Reports and Research

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ISSUE BRIEF ON SMALL BUSINESSES:
IDENTIFYING VULNUERABLE ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS IN CALIFORNIA UNDER HEALTH CARE REFORM

AUGUST 2013

APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

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APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The Asian & Pacific Islander American Health Forum (APIAHF) is a health justice non-profit organization dedicated to improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. We believe that all persons have the right to be healthy, the right to live in a thriving community, and the right to quality, affordable, and accessible health care.

For the past 26 years, APIAHF has worked with community advocates, public health leaders, and policymakers to generate policies, programs, and systems changes to improve the health of Asian American, Native Hawaiian, and Pacific Islander communities. Through our policy and advocacy efforts, APIAHF was instrumental in the creation of the White House Initiative on Asian Americans and Pacific Islanders, fought for the passage of the Patient Protection and Affordable Care Act, and continues to demand the inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the collection and reporting of local, state, and national health data. APIAHF works with local and state-based CBO's in 20 states and territories who provide services and advocate for AA and/or NHPI communities.

MISSION

The Asian & Pacific Islander American Health Forum (APIAHF) influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders.

VISION

APIAHF envisions a world where all people share responsibility and take action to ensure healthy and vibrant communities for current and future generations.

VALUES

Our work derives from three core values:

Respect because we affirm the identity, rights, and dignity of all people.

Fairness in how people are treated by others and by institutions, including who participates in decision making processes.

Equity in power, opportunities, and resources to address obstacles hindering vulnerable communities and groups from living the healthiest lives.

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August 2013, San Francisco, CA

EXECUTIVE SUMMARY

INTRODUCTION

The Affordable Care Act provides new health insurance coverage options and incentives for small business owners, employees, and their families. With high rates of both small business ownership and uninsurance, these options will be particularly helpful for the Asian American (AA) and Native Hawaiian and Pacific Islander (NHPI) community. The Asian & Pacific Islander American Health Forum conducted a study of AA and NHPI small business owners and employees throughout California to evaluate their socioeconomic and health status and understand the barriers they face in getting health insurance. Based on our analysis of California Health Interview Survey data and focus group research, we identified several important findings.

SELECTED KEY FINDINGS

- AAs and NHPIs who owned or worked for small business had significantly higher rates of uninsurance (no health insurance) than those who worked for larger businesses.
- AA and NHPI small business owners and employees know very little about the ACA and many are misinformed about its provisions.
- While trusted sources of information about the ACA vary by generation, most AA and NHPI small business owners and employees would prefer to get information through ethnic media and community-based organizations instead of online resources.

RECOMMENDATIONS

- Individuals and organizations engaging in outreach and education must use targeted strategies to reach the AA and NHPI small business community.
- Outreach and education efforts should include assistance in estimating the specific costs for small business owners who are interested in providing health insurance coverage to employees through the Small Business Health Options Programs (SHOP) marketplace.
- Even if they choose not to provide coverage, small business employers should be used as a resource in helping employees enroll in coverage through the individual health insurance marketplace.

CONCLUSION

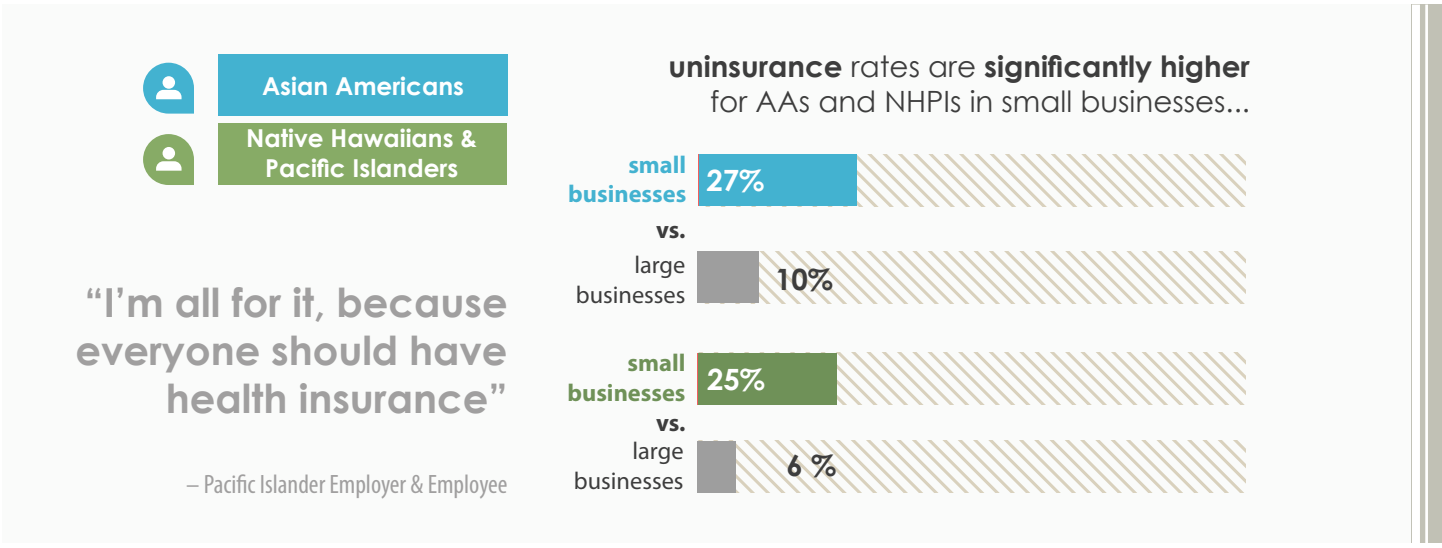
The ACA provides a critical opportunity for individuals to get health insurance coverage and access to health care services. By engaging in effective targeted outreach and education strategies to the small business community, millions of Asian Americans, Native Hawaiians, and Pacific Islanders will be able to enroll in affordable coverage, which will help us move toward the achievement of health equity in the U.S.

