January **2016**

The Affordable Care Act and Its Effect on Employers: Update

ISSUE BRIEF

The Patient Protection and Affordable Care Act of 2010 (ACA) contains several provisions that directly affect employers and impact the employer-sponsored health insurance (ESI) system through which the majority of Americans receive coverage. While some experts predicted declines of 4.5 percent[1] or more in employer-sponsored coverage from 2010 to 2016, ESI remained stable in Michigan in 2014, with the continuation of many notable trends. This brief updates one published earlier in 2015[2] by summarizing trends in employer coverage in 2014, when many ACA provisions took effect. This brief also summarizes recent legislative and regulatory changes to provisions of the ACA relevant to employers, as well as an update on certain key provisions that have faced implementation challenges.

Key Findings

- Similar to prior years, more than three out of four business establishments in Michigan had fewer than 50 workers in their firm in 2014. However, the share of these firms that offered health insurance to their workers declined from 40 percent in 2013 to 33 percent in 2014. In contrast, over 90 percent of larger firms offered coverage.
- From 2009 to 2014, average premiums grew faster for larger employers than for small employers, while overall premium growth remained below the national average. On the other hand, average deductibles grew faster from 2013 to 2014 than the national average. However, average deductible levels remain below the national average.
- The enrollment rate of eligible workers in their employer's health plan increased both in Michigan and nationwide in 2014. However, the rate of self-insurance among small groups in Michigan decreased in 2014.
- Multiple ACA provisions for employers were substantially changed in 2015, as Congress passed separate legislation pausing three ACA taxes, repealing the automatic enrollment requirement, and making the small group definition a state option for 2016. The employer mandate was implemented for firms with 100 or more full-time equivalent (FTE) workers in 2015, and will be fully implemented for firms with 50 or more FTE workers in 2016.

[1] Ahlquist, G., Borromeo, P. et al. (2011) *The Future of Health Insurance: The Demise of the Employer-Sponsored Coverage Greatly Exaggerated*. Booz & Company.
[2] J. Fangmeier and M. Udow-Phillips. The Affordable Care Act and Its Effect on Employers: 2015 Update (Ann Arbor, MI: Center for Healthcare Research and Transformation, February 2015).

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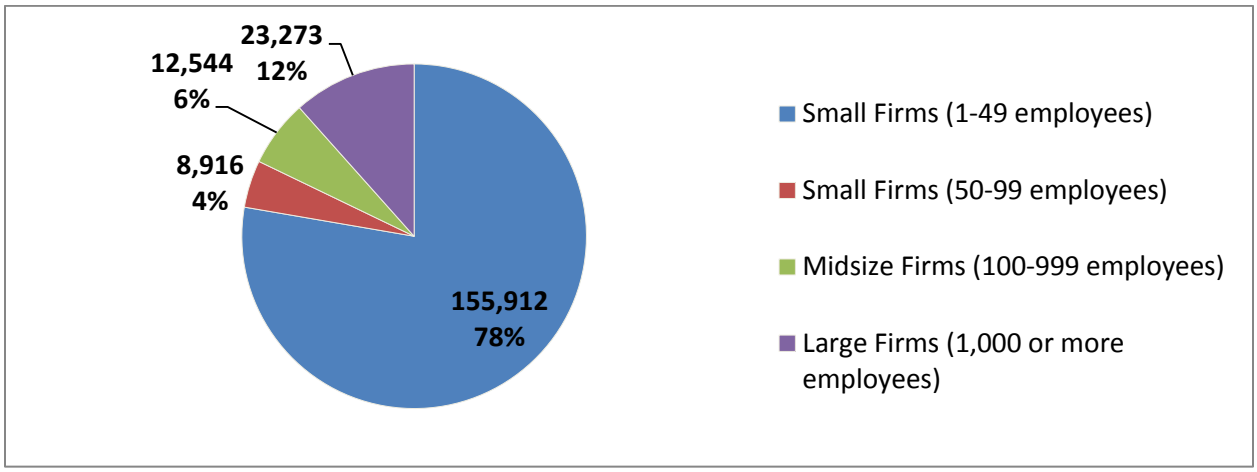
Michigan Employer-based Coverage Trends

