” care—medical care that is either freely donated by providers or results in an unpaid bill. Hadley et al. (2008) estimated that in 2008 the uninsured received about \$56 billion in uncompensated care during the time they lacked insurance coverage.<sup>2</sup> The government paid the lion’s share of this bill—about \$43 billion—through Medicare and Medicaid Disproportionate Share Hospital (DSH) payments, graduate medical education payments, various other federal programs, and state and local tax appropriations. To the extent that uninsured people gain insurance coverage under reform, these resources could be redirected, for example, towards offsetting government costs.

In this brief, we compare the distribution of health care spending in the current system to spending under reform, in particular looking at how spending would change for employers of different sizes, government, families, and uncompensated care. We focus this analysis on the bill passed by the House of Representatives on November 7, 2009, using a microsimulation model to estimate cost and coverage implications of the key provisions of the Affordable Health Care for America Act (H.R. 3962).<sup>3</sup> Results suggest that reform would lead to lower costs for small firms while expanding coverage among employees and their dependents. In addition, we find that savings from decreases in uncompensated care under reform could provide significant spending offsets for federal and state governments. In the discussion section, we suggest how the results could differ under the proposed Senate bill.

## Methods

To evaluate how health spending would shift across sectors under health reform, we use the Urban Institute’s Health Insurance Policy Simulation Model (HIPSM).<sup>4</sup> HIPSM simulates the

decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private costs, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specified reforms.<sup>5</sup>

The reforms are modeled as if the policy had been fully implemented in 2009. With some simplifications, the model captures the basic elements of the comprehensive reforms specified in the House bill related to the coverage choices of nonelderly Americans. These elements include the following:

- A Medicaid expansion of eligibility to all those with incomes up to 150 percent of the federal poverty level (FPL).<sup>6</sup>
- An individual mandate with a penalty for remaining uninsured, with exemptions for individuals and families with incomes below the tax filing threshold and for financial hardship.<sup>7</sup>
- A requirement for employers with annual payrolls of more than \$750,000 to offer coverage or pay an assessment equal to 8 percent of wages. The assessment for those not offering coverage phases out for firms with lower payrolls; those with annual payrolls of less than \$500,000 would be exempt.<sup>8</sup>
- A new health insurance exchange (“the exchange”) offering plans constructed to meet actuarial value standards of 70 percent.<sup>9</sup> Exchange plan premiums would be age rated using 2:1 age bands, meaning the oldest purchasers (64 year olds) could be charged premiums up to two times as high as the youngest adult purchasers.<sup>10</sup> Exchange-based insurance coverage would be available to individuals and families purchasing nongroup coverage independent of an employer and to small employers.<sup>11</sup>

- Refundable premium tax credits (“premium subsidies”) available to eligible families purchasing insurance through the exchange. The premium subsidies would be provided on a sliding scale basis. These subsidies would limit the maximum percentage of income that a family would have to spend on its health insurance premium to 1.5 percent of income for those at 133 percent of the FPL, phasing up to 12 percent of income for those at 400 percent of the FPL.<sup>12</sup>
- Cost-sharing subsidies available to eligible families purchasing insurance through the exchange. Cost-sharing subsidies would decrease household out-of-pocket medical costs by effectively increasing the actuarial value of the basic exchange plan. The subsidy would decrease as income increases, and no cost-sharing subsidies would be available to those above 350 percent of the FPL.<sup>13</sup>
- All health plans offered in the exchange would be required to set out-of-pocket maximums no higher than \$5,000/individual and \$10,000/family to satisfy the coverage requirement.<sup>14</sup>
- Employees of firms that offer coverage would be ineligible for subsidized coverage in the exchange unless the employee’s share of the employer-based coverage premium exceeded 12 percent of income.
- A small employer tax credit (“employer subsidies”) for firms that offer health insurance and have 25 or fewer employees with average wages of less than \$40,000. The tax credit would be available for up to 2 years, and would cover up to 50 percent of the employer’s share of the premium for the lowest wage employees in the smallest firms. The credit phases out for higher-wage employees and larger firms.<sup>15</sup>