INTRODUCTION

In October of 2013, one of the major components of the Affordable Care Act (ACA) will be implemented – the opening of the health insurance marketplaces (or exchanges). These online sites will provide one location for individuals to compare and purchase health insurance plans for themselves and their families. Millions of uninsured individuals will have the opportunity to purchase affordable, quality health insurance. Individuals can also receive subsidies from the government to help cover their insurance premium costs if they purchase insurance through the marketplaces.

The ACA includes several features to help small business owners. By using the Small Business Health Options Program (SHOP) marketplace, small business employers can choose from private health plans, compare costs and benefits, identify their contribution amount for premiums, and select a health plan for their employees. Already, small business owners can also get tax credits if they provide health insurance to their employees. Ideally, small business owners will take advantage of this incentive and more small business employees will have the opportunity to get health insurance through their employer.

The health insurance provisions of the ACA are particularly important for Asian Americans (AAs) and Native Hawaiians and Pacific Islanders (NHPIs) in the U.S. and California. They have high rates of uninsured individuals and many also own or work for small businesses. Of all Asian-owned businesses in California, 22% are small businesses, the highest proportion among all racial groups.[1]



1 *U.S. Census Bureau, 2007 Survey of Business Owners*

STUDY DESCRIPTION

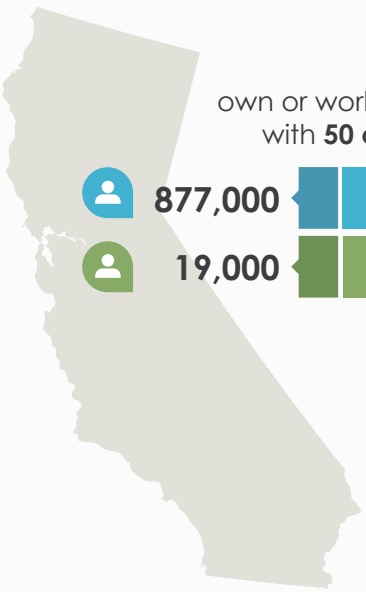
Beginning in 2012, the Asian & Pacific Islander American Health Forum (APIAHF) conducted a two-part study consisting of data analysis and focus group research to: 1) identify barriers faced by California AA and NHPI small business owners and employees in getting health insurance, 2) learn about their understanding of the ACA, and 3) get their feedback on which ACA provisions, if any, would be most helpful to them in getting health insurance.

The first part of the study involved an analysis of California Health Interview Survey (CHIS) data to identify predictors of uninsurance for small business owners and employees, and to understand the impact of uninsurance on their health and health care use. In the second part of the study, we conducted a series of focus groups with small business owners and employees representing Asian American and Pacific Islander ethnic groups with high rates of uninsurance. We also performed several in-depth interviews with key informants who serve the small business community.

PART 1: PROFILES OF AA AND NHPI SMALL BUSINESS OWNERS AND EMPLOYEES IN CALIFORNIA

We analyzed data from the 2005-2009 California Health Interview Survey (CHIS), the nation's single largest state health survey. The survey provides detailed information on a broad range of topics including demographic and socioeconomic characteristics, health behaviors, health conditions and status, and access to and use of health care services among California's diverse population. Information is collected through telephone surveys of households and is administered in several different languages, including the Asian languages of Cantonese, Mandarin, Korean, and Vietnamese.

In our analysis, we reviewed demographic information, such as income levels and rates of uninsured, and examined whether small business owners and employees were more disadvantaged than those who work for large employers in their socioeconomic status, health conditions and status, health insurance coverage, and health care use.



own or work for a small business with **50 or FEWER EMPLOYEES**

877,000 Asian Americans

19,000 Native Hawaiians & Pacific Islanders

total population in **CALIFORNIA**

AAs
5,556,592
NHPIs
286,145

"Any kind of coverage is better than none"

– Hmong Employee

KEY FINDINGS FROM CHIS ANALYSIS

There are an estimated 877,000 Asian American (AA) and 19,000 Native Hawaiian and Pacific Islander (NHPI) adults who own or work for small businesses with up to 50 employees in California. They account for 11.6% and 0.3%, respectively, of California's workforce working in small businesses with up to 50 employees. Asian Americans account for about 12.1% and NHPIs about 0.3% of California's population.

- The rate of uninsured was significantly higher for AAs who owned or worked for small businesses (27%) than those who worked for larger employers (10%). NHPIs who owned or worked for small businesses also had significantly higher rates of uninsured (25%) compared to their counterparts who worked for larger employers (6%). Both AAs and NHPIs who worked for larger businesses also had significantly higher rates of private insurance than those who owned or worked for small businesses (see Table 1). When comparing AA ethnic subgroups, Koreans were about 7 times and South Asians about 2 times more likely to be uninsured than Japanese (who had the highest insurance rate and the highest socioeconomic status among all AA ethnic groups).

- AA adults who owned or worked for small businesses were less likely to have a regular provider than those who worked for large employers (76% vs. 86%), and were also less likely to have visited a doctor's office in the past twelve months than those who worked for large employers (74% vs. 83%). Health conditions and status were not significantly associated with employer type for NHPIs.

- AA small business owners and employers were more likely to have limited English proficiency and represented a higher proportion of foreign-born individuals and non-citizens than those who worked for large employers (see Table 1). This is significant because language and immigration status have both been identified as potential barriers in getting health insurance.

