The Effects of Health Reform on Small Businesses and Their Workers

Timely Analysis of Immediate Health Policy Issues

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Summary

Some critics have raised concerns about the effects of the Patient Protection and Affordable Care Act (ACA) on the health insurance landscape for small firms. Here, we consolidate the results of several Urban Institute studies that address the likely effects of the ACA on small firms. We also present estimates of the impact of the ACA on employer costs, offers and coverage from the Urban Institute's Health Insurance Policy Simulation Model (HIPSM). Historically, small businesses have faced multiple barriers to offering affordable health insurance coverage to their employees. High administrative costs and a limited ability to spread risk contribute to high premiums for small firms. The low wages of many small-firm workers and the costs associated with shopping for a health plan present further challenges for small firms wishing to offer coverage. As a result, small firms have lower offer rates than large firms, their employees are more likely to be uninsured and small firms are at a disadvantage in competing with larger firms for employees.

Several components of the ACA are likely to affect the health insurance options and decisions of small firms. The introduction of health insurance exchanges and reforms to health insurance markets are expected to benefit small firms seeking coverage for their employees. Tax credits to assist in purchasing coverage will be available to the smallest low-wage employers, while larger employers will face new requirements to contribute to the cost of their employees' health insurance coverage. Expanded options outside of employer-sponsored coverage, including a Medicaid expansion, a reformed individual health insurance market and premium subsidies for low-income individuals, are also expected to benefit small-firm employees and their families.

Despite claims to the contrary, we find the following generally positive effects of the ACA on small firms and their workers:

- Employers with fewer than 50 employees are expected to experience substantial savings on health care costs due to the benefits of the health insurance exchanges and subsidies for the smallest firms. These employers face no requirements to contribute to the health care costs of their workers under the ACA;
- Savings on premium contributions are offset by employer responsibility assessments for those employers with 50 to 100 workers, which is expected to result in a very small increase in total costs for this group;
- The smallest firms are expected to experience a significant increase in offer rates under the ACA, while offer rates for those with 25 or more employees are expected to remain stable;
- A small increase in employer-sponsored insurance (ESI) coverage for small-firm workers and their dependents is expected for those in firms with fewer than 50 workers, while ESI coverage for those in larger firms is expected to remain stable;
- Small-firm workers and their families are also expected to reap substantial benefits from the Medicaid expansion, individual health insurance exchanges and premium subsidies to low-income families, resulting in significantly reduced rates of uninsurance for this group under reform.

Introduction

Several components of the Affordable Care Act have the potential to affect the health insurance choices and responsibilities of employers. The implications of the reforms will vary, however, depending upon employer size. Some have raised concerns, in particular, with the effects of the reforms for small firms. Specifically, claims have been made that the ACA will increase health care costs for small firms, which could reduce health insurance offers and coverage for small firm employees.[1] Here we summarize the findings of several Urban Institute analyses related to the impacts of health reform on small businesses.[2] We discuss the challenges small businesses face in the current system, as well as the components of the ACA with the strongest implications for this population. We also present estimates of the impact of the ACA on employer costs, offers and coverage from the Urban Institute's Health Insurance Policy Simulation Model (HIPSM).

Ultimately, we find little evidence that the ACA will negatively affect small firms, and, instead, we find evidence of significant benefits for these employers

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and their workers. The law expands coverage options for small firms while limiting the new requirements imposed on this group. The smallest firms will see a significant increase in offer rates under the ACA, and firms of all sizes will see substantial savings on premium contributions. While the effects of the ACA on employer-sponsored coverage for small-firm workers and their dependents are estimated to be small, these workers and their families are expected to reap significant benefits from the law as a whole. When accounting for the effects of the Medicaid expansion, individual health insurance exchanges and federal subsidies for low- and moderate-income families, small-firm workers and their families are expected to experience large increases in insurance coverage under reform.