We assume that under full implementation of reform, state eligibility for public insurance would be maintained at current Medicaid and CHIP eligibility levels. If states scale back eligibility for public insurance,

overall coverage under reform could be substantially lower, which could change the distribution of health care spending across sectors. We account for DSH payments as a component of uncompensated care spending, rather than in a separate government cost line, because DSH payments help fund the cost of uncompensated care provided by hospitals. Budgeted reductions in DSH payments under reform are reflected as reduced uncompensated care spending. Except for individual and employer assessments related to coverage requirements, financing provisions of the House bill are beyond the scope of this analysis.<sup>16</sup> We make several additional simplifications that we believe are not likely to substantially affect our overall findings.<sup>17</sup>

## Results

Table 1 shows the change in the distribution of health insurance coverage that would result from the House bill. We estimate that the number of uninsured would fall from 49.1

million to 15.1 million—a decrease of 12.7 percentage points or 69.3 percent. The main source of coverage for the nonelderly population would continue to be through employer-sponsored plans. More than half (56.5 percent) of the nonelderly population, 151 million people, currently have health insurance coverage through employer-sponsored plans. Including employer-sponsored coverage through the exchange, this figure would increase on net by 4.8 million people to 155.8 million (58.3 percent of the nonelderly population).

The expansion in coverage among small firm employees is significant—the 14.4 million enrolling in small firm coverage through the exchange would more than offset decreases in traditional (non-exchange) employer coverage.<sup>18</sup> Medicaid/CHIP coverage would increase from 42.9 million to 65.1 million people, reflecting the expansion of Medicaid to 150 percent of the FPL—a significant expansion in eligibility for many states. Many with nongroup coverage or who were uninsured at baseline would

switch to coverage in the nongroup exchange, which would cover 22.7 million people.

Table 2 presents baseline nonelderly spending and changes in spending for government, employers by size, families by income, and uncompensated care. Health system spending for the nonelderly would increase by 8.0 percent, or \$83.2 billion, under the House bill if fully implemented in 2009. Although this analysis focuses on the nonelderly, it is important to note that the net increase in health care spending will be far less when the elderly are included, since spending on the elderly would decline relative to baseline. For example, estimates from the Centers for Medicare & Medicaid Services (CMS) predict that overall national health expenditures (NHE) under the House bill would increase by only about 0.8 percent over the ten-year period 2010-2019, reflecting the net impact of coverage expansions and savings provisions in Medicare and Medicaid. This translates into a modest increase

**Table 1. Health Insurance Coverage Distribution of Nonelderly in Baseline and Reform**

Coverage	Baseline		Affordable Health Care for America Act (H.R. 3962)		Difference Relative to Baseline	
	Millions	%	Millions	%	Millions	% Point Difference*
Employer (Excluding Exchange)	151.0	56.5%	141.4	52.9%	-9.6	-3.6%
Employer Exchange	0.0	0.0%	14.4	5.4%	14.4	5.4%
Nongroup (Excluding Exchange)	15.7	5.9%	0.0	0.0%	-15.7	-5.9%
Nongroup Exchange	0.0	0.0%	22.7	8.5%	22.7	8.5%
Medicaid/CHIP	42.9	16.1%	65.1	24.4%	22.2	8.3%
Other (including Medicare)	8.4	3.2%	8.4	3.2%	0.0	0.0%
Uninsured	49.1	18.4%	15.1	5.6%	-34.0	-12.7%

\*Percentage point difference in coverage rate compared to baseline.

Note: Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

Source: Urban Institute analysis, HIPS 2009.

**Table 2. Health Care Spending of Government, Uncompensated Care, Employers, and Families for Nonelderly in Baseline and Reform**