Table 1. Demographic Differences between Small and Larger Businesses (CHIS, 2009)

Insurance Coverage	Adults who owned or worked for small businesses (up to 50 employees)	Adults who worked for large employers (51+ employees)
Asian Americans		
Uninsured	27%	10%
Public insurance	16%	9%
Private insurance	56%	81%
LEP	42%	23%
Foreign-born	38%	29%
Non-citizen	23%	12%
Native Hawaiians/Pacific Islanders		
Uninsured	25%	6%
Public insurance	7%	15%
Private insurance	67%	79%

Note: All differences reported are statistically significant. We did not report LEP, Foreign-born, or Non-citizen Status for NHPIs because their differences were not statistically significant.

- While there is significant variation among AA ethnic subgroups for small business ownership and employment, a relatively high proportion own or work for small businesses overall. The proportion of major ethnic subgroups who own or work for small businesses ranged from 52% (Koreans) to 27% (South Asian) (see Table 2).

- There is significant variation among AA ethnic groups with regard to income level and eligibility for Medi-Cal and subsidized insurance provided by the ACA (see Table 2).[2] Among the different AA subgroups, the proportion of those eligible for Medi-Cal was the highest for the Vietnamese (33%) and the lowest for the Japanese (7%) and South Asians (7%). The proportion of those eligible for subsidized insurance was also the highest for the Vietnamese (45%), followed by Filipino (44%), Southeast Asians (42%), and Koreans (39%). The high proportions of AA small business owners and employees who would be eligible for either Medi-Cal or subsidized insurance are striking, ranging from about 40% of Japanese and South Asians to about 80% of Vietnamese. On average, about one in five of AA small business owners and employees would be eligible for Medi-Cal and almost two in five AA small business owners and employees would be eligible for subsidized insurance.

- About 70% of Korean and 50% of Southeast Asian small business owners and employees who will be eligible for the expanded Medi-Cal coverage are currently uninsured.

- About half (51%) of Asian American small business owners and employees who are green card holders and eligible for expanded Medi-Cal coverage are uninsured.

- 90% of all Asian American small business owners and employees who will be eligible either for Medi-Cal or subsidized insurance are Limited English Proficient.

Table 2. Asian American Ethnic Subgroup Differences (CHIS, 2009)

	Owned or worked for small businesses	Eligible For Medi-Cal	Eligible For Subsidized Insurance	Higher Income
Chinese	40%	22%	33%	45%
Japanese	39%	7%	32%	61%
Korean	52%	17%	39%	44%
Filipino	30%	18%	44%	38%
South Asian	27%	7%	33%	60%
Vietnamese	47%	33%	45%	22%
Southeast Asian	46%	20%	42%	38%
Mixed Asian American	39%	23%	34%	43%

Note: "Eligible for Medi-Cal" = income up to 138% of Federal Poverty Level (FPL); "Eligible for Subsidized Insurance = income between 138% and 400% of FPL; Higher Income = income greater than 400% of FPL; "South Asian" includes Bangladeshi, Indian, Pakistani, and Sri Lankan; "Southeast Asian" includes Cambodian, Laotian, and Hmong.

2 With regard to immigration status, "Lawfully Present Immigrants" are eligible to enroll in the health insurance marketplaces and get subsidized insurance. However, current Federal law restricts their access to Medicaid coverage during their first 5 years in the U.S. Currently, there are 14 states, including California, that provide state-only Medicaid benefits for all legal immigrants during their first 5 years in the U.S. The Medicaid Program in California is called "Medi-Cal".

PART 2: SMALL BUSINESS FOCUS GROUPS

In order to identify barriers to enrollment facing AA and NHPI small business owners and employees, we organized a series of focus groups throughout California. The goals of the focus groups were to identify reasons for small business owners and employees being uninsured, determine their knowledge and opinions about the ACA, and find out if they felt that key provisions, such as tax credits and Medi-Cal expansion, would be helpful in getting health insurance for themselves or providing health insurance to employees.

Using U.S. Census and CHIS data, we identified California counties with AA and NHPI subgroups having high rates of uninsured individuals and high numbers of small business owners. Focus groups were scheduled for five counties with individuals representing the subgroups with high rates of uninsurance and small business ownership in that specific county. Focus group participants were small business owners or employees (in businesses with less than 50 employees). The specific ethnic communities for the focus groups are shown in Table 3.

We used APIAHF's network of community-based organizations to help recruit participants and help manage the focus groups. We organized separate groups for small business employers and small business employees whenever possible. For one location (Sacramento), we held one focus group consisting of both small business owners and employees.
Between March and May 2013, we conducted nine focus groups with approximately 70 individuals throughout California. During the focus groups, translation services were provided, if necessary. They were conducted in various locations, including community health centers and restaurants. The group facilitator welcomed the group, asked each participant to describe their business (if business owner) or what business they worked for and their role (if small business employee).

Table 3. Focus Group Demographics

Focus Group Type	County	Ethnicity	No Health Insurance (% Uninsured)
Hmong Employee	Fresno	Hmong	71%
Hmong Employer	Fresno	Hmong	29%
Korean Employee	Los Angeles	Korean	50%
Korean Employer	Los Angeles	Korean	14%
Pacific Islander Employer and Employee	Sacramento	Tongan, Fijian, Samoan	29%
South Asian Employee	Los Angeles	Bangladeshi, Indian, Pakistani	50%
South Asian Employer	Los Angeles	Nepalese	67%
Vietnamese Employee	Alameda	Vietnamese	38%
Vietnamese Employer	Alameda, Santa Clara	Vietnamese	None (All had health insurance)

Employers

- Many employers are covered by their spouse's plan or have another job (in addition to owning their business) so they can have insurance.
- Employers are confused about whether they are required to provide insurance under the ACA, and what the penalties are if they don't.
- Employers felt online resources would NOT be helpful (due to language, complexity of information, and computer literacy).
- Most employers felt that tax credits would **NOT** help them because they would not offset the cost of providing health insurance to their employees.