While employer-sponsored coverage has declined in Michigan over the last decade, more than half of residents still rely on coverage through an employer. In 2014, 60.7 percent of Michigan residents had employer-based coverage—a slight increase from 60 percent in 2013 but a decrease from 65.1 percent in 2008.[3]

Small firms make up the vast majority of private-sector employers in Michigan. In 2014, 78 percent of business establishments were firms with fewer than 50 employees.[4] Large firms with more than 1,000 employees made up 12 percent of the total business establishments in the state (*Figure 1*). Compared to 2013, the number of small firm establishments grew slightly relative to large firm establishments.

Figure 1: Private-Sector Establishments by Firm Size, Michigan, 2014



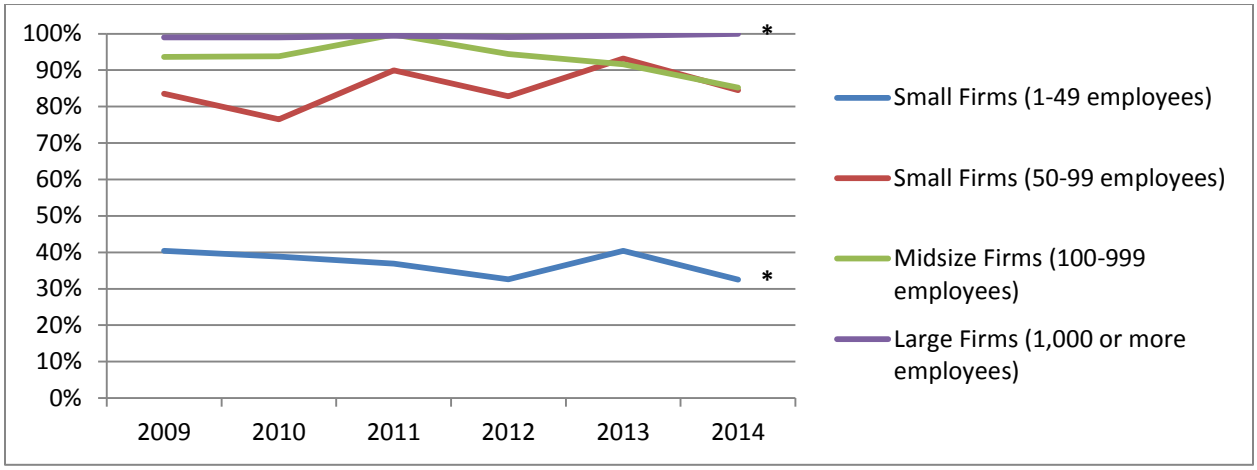
Source: Medical Expenditure Panel Survey, Insurance Component

Employer Health Insurance Offer Rates

Small firms with fewer than 50 employees have historically been less likely to offer health insurance to their workers than larger firms. In 2013, the offer rate of small firms increased from 33 percent in 2012 to 40 percent (*Figure 2*), but dropped back to 33 percent in 2014, closer to the national average for similarly sized firms (32 percent). Michigan firms with 50 to 99 workers had offer rates of 84 percent in 2014, down from 93 percent in 2013 but still above the national average for similarly sized firms (81 percent in 2014). Virtually all large firms in Michigan continued to offer health insurance to their workers in 2014.