	Baseline	Affordable Health Care for America Act (H.R. 3962)	Difference Relative to Baseline	
	Billions	Billions	Billions	%
<b>Total Government Spending (Federal + State)</b>				
Medicaid/CHIP	\$246.8	\$308.9	\$62.0	25.1%
Exchange Cost-sharing Subsidies	\$0.0	\$6.4	\$6.4	—
Exchange Premium Subsidies	\$0.0	\$25.5	\$25.5	—
Employer Subsidies (<25 Employees)	\$0.0	\$6.7	\$6.7	—
Individual Mandate Penalties	\$0.0	\$4.0	\$4.0	—
Employer Assessments	\$0.0	\$7.3	\$7.3	—
Net Government Spending	\$246.8	\$336.2	\$89.4	36.2%
<b>Uncompensated Care Spending</b>				
	\$61.1	\$25.2	-\$35.9	-58.7%
<b>Employer Spending by Firm Size*</b>				
<50 Employees	\$84.4	\$77.4	-\$6.9	-8.2%
50–499 Employees	\$90.0	\$97.8	\$7.8	8.7%
>500 Employees	\$238.2	\$249.2	\$11.0	4.6%
Net Employer Spending	\$412.6	\$424.4	\$11.8	2.9%
<b>Individual and Family Spending by Income as a % of the FPL**</b>				
<150% FPL	\$32.0	\$16.1	-\$15.9	-49.7%
150–199% FPL	\$13.8	\$14.5	\$0.7	4.9%
200–399% FPL	\$81.8	\$95.2	\$13.4	16.4%
>= 400% FPL	\$187.4	\$207.1	\$19.7	10.5%
Net Individual and Family Spending	\$315.0	\$332.9	\$17.9	5.7%
<b>Total Nonelderly Health Care Spending</b>	<b>\$1035.5</b>	<b>\$1118.7</b>	<b>\$83.2</b>	<b>8.0%</b>

\*Employer spending includes premium contributions and employer assessments, less employer subsidies.

\*\*Individual and family spending includes premiums plus out-of-pocket health care spending, less premium and cost-sharing subsidies, or individual mandate penalties. For an individual in 2009, 150% of the FPL is \$16,245, 200% of the FPL is \$21,660, and 400% of the FPL is \$43,320. For a family of four in 2009, 150% of the FPL is \$33,075, 200% of the FPL is \$44,100, and 400% of the FPL is \$88,200. <http://aspe.hhs.gov/poverty/09poverty.shtml>.

Note: Table shows spending for nonelderly people only. Reforms are modeled as if they were fully implemented in 2009, and estimates are for that single year.

Source: Urban Institute analysis, HIPSIM 2009.



in NHE as a share of gross domestic product (GDP) of 0.3 percentage points in 2019 under the House bill, compared to baseline projections.<sup>19</sup>

Turning back to the spending of the nonelderly under the House bill, government costs would increase by \$89.4 billion, largely due to increases in Medicaid/CHIP enrollment, which would add \$62.0 billion to government costs. Premium and cost sharing subsidies for families purchasing insurance through the exchange would cost the government \$25.5 billion and \$6.4 billion, respectively. Employer subsidies (for those with fewer than 25 employees) would cost the government an additional \$6.7 billion. These government costs would be offset to a small extent by revenue collected under the individual mandate penalties and employer assessments, which would total \$4.0 billion and \$7.3 billion, respectively. Due to the large estimated decrease in the number of uninsured under reform, the total cost of uncompensated care provided to the uninsured would decrease 58.7 percent, from \$61.1 billion to \$25.2 billion.

Estimated employer spending in the baseline and under reform is also shown in Table 2. Net employer costs associated with contributions to health insurance premiums and assessments would increase by 2.9 percent of employer spending (\$11.8 billion), reflecting the increase in employer-based coverage that would result from the reforms.<sup>20</sup> However, the change in spending relative to baseline would differ by employer size, with higher net costs for larger firms (50 or more employees) but lower net costs for smaller firms (fewer than 50 employees). Compared to spending at the baseline, the net decrease in smaller firm spending of 8.2 percent (-\$6.9 billion) under the House bill reveals the combined effects of the small employer subsidies, broad exemptions from the employer assessment, and lower administrative loads experienced by firms that would switch from non-exchange to exchange based coverage. These effects would more

than outweigh increases in cost due to increased enrollment in employer coverage and any assessments that would be paid by small firms.<sup>21</sup> Even without the small employer subsidy, smaller firms would spend slightly less on health care after reform compared to baseline. Larger firms would experience net increases in costs, due to increased enrollment in employer coverage and the assessments that some firms would face for not offering coverage.