Barriers to small-firm health coverage

Historically, small firms have faced unique challenges in providing health insurance to their employees. Health insurance premiums for small firms are considerably higher than insurance premiums for identical coverage faced by their larger counterparts due, in part, to higher administrative costs.[3] The administrative costs to insurers of providing coverage are largely fixed, and thus they lead to higher burdens on small firms, where those costs are spread across fewer enrollees.[4] Premiums for small groups are also higher to account for the increased year-to-year variability in claims.[5] This follows directly from the law of large numbers—the larger the group over which risk is spread, the more stable medical costs are likely to be over time. And, most states allow insurers to adjust small-firm group premiums to reflect the health status of the enrollees as well as other risk factors, including age and industry.[6] With few individuals to absorb the cost of those at risk for high medical expenditures, substantial premium increases can result from the presence of even one high-cost enrollee. Small firms, especially those with a high-risk workforce, therefore face significant barriers to accessing affordable coverage.

Small firms are at an additional disadvantage for providing health insurance coverage due to the lower wages their workers earn, on average.[7] Economic theory suggests, and empirical research has confirmed, that employees effectively pay for their employer-provided health insurance with lower wages than they would have received absent the benefits.[8] The lower wages of small-firm workers make the necessary wage tradeoff for health insurance coverage frequently undesirable. Finally, those small firms that may wish to offer insurance coverage are faced with the additional costs of searching for, comparing, and choosing plans—a time-consuming and, therefore costly, task. Most small firms do not have a dedicated staff for such tasks, making this burden particularly onerous.

High administrative costs and the limited ability to spread risk therefore result in high premiums for small firms, while low wages and the administrative burden of shopping for health plans further reduce the ability of small firms to provide coverage to their workers.

In addition, these challenges may result in labor market inefficiencies. In some cases, a worker may otherwise prefer a position in a small firm, but her demand for health insurance coverage will steer her toward a job in a large firm that provides coverage (or that provides coverage at a lower cost than the small firm). The barriers to small-firm health insurance provision and the limited ability for many workers to obtain affordable coverage outside employment may therefore place small firms at a disadvantage in attracting desired employees.

The multiple challenges small firms face in providing health insurance coverage are evident in the statistics on offer rates shown in Table 1. In 2009, only 33.6 percent of employers with fewer than 10 workers offered health insurance coverage, compared to 99.2 percent of those with 1,000 or more workers, according to the Medical Expenditure Panel Survey—Insurance Component. Offer rates have generally decreased over time, with the rate for all employers falling from 59.3 percent in 2000 to 55.0 percent in 2009. The declines were most dramatic among the smallest employers with those with fewer than 10 employees falling

Table 1. Percent of private sector establishments that offer health insurance, 2000 and 2009, by firm size and wage

	Number of Employees					
	All Sizes	< 10	10–24	25–99	100–999	1000+
All Firms						
2000	59.3	39.6	69.3	84.5	95.0	99.2
2009	55.0	33.6	62.5	81.6	94.3	99.2
Percentage change	**-7.3**	**-15.2**	**-9.8**	**-3.4**	**-0.7**	**0.0**
Firms with 50% or more employees low wage						
2000	42.5	25.4	46.3	73.5	94.2	96.4
2009	41.0	17.9	32.8	59.5	88.7	98.5
Percentage change	**-3.5**	**-29.5**	**-29.2**	**-19.0**	**-5.8**	**2.2**
Firms with less than 50% of employees low wage						
2000	64.7	50.2	83.4	92.4	96.9	99.4
2009	62.2	41.7	76.4	91.4	97.1	99.7
Percentage change	**-3.9**	**-16.9**	**-8.4**	**-1.1**	**0.2**	**0.3**

Source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 2000 and 2009 Medical Expenditure Panel Survey—Insurance Component

by 15 percent, and those with 10 to 24 employees falling by 10 percent. In contrast, there was no measurable change in offer rates among the largest employers.