[3] SHADAC analysis of the American Community Survey (ACS) Public Use Microdata Sample (PUMS) files.
[4] Establishments are physical locations of business, and firms are business entities consisting of one or more establishments. Based on CHRT analysis of Census Bureau Statistics of U.S. Businesses data, 94 percent of firms (enterprises) in Michigan have fewer than 50 workers. Data available at: http://www.census.gov/econ/susb/

Figure 2: Percent of Private-Sector Establishments that Offer Health Insurance by Firm Size, Michigan, 2009–2014



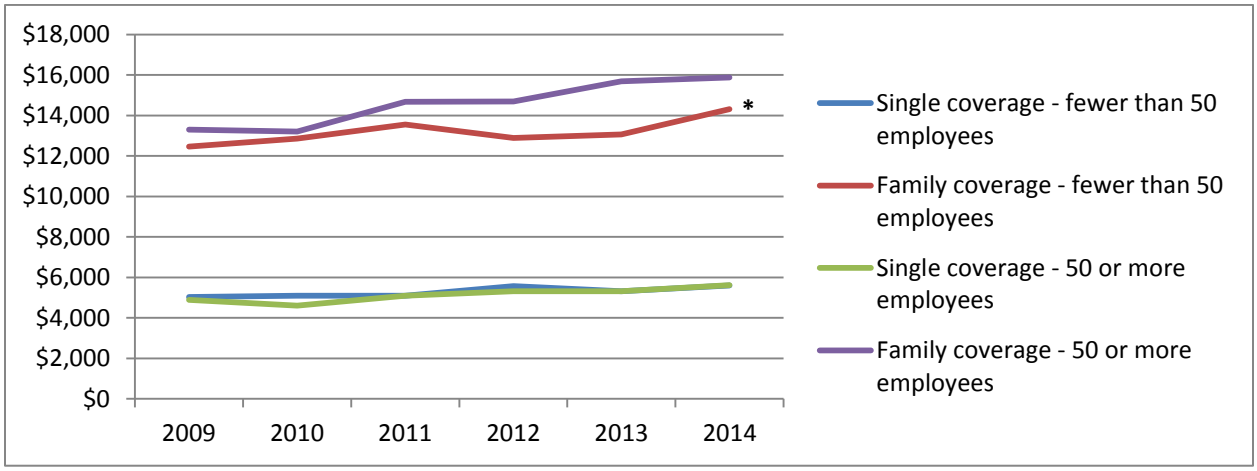
Source: Medical Expenditure Panel Survey, Insurance Component

* Estimate differs significantly from 2013 to 2014 at the 0.1 level

Premiums for Employer-based Coverage

Among Michigan employers that offered coverage in between 2009 and 2014, average total premiums for family coverage (including both employer and employee contributions) for firms with fewer than 50 employees increased by an average of 2.8 percent per year. Total average family premiums for all employers grew by 19 percent over these five years, and grew faster for Michigan employers with more than 50 employees than for those with fewer than 50. On average, single coverage in Michigan increased by 14 percent, while family coverage increased by 19 percent. These increases were less than the national average increases of 25 percent for single coverage and 28 percent for family coverage.

Figure 3: Average Total Premium per Enrolled Employee by Firm Size and Coverage Type, Michigan, 2009–2014



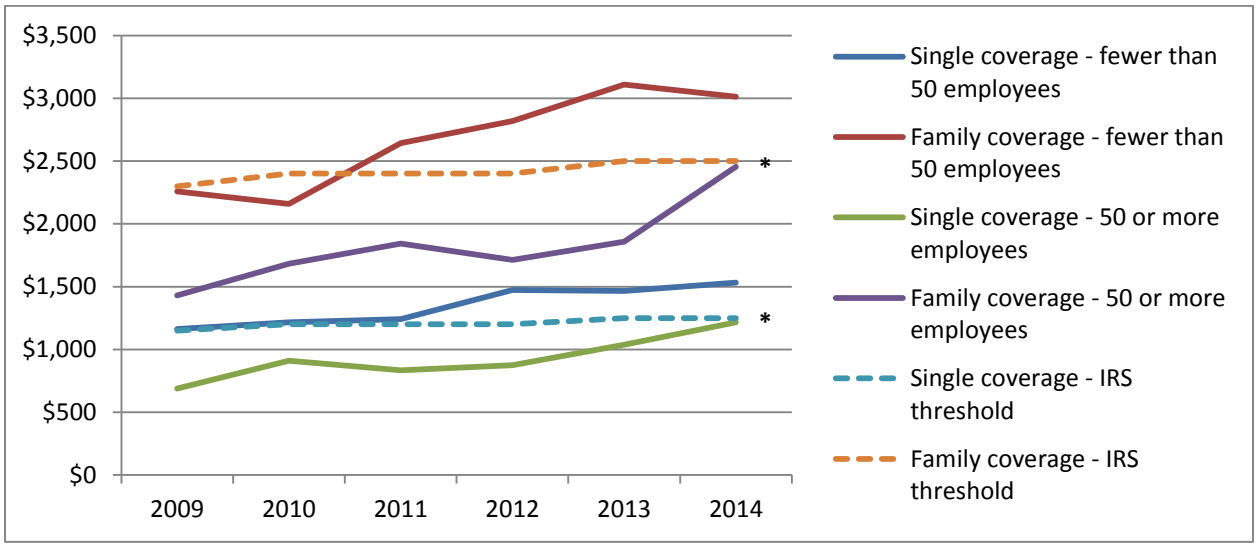
Source: Medical Expenditure Panel Survey, Insurance Component