Net individual costs would increase 5.7 percent (\$17.9 billion) under reform, as millions of people who were uninsured at baseline would enroll in private coverage, making contributions through premiums and cost sharing to the cost of their health care. Spending among those with incomes less than 150 percent of the FPL would decrease 49.7 percent (\$15.9 billion) as those who would newly enroll in Medicaid would gain access to comprehensive benefits with only nominal out-of-pocket costs. Income-related subsidies would hold costs relatively steady (an increase of 4.9 percent or \$0.7 billion) for those with incomes between 150 and 199 percent of the FPL, providing new coverage for some while helping others to maintain coverage. However, those with incomes between 200 and 399 percent of the FPL would experience a net increase in cost of 16.4 percent over baseline spending (\$13.4 billion), as many uninsured gain coverage and would have to pay for much of it since subsidies would phase down at these income levels. Large numbers of people in this income range would see reductions in costs.<sup>22</sup> Above 400 percent of the FPL, relative increases in costs would be somewhat lower than those with slightly less income, as most people in this income range have private coverage prior to reform and would continue to have coverage under reform.

## Discussion

Due to the estimated drop in the number of uninsured from 49.1 million to 15.1 million under the House health care reform bill, the total cost of uncompensated care provided to

the uninsured in a single year would decrease from \$61.1 billion to \$25.2 billion. Hadley et al. (2008) suggest that about three-quarters of uncompensated care is financed by federal, state and local governments, through DSH payments and other provisions.<sup>23</sup> If so, the \$89.4 billion estimated annual increase in government costs under the house bill could be significantly offset, by perhaps as much as \$27 billion, due to decreased spending on uncompensated care.

The House bill specifies some reductions in the uncompensated care costs financed through DSH payments.<sup>24</sup> Although some uncompensated care burdens would persist due to those remaining uninsured under reform, the savings due to the reduction in demand for safety net services would leave more in government funds that could be redirected to pay for health care reform. Those who provide care for the uninsured—primarily hospitals that now receive the largest subsidies for uncompensated care—may be reluctant to allow their existing subsidies to decrease, particularly if they are unsure whether an increase in their reimbursements due to the increase in health insurance coverage would be fully compensatory. On the other hand, the estimated \$83.2 billion net increase in total health spending under reform suggests that many providers stand to gain from reform.

The Chamber of Commerce claims that under a health care reform bill, all employers—including small businesses—would be required to provide extensive health benefits or pay a penalty of 8 percent of payroll.<sup>25</sup> However, the House bill has exemptions, tax credits and other provisions that would protect the vast majority of small employers; similar provisions exist in the Senate bill.<sup>26</sup> Contrary to the fears of some in the business community, we estimate that the impact of health reform under the House bill on employer's net costs would be relatively modest—an increase of just 2.9 percent over the current system. Moreover, spending differs by firm size, with higher spending

among larger firms and lower spending among smaller firms. The increase in costs for larger firms primarily reflects increased enrollment in existing employer coverage that will occur because of the individual mandate. For small firms, we estimate that net costs would *decrease* due to a combination of factors, including employer subsidies, the introduction of health insurance exchanges as a more efficient vehicle for small group coverage, the expansion of Medicaid coverage to some low-income employees, and little in the way of applicable penalties for not offering health insurance coverage to their workers.

On December 24, 2009, the Senate passed a health care reform bill with similar provisions to the House bill.<sup>27</sup> However, important differences exist.

Under the Senate bill, employers who do not offer coverage would be subject to lower assessments, and the expansion of Medicaid and premium and cost-sharing subsidies for lower income exchange enrollees are both lower compared to the House bill. On net, the costs of large and small employers and of government would be lower under the Senate bill, while costs for lower income families would be higher due to less coverage and lower subsidies. And while the Senate bill appears to allow for greater reductions in DSH allotments, more uninsured are likely to remain compared to the House bill, which could mean a greater burden of uncompensated care.