Low offer rates and declines in offer rates over time are especially pronounced among small firms with low-wage employees.[9] Among employers with fewer than 10 employees, the offer rate for higher-wage employers was 41.7 percent in 2009, compared to 17.9 percent for those with a lower-wage workforce. Declines in offers were also larger among low-wage employers. The offer rate among low-wage employers with fewer than 10 and 10 to 24 employees declined by almost 30 percent between 2000 and 2009, compared to declines of 17 and 8 percent, respectively, for the small firms with higher-wage employees.

The low offer rates by small businesses are further reflected in the health insurance coverage of small-firm workers. Table 2 provides rates of insurance coverage of workers, by firm size, using data from HIPSM. Almost 40 percent of workers in firms with fewer than 10 employees were uninsured in 2010, compared to 13 percent of workers in firms with 100 or more employees. These differences in the rate of being uninsured are largely due to differences in the rates of employer-based coverage, as those in the smallest firms had an employer coverage rate of 44 percent, compared to 78 percent for workers employed in the largest firms.

Table 2. Health insurance coverage of non-elderly workers, 2010, by firm size

	Number of Employees				
	<10	10–24	25–49	50–99	100+
Insurance Status					
Employer-sponsored Insurance	44.0%	53.5%	62.6%	71.1%	78.3%
Individually purchased	9.0%	6.5%	4.9%	3.3%	3.1%
Medicaid	6.5%	5.8%	5.5%	5.1%	3.7%
Other public	1.0%	1.3%	0.7%	1.2%	1.0%
Medicare	0.4%	0.5%	0.3%	0.2%	0.3%
Uninsured	39.2%	32.3%	26.0%	19.1%	13.4%

Source: Urban Institute Analysis, HIPSM 2010

Components of the ACA with implications for small firms

Several components of the ACA are likely to affect the health insurance options and decisions of small businesses and may reduce potential inefficiencies in matching workers to the best jobs for them. Some provisions aim to provide more affordable health insurance options with more stable premiums to small firms through health insurance exchanges, insurance market reforms and tax credits. Other elements of the ACA place new requirements on some employers to contribute to the cost of employees' coverage. Still others expand the health insurance options available outside employer-sponsored coverage.

The primary benefits of health reform for small firms will come from the introduction of the Small Business Health Options Program (SHOP) exchanges and reforms to health insurance markets. All plans offered in the exchanges will have to conform to new rating restrictions established in the ACA; the same is true for new policies issued outside the exchanges in the small-group and individually purchased markets. Premiums will only be allowed to vary in these markets based on age (with premiums charged for those age 64 capped at 3 times a premium for an 18-year-old for identical coverage) and tobacco use (with users charged no more than 1.5 times the premium for non-users), geography and policy type (e.g., single, family). No premium rating based on health status, claims history, industry, group size, duration of coverage, etc., will be permitted as of January 1, 2014.

Plans for small businesses and individuals will be required to provide essential health benefits including, but not limited to, ambulatory and hospital care, emergency services, prescription drugs, mental health services and maternity benefits, with further details to be provided in forthcoming regulations. Plans will also have to fit into actuarial value tiers (platinum, gold, silver and bronze plans at 90, 80, 70 and 60 percent actuarial value, respectively) and maximum cost-sharing limits will apply to all plans. These requirements will increase the adequacy of coverage offerings in these markets and will make cost comparisons across options more feasible than in many of today's markets. All plans in all markets will also be required to report the proportion of premium dollars spent on clinical services, quality and other costs. Rebates to enrollees will be provided when the proportion spent on clinical services and quality is below 85 percent for plans in the large-group market, and below 80 percent for plans in the small-group and individual markets. Collectively, the health insurance exchanges and market reforms are intended to reduce administrative costs, improve risk-sharing and promote transparency and competition to improve the accessibility and affordability of health insurance. Starting in 2014, all firms with fewer than 100 employees will be eligible to purchase coverage in the newly established SHOP exchanges and the reformed small group market outside the exchanges.[10]

As an additional benefit of the ACA, certain small businesses are eligible for tax credits to assist them in purchasing health insurance. The credits became

available in 2010, and only the smallest and lowest wage employers are eligible.[11] Employers can receive a credit for up to 35 percent of their premium contribution until 2014, depending on their size and average wages. In 2014, these employers will be eligible, for two consecutive years, for credits of up to 50 percent of their premium contribution to purchase coverage in the exchange. These credits aim to further improve access to affordable coverage for those employers least likely to offer coverage without assistance.