* Estimate differs significantly from 2013 to 2014 at the 0.1 level

Deductibles for Employer-based Coverage

Continuing previous trends, employees at small firms with fewer than 50 employees were enrolled in plans with higher deductible levels in 2014 than employees at larger firms. Between 2013 and 2014, deductibles for both single and family coverage offered by larger firms with more than 50 employees increased by an average of roughly 11 percent for each type of plan. Average deductibles for both single and family coverage offered by larger firms in Michigan increased slightly to below the Internal Revenue Service (IRS) high-deductible health plan definition in 2014.[5] As in the past several years, average deductibles for small firms in Michigan met the IRS high-deductible definition for both single and family coverage. The average increase in deductibles for larger Michigan employers between 2013 and 2014 for single (17 percent) and family coverage (32 percent) was above the national average of 8 percent and 7 percent, respectively. However, average deductibles in Michigan remain below the national averages.

Figure 4: Average Deductible per Enrolled Employee by Firm Size and Coverage Type, Michigan, 2009–2014



Source: Medical Expenditure Panel Survey, Insurance Component

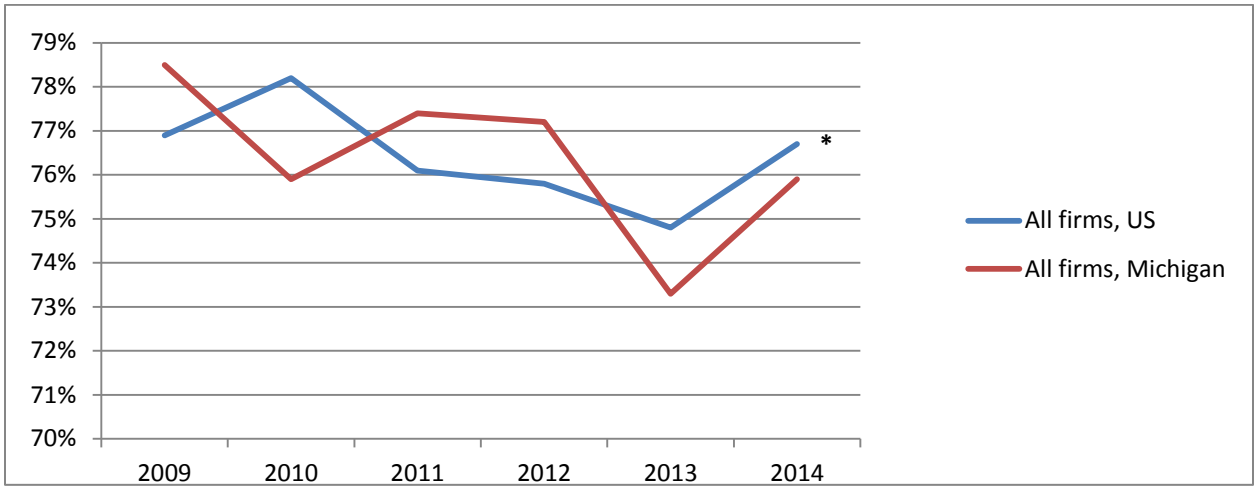
* Estimate differs significantly from 2013 to 2014 at the 0.1 level

