# How Will the Patient Protection and Affordable Care Act Affect Small, Medium, and Large Businesses?

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The Patient Protection and Affordable Care Act (PPACA) will have different implications for employers, depending upon their size and whether they currently offer health insurance coverage to their workers. The new law does not impose new requirements on small employers (fewer than 50 workers), but will provide new health insurance alternatives to them through state-based Small Business Health Options Program (SHOP) exchanges. As a result, they will tend to be unaffected or experience savings under reform. Slightly larger employers (50 to 100 workers) may face some new requirements related to their workers' health insurance coverage, but will also have access to SHOP exchange options. Employers with more than 100 workers may face new requirements related to their workers' coverage and will not have access to SHOP exchanges before 2017. While larger firms are unlikely to experience significant changes in the types of coverage they provide, they may face higher costs associated with increased take-up of the policies they offer their workers, due to the new requirement for individuals to obtain health insurance coverage.

*Employers of all sizes may find more options for covering their workers in a post-PPACA world, but their financial obligations will depend on their size.*

## Small Employers (Fewer than 50 Full-Time Workers)

### *Financial Obligations and Assistance*

Small employers have the most to gain under the PPACA employer provisions. The law imposes no financial requirements for small employers to contribute toward their workers' health insurance costs. However, the law does provide some financial assistance (i.e., tax credits) for some small employers to maintain or begin offering coverage to their workers. These tax credits become available in 2010 and will offset a portion of the purchase of health insurance by low-wage employers with 25 or fewer workers. Depending upon the size and average wage of the employer, these tax credits could cover up to 35 percent of the employer's premium contribution, and they will be available to an eligible employer until 2014. Credits of up to 50 percent of the employer's contribution will be available for two consecutive years as of January 1, 2014, for coverage purchased through the exchanges.

While no small employer will be required to provide coverage to their workers, those that do provide coverage must limit waiting periods to no more than 90 days and eliminate lifetime and annual benefit limits.[1] Employers that offer dependent coverage will also be required to offer that coverage to their workers' adult children up to age 26 (with no requirement that the employer contribute to that coverage, as is true today). Pre-existing condition exclusion periods for children will also be prohibited after six months of the enactment of the PPACA. These changes could increase premiums somewhat for some employers and workers purchasing plans today that are not in compliance with these requirements. However, the premium effects are expected to be very small and can be offset, if desired, with modest changes to deductibles or other cost sharing requirements.[2]

Plans sold in the small group market, other than grandfathered plans, will be required to meet essential benefit requirements, be rated consistent with rating limits in the law (i.e., 3:1 age bands[3] and a 1.5:1 rating for those using tobacco[4]), and limit deductibles to $2,000 for single coverage and $4,000 for family coverage (unless other employer contributions offset additional deductible amounts). Annual cost sharing for these plans will also be limited to the current law Health Savings Account limits ($5,959 for single coverage and $11,900 for family coverage in 2010).

Employers of any size that offer health insurance coverage to their workers outside the health insurance exchanges, and for whom the lowest

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cost policy option offered would require a contribution of 8 to 9.8 percent of a worker's income, must provide such workers with a "free-choice voucher." A free-choice voucher is an amount equivalent to what the employer would have contributed to the firm's plan on behalf of such a worker, but which would allow the worker to apply that amount toward the purchase of coverage through a nongroup insurance exchange. Workers using these vouchers are not eligible for premium subsidies in the exchange and no penalties will apply to employers providing them.

### *New Insurance Options*

Small employers currently offering health insurance coverage can continue to provide this coverage to their workers, with their current policies being "grandfathered," exempt from most of the law's regulatory reforms and the new essential benefits definitions.[5] However, once an employer terminates a grandfathered policy, any new coverage purchased through the small group market will be subject to these regulatory reforms and the benefit minimums. Small employers will be able to purchase coverage in the small group market as they do today, but beginning in 2014, all small employers will also have the option of purchasing insurance coverage for their workers through the new SHOP exchanges. At state discretion, a combined small employer and individual exchange could be developed as an alternative to two separate exchanges serving these populations. The insurance exchanges are intended to lower administrative costs of small group and individual coverage, as well as provide a more organized insurance market that promotes competition, implements many consumer protections and market oversight functions, and provides consumer information to assist purchasers in making cost-effective insurance choices.