Employees

- Most small business employees had health insurance through Medi-Cal (California Medicaid) or were uninsured; most small business owners reported having private insurance.
- Employees expressed **concerns** that the new ACA rules for businesses may drive business owners to **pay employees less** or reduce their number of employees.
- Employees felt that online resources **WOULD** be helpful.
- Even with the new ACA subsidies, health insurance will still be too expensive for employees. Expanding Medi-Cal would be better.

As facilitators, APIAHF staff described some of the key provisions of the Affordable Care Act to participants and collected feedback from them about those provisions. Some of the questions we asked to both small business owners and employees included the following:

- Do you have health insurance? If so, what type of insurance do you have? If not, what are the reasons why you don't have insurance?
- What do you know about the Affordable Care Act (Health Reform, "Obamacare")?
- What sources are best for you to get more information about the Affordable Care Act?

For owners, we also asked the following questions:

- Do you provide insurance to your employees? Why or why not? What difficulties or barriers have you face in providing insurance? What are the major reasons for not providing insurance?
- What do you know about the tax credits for small business owners? After describing the tax credits available, we asked small business owners if they thought the credits would help and encourage them to provide insurance to employees.

We also talked to participants about provisions of expanded Medi-Cal, including coverage for single adults and families with incomes up to 138% of the Federal Poverty Level. At the end of the focus groups, we provided time for participants to ask any questions and provide additional feedback.

KEY FINDINGS FROM SMALL BUSINESS FOCUS GROUPS

- **Cost of coverage is the biggest barrier for obtaining insurance.** As expected, cost of coverage is the biggest reason for either not providing insurance coverage to employees, or not having coverage as an individual. In all employee focus groups, participants talked about the cost of insurance as the primary barrier to getting insurance. Many shared that they avoid seeking care as long as possible. Some mentioned that they pay out-of-pocket when they really need health care services, or seek alternative ways to resolve health problems, including traveling to other countries to get the care they need.

- **Immigration status prevents some individuals from seeking health insurance coverage and medical care in the U.S.** Some participants from both the small business employer and employee focus groups mentioned that undocumented immigrants in their communities are often scared to try to get health insurance and medical treatment due to fears of deportation and negative implications for their immigration status. Specifically, participants from the Pacific Islander, Korean, and South Asian employee focus groups indicated that the barriers of cost and immigration status have encouraged them and members of their community to travel to their home country or other foreign countries to get necessary health care services.

- **Many small business employers and employees have heard about the ACA, but know very little about its provisions.** The majority of participants across all the focus groups expressed that they did not know very much about provisions of the ACA. Some participants have heard about the coverage expansion, believed that businesses will be affected, and that insurance costs will increase. However, the majority of participants were unfamiliar with the specifics of what incentives are available and how small businesses will be affected. Some participants also said they do not have any information on the new law.

- **Many small business employers believe that the ACA requires them to provide insurance to their employees, which has led to their negative impression of health reform and belief that it will increase costs for small businesses.** In all employer focus groups, at least some of the individuals believed that they would now be required to provide insurance to employees, even if they only had a few employees. Very few knew that small businesses with less than 50 full-time equivalent employees are exempt from the requirement to provide insurance.

- **Small business owners and employees want specific details on cost of insurance and the amount of subsidies they would receive before deciding whether to provide insurance or purchase insurance through the health insurance marketplace.** Employees want details on the cost of premiums and how to obtain the insurance. Employers were very concerned about the financial impact to their business if they provide insurance to employees. Some participants felt the new provisions are targeting small business owners, creating an extra burden on top of their struggling businesses.

- **Both employers and employees indicated that Medi-Cal expansion would be helpful, but subsidized insurance through the health insurance marketplace may not help them get insurance coverage**. In both employer and employee focus groups, participants generally were in favor of the expansion of Medi-Cal to all individuals and families with incomes up to 138% of the Federal Poverty Level (FPL). They indicated that this expansion would be very helpful to them in getting access to health care. Others also expressed that while Med-Cal expansion would be helpful, the income eligibility criteria of 138% of FPL is too low and should be raised so more people will qualify. Participants talked about the high costs of living, their financial challenges as small business owners, and the high cost of health insurance. They talked about the appeal of Medi-Cal in being free and having some base level of health insurance coverage.

Many indicated that because their incomes are still very low (although more than 138% of FPL), they would still not be able to purchase insurance through the marketplace. While they like the idea of the government sharing in the cost of coverage, participants feared that monthly premiums would still be too expensive for them to purchase insurance.

- **Tax credits do not provide a strong enough incentive for most employers to provide insurance to their employees.** Many employers felt the tax credits would not be helpful. They indicated that the percentages offered back as tax credits would not be able to offset the cost of providing insurance to employees. Some participants also said they might not be eligible for tax credits, even if they provide insurance because their employees are often times family members. For the few that felt tax credits would be helpful, they said a tax credit is a small way to offset the financial burden of providing insurance to employees.

- **The preferred sources of information about the Affordable Care Act vary based on generation and ethnic group.** We informed participants about the Covered California website as a place to get more information about the ACA and the health insurance marketplace in California. The majority of first-generation immigrants (those who immigrated to the U.S. as an adult) did not think a website would be helpful for getting information or enrolling in health insurance coverage. Many do not feel comfortable using a computer, and would prefer getting information face-to-face from another person. They felt that in-person assistance would be more helpful because many need language assistance and want someone to explain the complicated information to them. First-generation immigrants (both employers and employees) also indicated that they would prefer getting information about the ACA and insurance coverage from ethnic media (newspapers, TV) in their own language, family members, community-based organizations, churches, community health centers, and faith-based organizations because they are trusted resources in their community. For second generation participants, (those born or raised in the U.S.), they indicated that a website is the best place to get information because of convenience and having one centralized location.