Employee Enrollment Rates in Employer-based Coverage

Along with expanded Medicaid eligibility and health insurance marketplaces, another opportunity to increase health insurance coverage is through increasing the number of workers who accept available coverage from their employer. Nationally, the share of workers that accepted health benefits declined from 77 percent in 2009 to 75 percent in 2013. Similarly, from 2009 to 2013, the percentage of eligible employees in Michigan enrolled in health insurance dropped from 79 percent to 73 percent. However, the enrollment rates increased in 2014 to 76 percent in Michigan and 77 percent nationwide. It is possible that penalties in the ACA for people who do not have coverage played a role in the increase in the employer coverage take-up rate.

[5] The IRS threshold for high-deductible health plans in 2014 was $1,250 for single coverage and $2,500 for family coverage.

Figure 5: Percentage of Eligible Employees Enrolled in Health Insurance, Michigan and U.S., 2009-2014



Source: Medical Expenditure Panel Survey, Insurance Component

* Estimate differs significantly from 2013 to 2014 at the 0.1 level

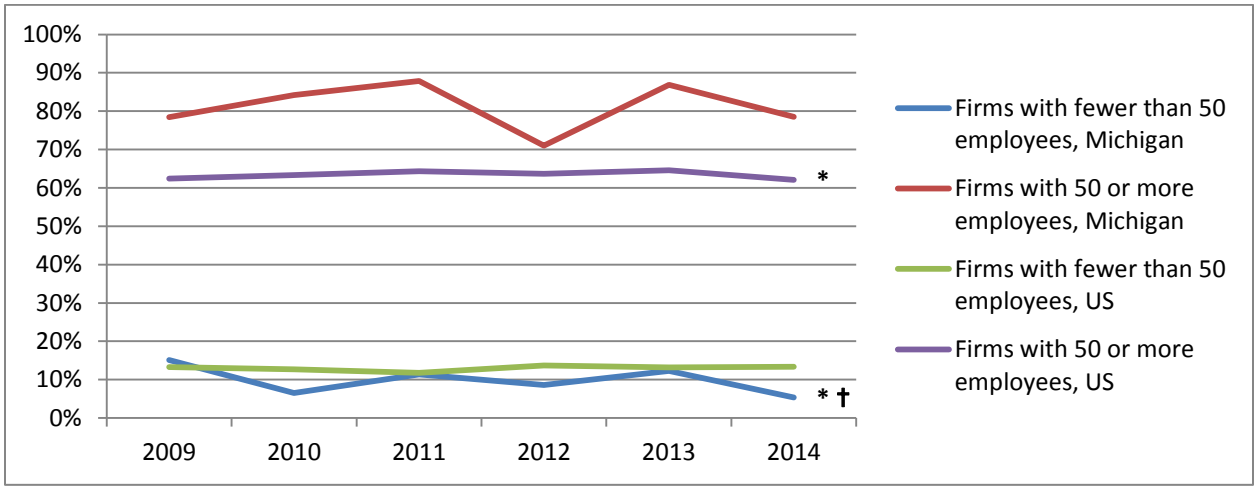
Employer Rates of Self Insurance for Health Benefits

While the ACA introduced several new provisions for employers, many of these requirements, such as essential health benefits, do not apply to large employers or small employers who self-insure the health coverage of their workers. These aspects of the ACA could potentially motivate small businesses to self-insure to avoid these provisions.[6] Historically, the rate of self-insurance among small firms in Michigan has traditionally been low. While state-specific numbers are from a small survey sample, it appears that the percentage of small firms in Michigan that self-insured at least one plan dropped significantly, from 12 percent in 2013 to 5 percent in 2014, which was below the 2014 national average of 13 percent for small firms.[7] From 2009 to 2014, roughly four out of every five large private firms in Michigan self-insured at least one plan, above the national average for similarly sized employers (62 percent in 2014).