New regulations in the small group and individual markets will make insurance coverage more inclusive and accessible for all, regardless of health status. Under the broader risk pooling[6] that will occur in these markets as a consequence, coverage will be more affordable for those small groups and individuals with higher health care needs. Those with lower health care needs who purchase in the new markets outside grandfathered plans will share in the costs associated with their less healthy counterparts. This may lead to higher premiums than they would have faced in a pre-reform market, but lower administrative costs will offset some, if not all, of those higher costs. These healthier enrollees will also have the benefit of knowing that affordable coverage will be available to them as they age or incur health issues over time. Grandfathering of existing plans will, to a considerable extent, protect small groups that currently have an advantage in the risk-rated insurance market from the higher rates associated with broader pooling. Plus, because there is no requirement for these employers to offer coverage, those disadvantaged by such changes can choose not to participate.

Because many small firms do not offer health insurance coverage today, reforms to the individual market will help many of their workers, especially such reforms as guaranteed issue of coverage, subsidies for purchasing coverage for those with modest incomes, and federal regulatory minimums (e.g., new limits on rating variations and prohibitions against preexisting-condition exclusion periods, rescissions, lifetime- or annual-benefit limits, and medical underwriting). The availability of accessible and affordable coverage outside the workplace should improve small employers' ability to compete for labor with large employers.

Small group and nongroup health insurance inside and outside the new exchanges will be risk adjusted to ensure one pool of enrollees is not disadvantaged by enrollment of disproportionate numbers of individuals with high medical needs.

## Medium-Size Employers (50 through 100 Workers)

### *Financial Obligations*

While no employer, regardless of size, is required to provide health insurance coverage to their workers under the PPACA, employers of 50 or more workers will be assessed financial penalties if their workers obtain subsidized health insurance coverage through the new health insurance exchanges open to those without employer-based coverage.

If an employer with 50 or more workers does not offer health insurance coverage to its workers and at least one full-time employee receives a subsidy through the exchange, the employer will be assessed $2,000 per full-time employee, excluding the first 30 employees. If an employer does offer insurance to its workers but at least one full-time employee obtains coverage through the exchange with a subsidy, the employer will be assessed $3,000 for each employee getting a subsidy or $2,000 per full-time employee, whichever is less. For such penalties to apply to an offering employer, a worker would have to face a premium contribution requirement under the firm's plan of

more than 9.5 percent of his or her family's income and then choose to purchase coverage through the nongroup exchange.

Employers in all size groups will be required to provide free choice vouchers, if applicable, as described above.

### *New Insurance Options*

Employers with 50 to 100 workers will have the same option as their smaller counterparts to purchase coverage for workers and their dependents through the new health insurance exchanges. They may also choose to purchase new coverage outside the exchange if they prefer, or to not offer coverage at all. The essential benefits delineated in the law, as well as the insurance regulatory reforms on rating and limits on deductibles and out-of-pocket maximums, apply to this portion of the market as well. As is the case with smaller employers, however, they may retain the health insurance policies they provided as of the law's enactment under the "grandfather" provisions, exempting them from most of the new insurance regulations and benefit minimums. Before 2016, states may, at their discretion, choose to define small groups as firms with 50 or fewer workers, delaying the imposition of additional regulations on these employers.

## Large Employers (More than 100 Workers)

Because almost all large employers currently offer health insurance—98 percent of employers with 100 or more workers offered insurance in 2009 according to the Medical Expenditure Panel Survey-Insurance Component[7]—the health care reforms are generally expected to have the least impact among this group. To a great extent, these employers are expected to continue to provide the coverage that they currently do. There are, however, provisions that will affect large employers' coverage and costs.

### *Financial Obligations*

Large employers with at least one full-time employee enrolling in subsidized insurance through the nongroup exchange will face the same penalties outlined for the medium-size employers above.

Employers with 200 or more full-time workers that offer health insurance to their workers will be required to automatically enroll all full-time workers and all previously enrolled workers into a plan each year. Workers will have the opportunity to opt out of the plan if they so choose. This provision for larger workers will tend to increase employment-based insurance coverage and employer contributions toward health insurance. However, employers could decide to decrease their contributions to employee premiums to keep the firm's health insurance spending from changing significantly.

A particular tax provision within the PPACA will have financial implications for some large firms (and perhaps a small number of smaller firms) that offer prescription drug benefits to their retirees. To keep corporations from dropping retiree coverage and having those retirees enroll in the Medicare drug program, the Medicare Modernization Act (MMA) of 2004 provided subsidy payments to corporations equal to 28 percent of their costs for retiree prescription drug benefits. Prior to 2004, 100 percent of payments for retiree health benefits were tax deductible for the firm. After the MMA, firms could deduct their premiums for retiree health benefits, including those paid for by the subsidy; that is, they deducted not only contributions the firm made but the amount the government paid in subsidies. This was an incredibly unusual situation to have legislated—firms were receiving a tax break for payments they did not make.