In broad terms, both the Senate and House bills would counteract the

projected increase in the number of uninsured Americans by expanding public insurance for the lowest income families, increase affordability and access for millions of employees and others, and decrease financial pressures on the hospitals and clinics that provide care to the uninsured. Policymakers should also consider the budgetary benefits of reduced uncompensated care costs. These funds, if redirected fully, could, for example, be used to increase premium and cost-sharing subsidies in the exchange, further reducing family financial burdens. These are important considerations, since public support for health reform is related to the extent to which employers and families consider the costs they face to be affordable and fair.

## Notes

- 1 See Linda J. Blumberg and Stacey McMorow, "What Would Health Care Reform Mean for Small Employers and Their Workers?" December 16, 2009. The Urban Institute, <http://www.rwjf.org/healthreform/product.jsp?id=53272>. for a review of the disadvantages of small group coverage and an examination of the implications of the proposed reforms in the House and Senate. Their main points are summarized here.
- 2 Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs, Health Affairs Web Exclusive, August 25, 2008. <http://content.healthaffairs.org/cgi/content/abstract/hlthaff.27.5.w399>.
- 3 Affordable Health Care for America Act (H.R. 3962) introduced in the House on October 29, 2009. <http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.3962>.
- 4 A description of the construction of the model can be found in Bowen Garrett, John Holahan, Irene Headen, and Aaron Lucas. "The Coverage and Cost Impacts of Expanding Medicaid." Washington DC: The Kaiser Commission on Medicaid and the Uninsured. May 2009. <http://www.kff.org/medicaid/upload/7901.pdf>.
- 5 HIPSM uses data from several national data sets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File, and the Statistics of US Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount. Behavioral modules in HIPSM represent individual and family demand for health insurance coverage through a utility-based approach in which each individual is assigned a utility value that measures the relative desirability of each health insurance option. These utilities then shape decisions when reform options are introduced. The responsiveness of health insurance decisions to changes in health insurance options and premiums are calibrated in HIPSM to findings in the empirical economics literature.
- 6 The House bill would repeal the Children's Health Insurance Program (CHIP). Children with incomes up to 150% of the FPL and those formerly covered under CHIP would be transitioned to Medicaid, except for those who were covered under a "separate" state CHIP program. Under the bill, these children would be enrolled in the new health insurance exchange. For this analysis, we assume that children eligible for Medicaid or CHIP before reform would be eligible for enrollment in Medicaid after reform. See the caveat regarding this assumption in the last paragraph of the methods section. Note that the Senate bill requires states to maintain current eligibility levels for children, but not for adults.
- 7 In the House bill, the authority to establish a hardship exemption from this penalty is left to the discretion of the Secretary of Health and Human Services or the exchange commissioner. For the purpose of this analysis, we assume an exemption would be authorized if the lowest cost health insurance premium exceeds 12 percent of an individual's income. A lower exemption (8 percent) is allowed in the Senate bill and in previous Senate proposals (10 percent, in the earlier Senate Finance Committee bill). A 12 percent exemption would impose a stronger individual mandate in the House Bill, and would reflect a notion of "affordability" that is consistent with House bill's premium subsidy schedule: the maximum percentage of income that a subsidized family would have to spend on a health insurance premium in the exchange is 12 percent.
- 8 Firms with annual payrolls of \$670,000 to \$750,000 would pay 6 percent of wages, those with annual payrolls of \$585,000 to \$670,000 would pay 4 percent of wages, those with annual payrolls of \$500,000 to \$585,000 would pay 2 percent of wages.
- 9 Actuarial value reflects the share of average covered benefits paid by the insurer, where the remaining amount is the responsibility of the enrollee. While the House bill would provide enrollees in the health insurance exchange a choice among private plans and a public plan with three different levels of actuarial value, we simulate only one level of actuarial value (70%, not the enhanced exchange packages of 85% and 95% actuarial value) for this analysis and do not model the presence of the public plan. Take-up of these higher actuarial value plans will likely be low, given the experience of health reform in Massachusetts and the fact that the subsidies in H.R. 3962 are based on the 70% plan. Previous HIPSM results with enhanced exchange plans included did not show a substantive change to the results presented here. We do not model the public plan since we do not expect the one outlined in the House bill to result in significant cost savings over the private exchange. For an analysis of the types of components of a public plan approach that have cost saving potential, see John Holahan and Linda J. Blumberg. "Is the Public Plan Option a Necessary Part of Health Reform?" Washington DC: The Urban Institute. June 2009. [http://www.urban.org/health\\_policy/url.cfm?ID=411915](http://www.urban.org/health_policy/url.cfm?ID=411915).
- 10 Exchange plans would be prohibited from excluding enrollment or setting premiums based on health status or claims experience. For an analysis of the effects of different age rating bands, see Linda J. Blumberg, Matthew Buettgens, and Bowen Garrett, "Age Rating under Comprehensive Health Care Reform," Washington DC: The Urban Institute. October 2009. <http://www.urban.org/url.cfm?ID=411970>
- 11 Under the House bill, eligibility for the exchange is phased-in for small employers, with the smallest gaining eligibility earlier. The bill allows the exchange to be open to employers larger than 100 employees in 2015 at the discretion of the Commissioner of the Health Insurance Exchange.