[6] Hall, M. February 2012. *Regulating Stop-Loss Coverage May Be Needed To Deter Self- Insuring Small Employers From Undermining Market Reforms*. Health Affairs. http://content.healthaffairs.org/content/31/2/316.full

[7] The MEPS-IC estimate for small self-insured firms in Michigan did not meet the Agency for Healthcare Research and Quality's standard of reliability or precision for 2014.

Figure 6: Percentage of Private Firms That Self-Insure At Least One Plan, by Firm Size, 2009-2014



Source: Medical Expenditure Panel Survey, Insurance Component

* Estimate differs significantly from 2013 to 2014 at the 0.1 level; † Estimate does not meet standard of reliability or precision

Notable Changes to ACA Employer Provisions

Since the passage of the ACA in March 2010, multiple provisions have been delayed or stopped due to regulatory or legislative action. 2015 marked another year with significant changes to the ACA as it relates to employers. The small group definition, which is associated with several other provisions of the ACA, was modified to allow states to determine the definition in 2016. The automatic enrollment requirement, which was never implemented, was repealed by Congress. The Cadillac tax on high-cost health plans was delayed two years until 2020, and the taxes on insurers and medical device manufacturers, which were in effect in 2015, were suspended for one and two years, respectively. However, the employer mandate was partially implemented in 2015 and will be fully implemented in 2016.

Definition of Small Group Size

On October 7, 2015, President Obama signed the Protecting Affordable Coverage for Employees (PACE) Act, eliminating a provision of the ACA that would have expanded the definition of a "small group" from those that employ up to 50 employees to include those with 51 to 100. Instead, states have the option to expand the definition of "small group" to include firms with 51 to 100 employees if they choose to. Upon the PACE Act's passage, the Michigan Department of Insurance and Financial Services decided to retain the traditional definition of "small group" as firms with up to 50 employees.[8] Changing the definition of small group size would have required employers with 51 to 100 workers to abide by the rules and regulations of the small group market, which affect issues such as benefit coverage, actuarial value, and premium rating restrictions. According to the American Academy of Actuaries (AAA), firms sized 51-100 would have faced more restrictive rating rules under the change, causing increased

[8] Michigan Department of Insurance and Financial Services. October 2015. *Order Rescinding Order No. 15-012-M Regarding Affordable Care Act Large Group Market Transitional Policy.* http://www.michigan.gov/documents/difs/Transitional_Order_15-044-M_502638_7.pdf

premiums for some groups and decreased ones for others.[9] The small group market rules have additional benefit and cost-sharing requirements that the AAA said could reduce benefit flexibility and lead to increased premiums. The legislation was a rare example of ACA-related Congressional action that had bipartisan support.

Repeal of the Automatic Enrollment Requirement for New Employees (ACA §1511)

On November 2, 2015, President Obama signed the Bipartisan Budget Act of 2015, which contained the repeal of the ACA's automatic enrollment requirement. This provision of the health law required firms with more than 200 full-time employees to automatically enroll new workers in the health plan with the lowest employee premium contribution if the worker did not actively select a plan. The ACA did not specify an effective date for this provision, and federal regulations had not been released prior to its repeal. The automatic enrollment requirement was meant to encourage enrollment in coverage by employees who might otherwise not make an active plan selection decision. According to the Congressional Budget Office, repeal of this ACA provision will result in 750,000 fewer people enrolled in employer-sponsored coverage after 2018.[10]

Delay of the Cadillac Tax (ACA §9001) and Suspension of the Health Insurance Provider Tax (ACA §9010) and Medical Device Excise Tax (HCERA §1405)