Corporations, following required accounting practices, recorded these payments and the related tax effects as assets. Under the PPACA, the government subsidies continue, but firms can no longer take a tax deduction for payments the government makes. The Joint Committee on Taxation estimated that this change would increase government revenues by $4.5 billion between 2010 and 2019.[8] Government revenues will increase because the subsidy payments will no longer be deductible. Considerable press attention has been given to the large write-downs by many U.S. corporations (e.g., $1.0 billion by AT&T alone). The large write-downs reflect the fact the corporations must account for the net present value of the loss of the future tax deduction over an infinite timeframe. Thus, much as they had recorded a large tax asset in 2004, they now have to take a large charge in 2013. The true cost for corporations, however, is the $4.5 billion over seven years as estimated by the Joint Committee on Taxation, which is very small compared with corporate tax liabilities.

### *New Insurance Options*

Employers of more than 100 workers will not be eligible to purchase coverage through the new SHOP exchanges prior to 2017. Beginning in 2017, states can, at their discretion, permit large employers to obtain coverage through the exchanges.

Large employers are not subject to many of the insurance regulatory reforms included in the new law. While the prohibitions against preexisting-condition exclusions, rescissions, lifetime and annual benefit limits do apply to large employers, the rating rules, essential benefits minimums, and limits on deductibles, which apply to the small group and nongroup markets, do not. Large employers offering coverage to their workers are required to participate in the free-choice voucher program, however, just as smaller employers are.

## Summary

PPACA will affect employers differently, depending upon their size and whether they currently offer health insurance. Small employers, those with fewer than 50 workers, will face no new requirements but will have new insurance options made available to them through the new health insurance exchanges. These new options have the potential to save money for small businesses that wish to offer insurance to employees.

Medium-size employers, those with 50 to 100 workers, will have access to these new coverage options as well, but may face some financial penalties if their modest income, full-time workers obtain federal subsidies due to a lack of affordable coverage available through the workplace. New coverage sold to small and medium-size groups will be subject to regulations that will make insurance more affordable to groups with higher than average health care needs. Healthier groups will share in these costs more than they do today.

The vast majority of large employers (more than 100 workers) currently offer insurance coverage to their workers and, as a consequence, are the least likely to be significantly affected by health care reform. However, they may experience greater employee participation in their current insurance plans and will face penalties if their full-time workers obtain subsidized coverage through the exchanges.

## Notes

[1] Certain annual limits will be permitted prior to 2014 if they are consistent with guidelines defined in federal regulations. See U.S. Department of Treasury, Department of Labor, Department of Health and Human Services. "Patient Protection and Affordable Care Act: Requirements for Group Health Plans and Health Insurance Issuers under the Patient Protection and Affordable Care Act Relating to Pre-Existing Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections." *Federal Register*, June 28, 2010. http://www.gpo.gov/fdsys/pkg/FR-2010-06-28/pdf/2010-15278.pdf.

[2] Cost-sharing refers to the insured health care expenses paid directly by consumers out-of-pocket (e.g., deductibles, co-payments, co-insurance).

[3] Age bands of 3:1 would require that a premium for a 64-year-old not be more than three times the premium for an 18-year-old for identical coverage.

[4] The 1.5:1 rating for tobacco users indicates that smokers can be charged a premium 50 percent higher than nonsmokers of the same age for identical coverage.

[5] Regulations related to grandfathered plans were issued in U.S. Department of Treasury, Department of Labor, Department of Health and Human Services. "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act." *Federal Register*, June 17, 2010. http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf.

[6] An insurance risk pool is the population over which expected health care expenses are averaged for purposes of setting health insurance premiums. Broader pooling will include a more diverse set of health care risks (i.e., averaging over the sick and the healthy). Narrower pooling will set premiums more differentially as a function of health status (i.e., averaging within healthier populations and separately within sicker populations for purposes of setting premiums that vary with enrollee health).

[7] Author's calculations based upon published data from the Medical Expenditure Panel Survey—Insurance Component. Relevant tables are available at http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia1.pdf and http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2.pdf.

[8] The change will be implemented beginning in 2013, but JCT's estimates of the effect are presented as applying to the 2010-2019 budget window.

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