While the SHOP exchanges, market reforms and tax credits substantially expand the options available to small businesses seeking health insurance coverage, the ACA also establishes new requirements for some employers to contribute to the cost of their employees' health insurance coverage. The requirements are intended to encourage employers to provide affordable coverage and thereby limit the cost of federal subsidies to assist individuals in purchasing insurance coverage independently. Small businesses with fewer than 50 workers are exempt from the new requirements, but those with 50 or more employees will need to comply.

Employers with 50 or more workers that do not offer insurance coverage will be subject to an assessment if at least one of their full-time employees (FTEs) receives a federal subsidy in the exchange. In 2014, the assessment will be $2,000 per employee, excluding the first 30 employees. The amount will increase in proportion to the growth in the average per capita premiums for health insurance in the United States. For employers of 50 or more workers that do offer coverage but have at least one FTE receive a subsidy in the exchange, the penalty will be the lesser of $3,000 per federally subsidized employee or $2,000 per FTE, excluding the first 30 employees. For an employee with an employer offer to receive a subsidy in the exchange, the employee's contribution to the lowest-cost single ESI plan offered by the employer must be more than 9.5 percent of family income or the actuarial value of the plan must be below 60 percent.[12]

In addition to the elements of the law noted thus far that are directly aimed at employers, the establishment of individual insurance exchanges, the availability of federal subsidies for low- to moderate-income individuals, and the Medicaid expansion will also have impacts on small firms and their workers. By expanding coverage options for individuals, workers can more readily work at smaller firms, even if those businesses are not able to provide health insurance. The lack of accessible, affordable coverage options for individuals without access to employer-sponsored coverage is a notable shortcoming of the current health care system. This has contributed to challenges for small firms in competing for labor with their larger counterparts. With limited options outside employer-sponsored insurance, workers may choose large-firm jobs with health insurance over otherwise preferable small-firm employment opportunities. Thus, the availability of a more accessible and affordable individual insurance market offering more adequate insurance options, federal subsidies to purchase in that market for those with modest incomes, and Medicaid coverage available to the lowest-income workers[13] should improve the ability of small firms to compete for labor even if they do not choose to offer coverage under reform.

Expected impacts of the ACA on small-firm costs, offers and coverage

Ultimately, the effects of the various components of the ACA on premiums and offer rates for small firms will vary based on the size and risk profile of individual firms, as well as on their pre-reform insurance status and state small-group market regulations. Beginning in 2014, non-grandfathered plans will be subject to new benefit and rating regulations in the small group and individual markets. The effects on premiums faced by individual small firms will depend, in part, on their state's rating rules pre-reform. In New York, for instance, the current small-group and individual markets are subject to pure community rating and guaranteed issue requirements, but no requirement to obtain coverage. These regulations have generally resulted in high premiums as a result of low-risk individuals, and to some extent groups, declining to enroll in coverage. Some savings could result for small firms if reduced administrative costs, the requirement for individuals to obtain coverage, and other benefits of the exchange result in lower costs and stronger participation in this market.

Unlike New York, however, most states currently permit substantial variation in premiums that reflect individual or group health status. The new regulations limit this practice and aim to spread risk more broadly. This should result in more affordable premiums for high risks, but is also likely to result in a general upward pressure on average premiums. The general upward trend in the individual market may be somewhat offset, however, by increased participation of healthy individuals due to federal subsidies and the individual requirement to obtain coverage. Reduced marketing and underwriting costs will tend to lower administrative costs in both the small-group and individual exchanges, while limited benefit tiers and expanded information on plans and prices will promote competition. These reduced administrative costs and initiatives to promote transparency and competition should result in premium savings in the individual and small-group exchanges.