On December 18, 2015, President Obama signed the Consolidated Appropriations Act, 2016, which included a range of health care and non-health care appropriations and tax extenders. The law made significant changes to three tax provisions of the ACA relevant to employers. It delays the ACA's excise tax on high-cost plans (the "Cadillac tax") for two years and will not begin until 2020. The Cadillac tax is a 40 percent tax on the amount that total health plan premiums exceed thresholds of $10,200 for single coverage and $27,500 for family coverage in 2018 (for most situations, adjusted annually). According to the Congressional Budget Office, the Cadillac tax could affect one out of every five workers with employer-based coverage in 2018, but many employers are expected to make changes to their health benefits to minimize triggering the tax.[11]

The Consolidated Appropriations Acts also suspended the ACA's Health Insurance Provider Tax for one year and the Medical Device Excise Tax for two years. The Health Insurance Provider Tax is an industry-wide fee on health insurance companies based on a percentage of applicable net premiums. The Medical Device Excise Tax is a sales tax on certain medical devices but excludes eyeglasses, hearing aids, and other over-the-counter devices. While neither tax is paid directly by consumers, most economists believe that consumers bear the costs of these taxes through higher premiums. Therefore, the suspension of these two taxes may result in otherwise lower premiums. However, according to the

[9] American Academy of Actuaries. March 2015. *Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees*. http://actuary.org/files/Small_group_def_ib_030215.pdf

[10] Congressional Budget Office. September 2015. *Reconciliation Recommendations of the House Committee on Education and the Workforce*. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/reconciliationrecommendationseducationandtheworkforce.pdf

[11] Congressional Budget Office. November 2013. *Options for Reducing the Deficit: 2014 to 2023*. https://www.cbo.gov/content/options-reducing-deficit-2014-2023

Committee for a Responsible Federal Budget, the federal government will forgo $32 billion in revenue due to the delay and suspensions of all three ACA taxes.[12]

Implementation of the Employer Mandate (ACA §1513, IRC §4980H)

The employer mandate provision of the ACA consists of two types of potential penalties:

1. A $2,000 penalty per full-time worker after the first 30 workers for firms that do not offer coverage to 95 percent of eligible workers and their dependents,[13] and;
2. A $3,000 penalty for each worker who receives a marketplace tax credit because their offer of coverage from their employer is inadequate or unaffordable.

The total amount of the second penalty cannot exceed the total possible penalty amount for not offering coverage at all. Over 80 percent of private firms that would be eligible for penalties in Michigan offered coverage to their employees in 2014, although this number declined from 2013 (see *Figure 2*). After the IRS delayed implementation of the employer mandate by one year, the ACA's penalties for firms not meeting certain standards of coverage went into effect for large employers (100 or more full-time employees) on January 1, 2015. Penalties for employers with 50 to 99 full-time employees began January 1, 2016.

[12] Committee for a Responsible Federal Budget. December 2015. *Negotiated Tax Deal Would Cost $680 Billion*. http://crfb.org/blogs/negotiated-tax-deal-would-cost-about-650-billion

[13] The threshold for offering coverage is 70 percent in 2015, but rises to 95 percent in 2016.

Conclusion

Implementation of the ACA continues to affect the employer-sponsored insurance system nationwide, but employer trends vary across states and may depend on the enactment of certain employer-related provisions. The most recent Congressional Budget Office projections estimate that the ACA will lead to a 4 percent reduction in employer-sponsored coverage in 2025, as firms drop coverage and some workers switch to other coverage options, but employer-sponsored health insurance will likely continue to cover the majority of non-elderly Americans.[14]

Recent legislative action regarding the definition of small group size and automatic enrollment has shown that bipartisan support exists in Congress for targeted changes to the ACA, and may affect future trends in employer coverage. As delayed or suspended provisions such as the employer mandate and the three ACA taxes begin to take effect, their effect on employer trends in coverage should be examined in coming years. The trends and issues examined in this brief will continue to warrant monitoring as ACA implementation moves forward.

[14] Congressional Budget Office. March 2015. *Insurance Coverage Provisions of the Affordable Care Act – CBO's March 2015 Baseline*. https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-03-ACAtables.pdf

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