We observed some differences between ethnic subgroups in their preferences for getting information. For example, Korean small business owners preferred newspaper sources, while Pacific Islanders indicated that radio would be an effective means of information dissemination because of its broad use in their community and its easy accessibility. Vietnamese owners and employees reported that ethnic TV and weekly magazines would be the most effective sources of information.

Trusted information sources vary by age...

RECOMMENDATIONS

- **Targeted methods of outreach must be used to help the small business community understand the ACA.** For the AA and NHPI community, ethnic subgroup and generation are two key factors in determining resource allocation for outreach, what type of outreach will be most effective, and which targeted strategies must be used to provide accurate and useful information about the ACA. Federal, state, and local entities who engage in ACA outreach and education must be aware of these preferred methods if they want to be successful in getting AAs and NHPIs enrolled in health insurance coverage.

- **When engaging in outreach and education about the ACA to small business owners, individuals should be prepared to discuss the specific costs of providing insurance.** Small business owners need someone who can help determine their actual costs and calculating their full-time equivalent employees when deciding whether or not purchase insurance for employees through the SHOP health insurance marketplace. Whoever assists them in learning about insurance coverage options must be both a trusted resource and someone who can assist with cost analysis, such as trusted brokers or agents, community-based organizations that help small businesses, the Small Business Administration, or ethnic chambers of commerce.

- **Small business employers should be utilized as a key resource in leading employees to the individual health insurance marketplace to get coverage even if the employer chooses not to provide coverage.** The ACA does not require small businesses with less than 50 full-time equivalent employees to provide insurance coverage, and as there are many AA and NHPI small businesses that are sole proprietorships, family businesses, and very small businesses, many employers will choose not the provide it. However, many employees will be eligible to get subsidized health insurance through the individual health insurance marketplaces and small business owners can refer them here to learn about coverage options and get enrolled.

CONCLUSION

Our data and focus group analysis of the AA and NHPI small business community helped us confirm some expected findings and learn some new information. Our research supports the great need for access to health care for small business owners and employees. AA and NHPI small business owners and employees have higher rates of uninsurance, less access to and use of health care services, and are more likely to face language and immigration status barriers then those who work for larger businesses. In California, a significant number of AAs and NHPIs from all ethnic subgroups will be eligible for coverage through the Medi-Cal expansion or will qualify for subsidized insurance through Covered California. In order to do effective outreach to the AA and NHPI small business community about these new coverage opportunities, organizations and individuals involved in outreach and enrollment must address their misconceptions about the ACA, be prepared to assist small business owners with cost analysis, and provide clear and concise information through preferred and trusted sources.

"It will be helpful for those who don't have health insurance at all."

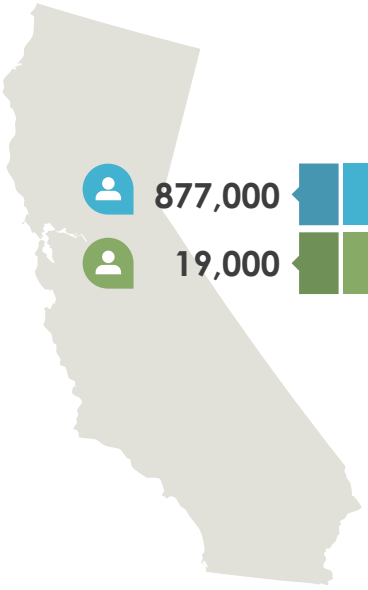
– Hmong Business Employer

"Even though I work hard, I feel excited because I know I will have healthcare"

– Vietnamese Employee

"In the big scheme of things, it's good policy to take care of uninsured individuals"

– Korean Employer



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Please find the full report of this Small Business study at:
http://bit.ly/ACASmallBusinessReport

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September 2013

An Early Look at Premiums and Insurer Participation in Health Insurance Marketplaces, 2014

Cynthia Cox, Gary Claxton, Larry Levitt, Hana Khosla

Under the Affordable Care Act (ACA), individuals and families may purchase private insurance coverage through new state-based exchanges (or "Marketplaces"), which are set to open in October of this year for coverage beginning January 1, 2014. In states that decide against operating their own exchanges, the federal government will either run the exchange or work in partnership with the state to create an exchange. Regardless of whether an exchange is state-run or federally-facilitated, enrollees with family incomes from one to four times the federal poverty level (about $24,000 to $94,000 for a family of four) may qualify for tax credits that will lower the cost of coverage through reduced premiums and, in some cases, also be eligible for subsidies to reduce their out-of-pocket costs. This report presents an early look at insurer participation and exchange premiums – both before and after tax credits – for enrollees in the 17 states plus the District of Columbia that have publicly released comprehensive data on rates or the rate filings submitted by insurers. These include eleven states operating their own exchanges and seven defaulting to a federally-facilitated exchange. Plan availability and premiums for all states are expected to be available by October 1.

HOW TO INTERPRET EXCHANGE PREMIUMS

Beginning in 2014, plans offered in the exchanges – along with coverage sold to individual and small businesses outside the exchanges – must meet several new regulatory requirements.[1] For example, insurers must cover a minimum set of services called essential health benefits and must organize their plan offerings into five levels of patient cost-sharing (catastrophic, bronze, silver, gold, and platinum, ranging from least to most protective). Also starting in 2014, insurers will be prohibited from denying coverage based on pre-existing conditions, and will be able to vary premiums only by age (to a limited extent), tobacco status, geographic region, and family size.