The impacts of health reform on premiums and offer rates for small firms will also vary based on the extent to which employers take advantage of grandfathering provisions included in the ACA. These provisions were included in the law to allow those happy with their coverage at the time of enactment to keep it and avoid most of the new benefit and rating

Table 3. Changes in employer health costs due to the ACA

	All Small Firms (<100)			<50 Employees			50–99 Employees		
	Without Reform	ACA	% Diff	Without Reform	ACA	% Diff	Without Reform	ACA	% Diff
Employer Costs (in billions $)									
Premium contributions	114.6	107.1	-6.5%	85.8	80.0	-6.8%	28.8	27.1	-5.9%
Employer subsidies	0.0	-4.5		0.0	-4.5		0.0	0.0	
Assessments	0.0	2.0		0.0	0.0		0.0	2.0	
Total contributions	**114.6**	**104.7**	**-8.6%**	**85.8**	**75.5**	**-12.0%**	**28.8**	**29.2**	**1.2%**

Source: Urban Institute analysis, HIPSM 2010
**We simulate the provisions of the Affordable Care Act fully implemented in 2010*

Table 4. Changes in average employer contribution per person covered

	Without Reform	ACA	% Diff
All small firms (< 100)	$3,760	$3,480	-7.4%
< 50 employees	$3,860	$3,560	-7.8%
50–99 employees	$3,470	$3,270	-5.8%

Source: Urban Institute analysis, HIPSM 2010
**We simulate the provisions of the Affordable Care Act fully implemented in 2010*

requirements. As many of the new regulations are intended to improve access for those with higher expected costs and thus require greater sharing of risk, low-risk groups will be subsidizing higher risks under reform and are likely to face increased costs. The grandfathering provisions, however, allow firms with healthy employees to avoid these likely premium increases by maintaining their pre-reform coverage. The extent to which firms take advantage of this option may be limited, however, as firms are allowed to make only minor changes to their plans to maintain their grandfathered status. Given the high rates of turnover in coverage in the current small-group market and the variation in medical costs for small groups from year to year, employers can increasingly be expected to sacrifice their grandfathered status for small-firm tax credits, broader risk pooling, or different plan structures over time.

Estimates of the impact of the ACA on small firms

Small firms will face a new set of options under reform and will need to weigh the cost of providing coverage through their available options with any penalties they may face (in the case of employers of 50 or more workers) for not offering or offering unaffordable coverage to their employees. Small-employer workers will need to consider their eligibility for federal subsidies to purchase coverage as individuals, which could affect their demand for employer-based coverage. Despite multiple uncertainties surrounding how employers and individuals will respond to the varied incentives the ACA creates, we are able to provide some insights into the likely effects of health reform on small firms based on recent findings from HIPSM.[16]

HIPSM simulates the decisions of individuals and businesses in response to policy changes, including Medicaid expansions, insurance market reforms and new health insurance options. The model produces estimates of changes in spending by employers, individuals and the government as well as rates of employer offers and health insurance coverage resulting from specific reforms. The results presented here reflect a simulation that modeled the main coverage provisions of the ACA as if they were fully implemented in 2010. The results are compared with HIPSM's 2010 pre-reform baseline results on employer costs, offers and coverage. Additional information on HIPSM and how the ACA provisions are reflected in the modeling approach can be found in previous reports.[17]

Table 3 summarizes the impacts of health reform on health care costs for small firms. Without reform, small firms with fewer than 100 employees would contribute almost $115 billion in premiums for health insurance coverage for their employees. Under the ACA, this would fall to approximately $107 billion, a decline of 6.5 percent, largely due to the introduction of the SHOP exchanges. Small firms would also receive $4.5 billion in subsidies under reform and pay $2.0 billion in assessments. Overall, small-firm health care costs would decline by 8.6 percent as a result of the ACA.