For the purposes of this analysis, we assume that firms with 100 or fewer employees are eligible to offer coverage through the exchange. Those enrolling in nongroup coverage through the exchange would be pooled with those enrolling in employer-sponsored coverage through the exchange.

- 12 The bill would make those between 133 and 150 percent of the FPL eligible for Medicaid or subsidies through the exchange. Individuals and families in this income range could choose their preferred coverage option.
- 13 The cost-sharing subsidies would effectively increase the actuarial value of a plan from 70 percent in the basic exchange plan to 97 percent for those with incomes between 133 and 150 percent of the FPL, 93 percent for those with incomes between 150 and 200 percent of the FPL, 85 percent for those with incomes between 200 and 250 percent of the FPL, 78 percent for those with incomes between 250 and 300 percent of the FPL, and to 72 percent for those with incomes between 300 and 350 percent of the FPL.
- 14 Subsidized individuals receiving out-of-pocket subsidies would have even lower out-of-pocket maximums in the exchange as follows: \$500/individual and \$1,000/family for those with incomes from 133 to 150 percent of the FPL; \$1,000/individual and \$2,000/family for those with incomes 150 to 200 percent of the FPL; \$2,000/individual and \$4,000/family for those with incomes from 200 to 250 percent of the FPL; \$4,000/individual and \$8,000/family for those with incomes from 250 to 300 percent of the FPL; \$4,500/individual and \$9,000/family for those with incomes from 300 to 350 percent of the FPL. In addition, the House bill specifies that employers who offer coverage prior to the first year of the exchange would be required to adjust their plan benefits to comply with these out-of-pocket maximums in order to satisfy the coverage requirement. While small group coverage typically has larger annual out-of-pocket maximums than large group coverage, Bertko et al. (2009) estimate that in 2008, only about 2.3 percent of individuals in small group coverage were in plans where the typical maximum annual out-of-pocket amounts exceeded \$5,000. To the extent that these reported maximum annual amounts include all out-of-pocket spending (i.e. all copayments, coinsurance, and deductibles), the maximum annual cost-sharing defined in the House bill is not likely to affect the majority of employer sponsored health insurance plans, even those in the small group market. In our analyses presented here, all plans comply with the coverage requirements in the House bill.
- 15 We model this provision in the first two-year period where all qualified small firms would have access to the employer subsidy. However in the long run, fewer small firms would have access to

the subsidy. For example, in the third year after reform some firms would be ineligible, having already received the subsidy for two years. Computing eligibility for the subsidy is complex due to the creation, destruction, and growth of small firms over time. Accounting for these dynamics is beyond the scope of this paper.