Exchange premiums reflect insurers' estimates of the cost of offering the new benefits to the people who are expected to enroll. The coverage that will be available to people in exchanges will differ from coverage now sold in the individual insurance market in several important ways. For example, plans will not be able to deny coverage or vary premiums based on health status; benefits will be extended in many cases to cover services typically now excluded, such as maternity and mental health; and reinsurance, risk adjustment and risk corridor programs will be in place to help compensate for the enrollment of high-cost individuals.[2]

These changes make direct comparisons of exchange premiums and existing individual market premiums complicated, and doing so would require speculative assumptions and data that are not publicly available. Therefore, we do not attempt to compare the exchange premiums to existing market rates in this report. (In a previous brief, we assessed the differences between how nongroup premiums are calculated before and after

2014.[3]) Additionally, most people buying their own insurance will qualify for premium tax credits, which will significantly lower the cost of their premiums.[4] The rate information presented below looks at the full premiums for coverage available through exchanges, and provides examples of how enrollee costs would be lowered with premium tax credits.

ANALYSIS OF EXCHANGE PLANS AND PREMIUMS

At the time of this report, 17 states and the District of Columbia have published insurance company rate filings that detail exchange premiums for 2014 or compilations of filings sufficient to present comparable information. Using these rate filings, we tracked insurer participation and plan offerings in the exchanges. We then calculated the unsubsidized premiums for enrollees of bronze and silver plans at various ages (25, 40, and 60 years old) in the rating area of the largest city in each of these 17 states and Washington, DC. (Note that rates may vary substantially across rating areas.) For each of the rating areas, we calculated the expected tax credit amounts for individuals and families at various income levels and show what premiums they would pay after taking into account those tax credits.

INSURER PARTICIPATION IN STATE EXCHANGES

There are at least two insurers participating in each of the exchanges in the rating areas that we analyzed, and three or more insurers participating in most of the areas.

Participating insurers generally will offer a number of plans at various tiers of coverage (catastrophic, bronze, silver, gold, or platinum), and they also typically offer more than one plan option within a given coverage tier. As a result, the number of plans available to consumers will be significantly greater than the number of insurers participating.

A variety of plan types (e.g., HMOs or PPOs) are offered in most exchanges. In almost all states coverage is also available to individuals outside of the exchange, offering additional competition in the market (though the market outside of exchanges is not addressed in this report).

Figure 1: Insurer Participation in Exchanges, 2014

	Statewide	Rating Area of Largest City		
State	Number of Insurers	Number of Insurers	Number of Silver Plans	Number of Bronze Plans
CA	12	6	8	9
CO	10	10	53	43
CT	3	3	4	8
DC	4	4	10	11
IN	4	2*	8*	15*
MD	6	6	n/a	n/a
ME	2	2	11	7
MT	3	3	8	6
NE	4	4	14	22
NM	5	5	8	7
NY	16	11	n/a	n/a
OH	12	10	30	27
OR	11	10	32	27
RI	2	2	4	3
SD	3	3	24	6
VA	9	7	15*	20*
VT	2	2	6	6
WA	4*	4*	11*	11*

Source: Kaiser Family Foundation
*Plan information not available for certain insurers. See methods for details.

The current individual insurance market is highly concentrated, with a single insurer dominating at least half the market in 30 states and the District of Columbia.[5] That is not likely to change immediately, though the ease of purchasing through exchanges and guaranteed access to coverage regardless of health status should make it easier for consumers to switch plans.

Exchange Premiums

Unsubsidized exchange premiums vary from state to state due to several factors, such as differences in the underlying cost of health care, market competition, and the effectiveness of state rate review programs at lowering premiums.[6] Exchanges also vary in their authority to negotiate premiums with insurers or exclude plans.[7] State tables in the Appendix of this report show the cost of silver and bronze premiums in the rating area of the largest city in each of the 17 states and Washington, DC. Premiums vary across the rating areas in each state, sometimes significantly. Within a given rating area for a given insurer, premiums will vary by the age of an individual, as well as family income and household size, which determine eligibility for tax credits.

Bronze plans (which cover 60 percent of health care costs when averaged across all enrollees) have the most cost-sharing and represent the lowest level of coverage generally available through exchanges.[8] As a consequence, they typically have the lowest premiums. Premiums for bronze plans vary significantly across the areas we analyzed. For example, the lowest cost bronze plan for a 40-year-old ranges from $146 in Baltimore, Maryland and $155 in Albuquerque, New Mexico to $308 in New York, New York and $336 in Burlington, Vermont. (Note that Vermont and New York, unlike the vast majority of states, do not allow premiums to vary at all by age and had prohibited insurers from denying coverage based on health status prior to the passage of the ACA. As a result, premiums in those states are currently much higher than the norm.)

Figure 2: Exchange Tax Credit Calculation

Exchange subsidies limit the percent of one's income that he or she must spend on a silver premium. The cap depends on the enrollee's income range (Figure 6).

- Maximum Amount Enrollee Pays for Benchmark Silver Premium = Cap (%) * Income

If the enrollee's unsubsidized premium is already less than their cap, he or she would not receive a subsidy.

- Tax Credit = Unsubsidized Benchmark Silver Premium – Maximum Amount Enrollee Pays for Silver Premium

Subsidized enrollees can apply their tax credit toward the purchase of other levels of coverage, such as bronze plans.

- Amount Enrollee Pays for Bronze Premium = Unsubsidized Bronze Premium – Tax Credit

For more on exchange subsidies, see the Kaiser Family Foundation's Subsidy Calculator, available at: *http://www.kff.org/interactive/subsidy-calculator/*

Silver plans have lower cost-sharing than bronze plans (covering an average of 70 percent of enrollees' health care costs on average), and will therefore generally have higher premiums. The lowest cost exchange silver exchange plan available range in cost for a 40-year-old from $194 per month in Portland, Oregon to $395 per month for a 40-year-old in Burlington, Vermont, before tax credits.