The savings to small firms would be heavily concentrated among those with fewer than 50 employees. These firms are not subject to employer responsibility assessments and are the beneficiaries of the tax subsidies. As a result, employer health costs for this group fall from $86 billion before reform to $76 billion after implementation of the ACA, a decline of 12 percent. In contrast, firms with 50 to 99 employees show a slight increase in costs—about 1 percent—as a result of reform. Premium contributions fall by nearly 6 percent, but these savings

are offset by $2 billion in assessments. Firms in this size group are not eligible for employer subsidies.

Table 4 indicates that the decline in premium contributions is not primarily due to a decline in coverage for small-firm workers and their dependents. Without reform, the contribution per covered employee was $3,760; under the ACA, it falls 7.4 percent to $3,480. The ACA will therefore make it less expensive for small firms to provide coverage to their employees. This is further reflected in the offer rates for small firms as shown in Table 5. Offer rates for all small firms with fewer than 100 employees increase by almost 10 percent under the ACA. The biggest increases are seen in the smallest firms. Those with fewer than 10 employees would see an increase in rates of offering insurance of 14 percent, with 40 percent of these firms offering coverage under reform compared to 35 percent before. This is due, in part, to the additional tax credits available for this group, as well as larger savings on administrative costs due to the introduction of the SHOP exchanges and other market reforms. The increase in offers is smaller for firms with 10 to 24 employees, and is trivial for firms with 25 or more workers.

Ultimately, the effects of the ACA on costs and offer rates for small firms are reflected in the estimates of employer-sponsored coverage under reform (Table 6). Without health reform, 30.5 million small-firm employees and their dependents are covered by ESI. This number grows to 30.8 million under the provisions of the ACA. Among workers employed by firms of fewer than 50 employees and their dependents, there is a small increase in ESI coverage, and among those in firms of 50 to 99 employees, there is almost no change in the number covered by ESI.

Overall, the simulation results suggest that the smallest firms have the most to gain from the ACA. Firms with fewer than 50 employees are not subject to any assessments, and those with fewer than 25 employees are eligible for tax subsidies to aid in purchasing coverage. As a result, employer health costs go down significantly for these firms, resulting in higher offer rates and a small increase in those covered by ESI. Firms with 50 or more employees are not eligible for subsidies, however, and must comply with new regulations requiring employer contributions to coverage and associated assessments. Thus, these firms show a slight overall increase in employer health costs under reform and no change in individuals covered by their ESI plans.

Beyond the effects on employer-sponsored coverage, workers in small firms and their families have much to gain from some of the health reform components not aimed directly at employers. The Medicaid expansion and the federal subsidies for purchasing coverage in the exchange will have significant benefits for small firm employees. Table 7 displays the effects of reform on the coverage distribution for workers and their families, by firm size. The uninsurance

Table 5. Changes in ESI offer rates, by firm size

	Without Reform	ACA	% Diff
All small firms (<100)	43.4%	47.6%	9.7%
<10 employees	35.3%	40.3%	14.2%
10–24 employees	64.3%	66.9%	4.0%
25–49 employees	77.5%	77.7%	0.3%
50–99 employees	86.7%	86.7%	0.0%

Source: Urban Institute analysis, HIPSM 2010
**We simulate the provisions of the Affordable Care Act fully implemented in 2010*

Table 6. Changes in employer-sponsored coverage due to the ACA

	All Small Firms (<100)			<50 Employees			50–99 Employees		
	Without Reform	ACA	% Diff	Without Reform	ACA	% Diff	Without Reform	ACA	% Diff
ESI policyholders and coverage (in millions)									
Single policyholders	11.8	12.1	2.7%	8.8	9.0	2.5%	3.0	3.1	3.5%
Family policyholders	6.2	6.3	1.1%	4.5	4.5	0.8%	1.7	1.7	1.7%
Persons covered	30.5	30.8	0.9%	22.2	22.5	1.4%	8.3	8.3	-0.3%