- 16 For example, we do not model the income surtax. However, the overall effect of this tax on individuals and business owners is likely to be relatively small; the Urban Institute-Brookings Institution Tax Policy Center estimates that in the first year of implementation, the proposed income surtax would apply to 0.2 percent of all tax units, including 0.9 percent of tax units with business income. See <http://www.taxpolicycenter.org/numbers/displayatab.cfm?Docid=2500&DocTypeID=7>.
- 17 For example, we do not model temporary provisions such as the reinsurance program and high-risk insurance pools.
- 18 Underlying this increase in employer-sponsored coverage is an increase in the number of firms offering coverage (including employer-sponsored coverage through the exchange). Firm offer rates among smaller firms (<50 employees) would increase from 42.2 percent to 55.7 percent, while firm offer rates among larger firms (50 or more employees) would increase from 90.5 percent to 98.3 percent (data not shown).
- 19 Foster, Richard S. "Estimated Financial Effects of the "America's Affordable Health Choices Act of 2009" (H.R. 3962), as Passed by the House on November 7, 2009." CMS, November, 2009. [http://www.cms.hhs.gov/ActuarialStudies/Downloads/HR3962\\_2009-11-13.pdf](http://www.cms.hhs.gov/ActuarialStudies/Downloads/HR3962_2009-11-13.pdf). In addition, note that CMS estimates that overall increases in NHE and NHE as a share of GDP would be slightly lower under the Senate bill. See Richard S. Foster. "Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Passed by the Senate on December 24, 2009." CMS, January 2010. [http://www.cms.hhs.gov/ActuarialStudies/Downloads/S\\_PPACA\\_2010-01-08.pdf](http://www.cms.hhs.gov/ActuarialStudies/Downloads/S_PPACA_2010-01-08.pdf)
- 20 If, as economists predict, employees accept lower wages in return for compensation in the form of health care benefits, some of the increases in employer costs under reform would be offset. In turn, wage decreases would decrease income and payroll tax revenue. The impact of this "wage passback" is included in HIPSM's estimates of family income, where it tends to increase eligibility for Medicaid and exchange subsidies.
- 21 Due to exemptions from assessments in the House bill, only 1.5 percent of smaller firm employees are in firms that pay an assessment (data not shown.)
- 22 For analysis of how the levels of premium and cost-sharing subsidies in the exchange determine

how affordable insurance coverage would be for families under reform proposed in the House and Senate, see Bowen Garrett, Lisa Clemans-Cope, and Matthew Buettgens, "Premium and Cost-Sharing Subsidies under Health Reform: Implications for Coverage, Costs, and Affordability," December 2009. The Urban Institute. [http://www.urban.org/UploadedPDF/411992\\_health\\_reform.pdf](http://www.urban.org/UploadedPDF/411992_health_reform.pdf).

- 23 Hadley et al. (2008).
- 24 For example, decreases in Medicaid DSH allocations of \$1.5 billion in 2017, \$2.5 billion in 2018, and \$6 billion in 2019. In addition, the House bill gives the Secretary the discretion to reduce Medicare DSH allocations based on reductions in the rate of uninsurance. These reductions in DSH allocations are not included in our estimates of government costs under the House bill.
- 25 Chamber of Commerce of the United States of America, <http://www.uschamber.com/smallbusinessnation.com>, accessed January 14, 2010: "Under the new bill, businesses will be required to provide a government-mandated level of health care coverage - regardless of their ability to pay - or face a penalty of 8% of payroll."
- 26 See Linda J. Blumberg and Stacey McMorrow, "What Would Health Care Reform Mean for Small Employers and Their Workers?" December 16, 2009, The Urban Institute, <http://www.rwjf.org/healthreform/product.jsp?id=53272>. While the Senate bill passed on December 24, 2009 maintains exemptions for most employers with 50 or more employees, the revised bill struck the exemption for construction industry employers with 5 or more fulltime employees (on average during business days in the preceding year) with annual payroll over \$250,000. These small employers would be subject to the employer penalties and requirements in the Senate bill.
- 27 Patient Protection and Affordable Care Act (H.R. 3590), Engrossed Amendment as Agreed to by the Senate, December 24, 2009. [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_bills&docid=f:h3590eas.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590eas.txt.pdf)
- 28 Small employers who currently offer coverage to employees with higher than average costs may also fear the proposed excise tax on high-cost health plans in the Senate. However, these concerns are overstated, since small employers would gain the option of offering subsidized coverage within the broad risk pools of the health insurance exchange, an advantage for high cost firms. In addition, those with premiums in excess of an excise tax threshold that wish to continue to provide coverage to their workers outside of the exchange could restructure benefits to avoid the tax (e.g. lowering premiums by increasing cost-sharing).

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## **About the Authors and Acknowledgements**

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