Figure 3: 2014 Monthly Premium for a Single 40-Year-Old at 250 Percent of Poverty ($28,725 per year)						
State	Largest City	Rating Area of Largest City	Second-Lowest-Cost Silver Plan Before Subsidies	Second-Lowest-Cost Silver Plan After Subsidies	Lowest Cost Bronze Plan Before Subsidies	Lowest Cost Bronze Plan After Subsidies
CA	Los Angeles	15	$255	$193	$188	$125
CO	Denver	3	$250	$193	$186	$129
CT	Hartford	2	$328	$193	$232	$97
DC	Washington DC	n/a	$242	$193	$166	$117
IN	Indianapolis	10	$295	$193	$250	$148
MD	Baltimore	1	$228	$193	$146	$111
ME	Portland	1	$295	$193	$235	$133
MT	Billings	1	$258	$193	$206	$141
NE	Omaha	1	$271	$193	$197	$119
NM	Albuquerque	1	$212	$193	$155	$136
NY	New York City	4	$390	$193	$308	$111
OH	Cleveland	11	$249	$193	$177	$121
OR	Portland	1	$201	$193	$165	$157
RI	Providence	n/a	$293	$193	$210	$110
SD	Sioux Falls	2	$264	$193	$239	$168
VA	Richmond	7	$253	$193	$170	$110
VT	Burlington	n/a	$413	$193	$336	$116
WA	Seattle	1	$283	$193	$213	$123

Source: Kaiser Family Foundation analysis of exchange rate filings. See methods section for detailed source information.

Figure 4: 2014 Monthly Premium for a Single 25-Year-Old at 250 Percent of Poverty ($28,725 per year)						
State	Largest City	Rating Area of Largest City	Second-Lowest-Cost Silver Plan Before Subsidies	Second-Lowest-Cost Silver Plan After Subsidies	Lowest Cost Bronze Plan Before Subsidies	Lowest Cost Bronze Plan After Subsidies
CA	Los Angeles	15	$200	$193	$147	$140
CO	Denver	3	$196	$193	$146	$142
CT	Hartford	2	$258	$193	$182	$117
DC	Washington DC	n/a	$180	$180	$124	$124
IN	Indianapolis	10	$232	$193	$196	$157
MD	Baltimore	1	$179	$179	$115	$115
ME	Portland	1	$232	$193	$185	$146
MT	Billings	1	$203	$193	$162	$152
NE	Omaha	1	$213	$193	$155	$135
NM	Albuquerque	1	$167	$167	$122	$122
NY	New York City	4	$390	$193	$308	$111
OH	Cleveland	11	$196	$193	$139	$136
OR	Portland	1	$158	$158	$130	$130
RI	Providence	n/a	$230	$193	$165	$127
SD	Sioux Falls	2	$207	$193	$188	$173
VA	Richmond	7	$199	$193	$134	$127
VT	Burlington	n/a	$413	$193	$336	$116
WA	Seattle	1	$222	$193	$167	$138

Source: Kaiser Family Foundation analysis of exchange rate filings. See methods section for detailed source information.

Figure 5: 2014 Monthly Premium for a Single 60-Year-Old at 250 Percent of Poverty ($28,725 per year)						
State	Largest City	Rating Area of Largest City	Second-Lowest-Cost Silver Plan Before Subsidies	Second-Lowest-Cost Silver Plan After Subsidies	Lowest Cost Bronze Plan Before Subsidies	Lowest Cost Bronze Plan After Subsidies
CA	Los Angeles	15	$541	$193	$398	$50
CO	Denver	3	$531	$193	$395	$57
CT	Hartford	2	$697	$193	$493	$0
DC	Washington DC	n/a	$521	$193	$357	$29
IN	Indianapolis	10	$626	$193	$531	$97
MD	Baltimore	1	$484	$193	$310	$19
ME	Portland	1	$626	$193	$499	$65
MT	Billings	1	$548	$193	$437	$82
NE	Omaha	1	$576	$193	$418	$36
NM	Albuquerque	1	$450	$193	$329	$72
NY	New York City	4	$390	$193	$308	$111
OH	Cleveland	11	$529	$193	$376	$40
OR	Portland	1	$427	$193	$350	$116
RI	Providence	n/a	$622	$193	$446	$16
SD	Sioux Falls	2	$561	$193	$508	$140
VA	Richmond	7	$537	$193	$361	$16
VT	Burlington	n/a	$413	$193	$336	$116
WA	Seattle	1	$601	$193	$452	$44

Source: Kaiser Family Foundation analysis of exchange rate filings. See methods section for detailed source information.

In the exchanges, the second-lowest-cost silver plan available in a rating area has special significance, since it will be the benchmark for calculating the premium tax credits that enrollees will receive (Figure 2). Tax credits work by setting a cap on the percent of an enrollee's income that he or she would need to spend on the second-lowest-cost silver plan available.

Before accounting for tax credits, the second-lowest-cost silver premium for a 40-year-old ranges from $201 in Portland, Oregon and $212 in Albuquerque, New Mexico to $390 in New York, New York and $413 in Burlington, Vermont.

Most of the people enrolling in nongroup plans through exchanges are expected to qualify for tax credits that will lower the amount they must pay for coverage, which means that most enrollees will pay a lower monthly premium than the unsubsidized rates presented above.[9] For example, a 40-year-old with an income of 250 percent of the federal poverty level (roughly $29,000 per year) would pay about 8 percent of his or her income or $193 per month to enroll in the second-lowest-cost silver plan, regardless of the rating area.

Differences from state to state in silver premiums generally level off after accounting for tax credits because the tax credit limits the amount enrollees must spend for coverage to a percentage of their income (as shown in Figure 3). Unsubsidized silver premiums for some younger enrollees may be so low as to fall below the income cap, meaning that these enrollees would not receive a tax credit even with income up to 400 percent of the poverty level, and would instead pay the full premium (for example, that is the case for a 25 year-old in several rating areas, as shown in Figure 4).