Source: Urban Institute analysis, HIPSM 2010
**We simulate the provisions of the Affordable Care Act fully implemented in 2010*

Table 7. Changes in coverage of non-elderly individuals in families with non-elderly workers

	In families with at least one small firm worker (<50)		In families with no small firm workers, but at least one medium firm worker (50–99)		In families with only large firm workers (100+)	
	Without Reform	ACA	Without Reform	ACA	Without Reform	ACA
Coverage						
Employer-sponsored Insurance	53.5%	52.8%	68.6%	67.8%	74.2%	75.1%
Individually Purchased	6.1%	12.9%	3.3%	8.1%	2.9%	6.3%
Medicaid	14.9%	21.4%	12.3%	16.0%	9.8%	13.2%
Other Public	1.1%	1.1%	1.2%	1.2%	1.2%	1.2%
Medicare	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%
Uninsured	23.8%	11.0%	13.9%	6.1%	11.2%	3.5%

Source: Urban Institute Analysis, HIPSM 2010
**We simulate the provisions of the Affordable Care Act fully implemented in 2010*

rate for individuals in families with at least one small-firm worker falls dramatically following reform from 24 to 11 percent. Those in families with only large-firm workers also see gains in coverage, albeit from much lower initial uninsurance rates. Increases in the rates of individually purchased coverage through the exchanges and expanded Medicaid coverage are primarily responsible for these declines in uninsurance.

Conclusions

Small firms face many barriers to purchasing coverage for their employees in the current health care system. The ACA has several components that will improve the accessibility and affordability of coverage for small firms. While each employer will face unique circumstances under health reform, our analysis finds that, in general, the smallest employers will see significant benefits from the ACA. They will be able to access more affordable coverage in the SHOP exchanges, and some will be able to use tax credits to aid in purchasing coverage. Our results show significant health care cost savings to firms with fewer than 50 workers, as well as a small increase in the number of people covered by their employer-sponsored plans.

The effects on employers with greater than 50 employees are estimated to be much smaller. A one percent increase in employer costs is found as a result of new assessments just offsetting declines in premium contributions. Offer rates for these firms remain relatively stable, however, and while the gains are not as strong as for the smallest firms, they are also not consistent with more negative predictions suggesting a virtual collapse of employer health insurance.[18] Furthermore, the trends prior to reform showed strong declines in offer rates and coverage among small firms. Thus, the evidence suggests that the ACA may have a stabilizing influence on small firm coverage.

It is also important to note that while ESI coverage does not increase substantially for employees of small firms or their families under the ACA, uninsurance rates are estimated to fall dramatically for individuals in families of small-firm workers. The Medicaid expansion and federal subsidies to purchase coverage in the health insurance exchanges result in significant coverage increases for small firm employees and their families, the group currently with the highest rates of uninsurance. Such coverage may be preferable to these individuals, and some employers with lower income workers may find that, accounting for the cost of the assessments (if they are a firm with 50 or more workers), offering coverage is no longer preferable. Employees and their families will still have access to affordable, portable coverage through Medicaid or the exchange and may even see a wage increase if employer assessments are lower than pre-reform ESI premiums. The availability of affordable coverage in the individual exchanges will also allow small firms to better compete with larger employers for workers.

Notes

1 "Health Care Law a Bad Prescription," *Politico* (March 23, 2011), http://www.politico.com/news/stories/0311/51749.html; Statement of the U.S. Chamber of Commerce to the House Energy and Commerce Committee, Subcommittee on Health, March 30, 2011.

2 Linda Blumberg and S. McMorrow, "What Would Health Care Reform Mean for Small firms and Their Workers?" (Washington, DC: Urban Institute, 2009), http://www.urban.org/url.cfm?ID=411997; Linda Blumberg, "How Will the PPACA Impact Individual and Small Group Premiums in the Short and Long Term?" (Washington, DC: Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412128; Linda Blumberg, "How Will the PPACA Affect Small, Medium, and Large Businesses?" (Washington, DC: Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412180; Bowen Garrett and Matthew Buettgens, "Employer-Sponsored Insurance under Health Reform: Reports of Its Demise Are Premature (Washington, DC: Urban Institute, 2011), http://www.urban.org/url.cfm?ID=412295.

3 Congressional Research Service, *Costs and Effects of Extending Health Insurance Coverage* (Washington, DC: U.S. Government Printing Office, 1988).

4 Linda J. Blumberg and L. M. Nichols, "Why Are So Many Americans Uninsured?" in *Health Policy and the Uninsured*, edited by Catherine G. McLaughlin (Washington, DC: Urban Institute Press, 2004).

5 D. Cutler, "Market Failure in Small Group Health Insurance," Working Paper No. 4879 (Cambridge, MA: National Bureau of Economic Research, Inc., 1994).

6 As of January 2010, 11 states restricted small group insurers from basing premiums on health status. Details at Kaiser State Health Facts, http://www.statehealthfacts.org/comparetable.jsp?ind=351&cat=7&sort=560.

7 In 2008, the median wage for workers in firms with fewer than 10 workers was $10,000 less than those in firms with more than 1,000 employees.

8 J. Gruber, "The Incidence of Mandated Maternity Benefits," *American Economic Review* 84, no. 3 (1994): 622–41.; Linda J. Blumberg, "Who Pays for Employer Sponsored Health Insurance? Evidence and Policy Implications," *Health Affairs*, 18(1999); J. Bhattacharya and M.K. Bundorf, "The Incidence of the Healthcare Costs of Obesity," NBER Working Paper 11303 (Cambridge, MA: National Bureau of Economic Research, 2005), http://www.nber.org/papers/w11303.

9 Low-wage employers are defined here as those with 50 percent or more of employees whose wages are at or below the 25th percentile for all hourly wages.

10 In 2017, the exchanges may be opened to larger firms. Prior to 2016, states have the option of limiting the small group reforms and SHOP exchange eligibility to employers of 50 and fewer workers.

11 Firms with fewer than 25 workers and average wages less than $50,000 are eligible. The most generous subsidies are available for those with fewer than 10 workers and wages less than $25,000.

12 According to the Joint Committee on Taxation (JCT) interpretation of the law. Also according to the JCT interpretation, dependents would be ineligible for subsidized coverage in the exchanges if the single premium is deemed affordable for the worker.

13 Just over 20 percent of small firm workers have modified adjusted gross income (MAGI) below 138 percent of the federal poverty level (FPL) and will gain eligibility for Medicaid according to the Urban Institute's HIPSM.

14 New employees as well as previously unenrolled employees or dependents in firms offering grandfathered plans are eligible for these plans.

15 Department of the 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" (2010) and "Amendment to the 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," http://www.hhs.gov/ociio/regulations/grandfather/index.html.

16 Garrett and Buettgens, "Employer-Sponsored Insurance."

17 See more about the Urban Institute's Health Microsimulation Capabilities at http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf, a more technical description of the model in Bowen Garrett, John Holahan, A. Cook, I. Headen, and A. Lucas, "The Coverage and Cost Impacts of Expanding Medicaid" (Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, 2009), http://www.urban.org/url.cfm?ID=411905, and details on modeling the ACA in Matthew Buettgens, Bowen Garrett, and John Holahan, "America under the Affordable Care Act" (Washington, DC: The Urban Institute, 2010), http://www.urban.org/url.cfm?ID=412267.

18 Garrett and Buettgens (2011) respond to the reasons given for some of these predictions more fully than can be done here.

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About the Authors and Acknowledgements

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