Enrollees eligible for premium tax credits can apply them toward the purchase of other levels of coverage, such as more expensive gold or platinum plans (which have lower levels of cost-sharing), or toward the purchase of a bronze plan, which would have a lower premium but also would leave the enrollee subject to higher cost-sharing.

While the enrollee premium after tax credits for the second-lowest-cost silver plan is quite similar across rating areas due to the way in which the tax credits are calculated, the cost of bronze coverage varies quite a bit from region to region. The lowest cost bronze premium for a 40-year-old at 250 percent of poverty ranges from as little as $97 per month in Hartford, Connecticut to $168 per month in Sioux Falls, South Dakota after accounting for premium tax credits. This represents the lowest amount that people would generally be required to pay to meet the so-called "individual mandate." However, by enrolling in a bronze plan, people with

Figure 6: Premium and Cost-Sharing Subsidies, by Income in 2014

Income *(% Poverty)*	**Premium Cap** *(% of income on 2nd lowest silver)*	**Cost-Sharing Subsidies?** *(OOP Limit Indiv./Family)*	
Under 100%	No Cap	No	($6,350 / $12,700)
100% - 133%	2.0%	Yes	($2,250 / $4,500)
133% - 150%	3% - 4%	Yes	($2,250 / $4,500)
150% - 200%	4% - 6.3%	Yes	($2,250 / $4,500)
200% - 250%	6.3% - 8.05%	Yes	($5,200 / $10,400)
250% - 300%	8.05% - 9.5%	No	($6,350 / $12,700)
300% - 400%	9.5%	No	($6,350 / $12,700)
Over 400%	No Cap	No	($6,350 / $12,700)

Source: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 Final Rule

incomes up to 250 percent of the poverty level would forego cost-sharing subsidies, which only apply to silver plans (Figure 6).

The Appendix presents detailed premium information before and after tax credits for sample individuals and families for each rating area that we examined.

DISCUSSION

As open enrollment in the exchanges begins October 1, 2013 for coverage starting in 2014, premium information for all states will soon become available. Exchange websites are expected to present unsubsidized premiums for each plan, and are also required to have a subsidy calculator so that low and middle income enrollees can determine how tax credits will affect what they will actually pay for coverage.

This report – based on 17 states and the District of Columbia that have made data publicly available – provides a preview of how premiums will vary across the country, and how much consumers in different circumstances will actually pay after taking into account the tax credits available under the ACA.

While premiums will vary significantly across the country, they are generally lower than expected. For example, we estimate that the latest projections from the Congressional Budget Office imply that the premium for a 40-year-old in the second lowest cost silver plan would average $320 per month nationally.[10] Fifteen of the eighteen rating areas we examined have premiums below this level, suggesting that the cost of coverage for consumers and the federal budgetary cost for tax credits will be lower than anticipated.

APPENDIX: STATE EXCHANGE PREMIUMS

CALIFORNIA (LOS ANGELES)

State Exchange Overview

- 12 insurers participating in exchange (statewide)
- 6 insurers offering coverage in rating area 15 (Los Angeles)
- 8 silver plans offered in rating area 15 (Los Angeles)
- 9 bronze plans offered in rating area 15 (Los Angeles)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums California Rating Area 15 (Los Angeles)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Health Net of California – Standard Copay Silver 008	$176	$224	$475
California Physicians Service, d.b.a. Blue Shield of CA– Standard Coinsurance Silver 003	$200	$255	$541
Lowest Cost Bronze Plan			
L.A. Care Health Plan – Standard Coinsurance Bronze 004	$147	$188	$398

Monthly Premiums Before and After Tax Credits California Rating Area 15 (Los Angeles)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$200	$763	$1,082
Tax Credit	$56	$354	$932
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$147	$562	$797
Lowest Cost Bronze Plan After Tax Credit	$91	$208	$0

COLORADO (DENVER)

State Exchange Overview

- 10 insurers participating in exchange (statewide)
- 10 insurers offering coverage in rating area 3 (Denver)
- 53 silver plans offered in rating area 3 (Denver)
- 43 bronze plans offered in rating area 3 (Denver)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Colorado Rating Area 3 (Denver)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Kaiser Foundation Health Plan of Colorado— KP CO Silver 1750/25%/HSA	$192	$245	$520
Humana Health Plan Inc.— Humana Connect Silver 4600/6300 Plan	$196	$250	$531
Lowest Cost Bronze Plan			
Kaiser Foundation Health Plan of Colorado— KP CO Bronze 5000/30%/HSA	$146	$186	$395

Monthly Premiums Before and After Tax Credits Colorado Rating Area 3 (Denver)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$196	$748	$1062
Tax Credit	$52	$339	$912
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$146	$557	$790
Lowest Cost Bronze Plan After Tax Credit	$94	$218	$0

CONNECTICUT (HARTFORD)

State Exchange Overview

- 3 insurers participating in exchange (statewide)
- 3 insurers offering coverage in rating area 2 (Hartford)
- 4 silver plans offered in rating area 2 (Hartford)
- 8 bronze plans offered in rating area 2 (Hartford)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Connecticut Rating Area 2 (Hartford)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
ConnectiCare Benefits, Inc.— Standard Silver - 70%	$248	$316	$671
Anthem Health Plans, Inc, d.b.a. Anthem Blue Cross and Blue Shield of Connecticut— 86545CT1330001 Silver	$258	$328	$697
Lowest Cost Bronze Plan			
Anthem Health Plans, Inc, d.b.a. Anthem Blue Cross and Blue Shield of Connecticut— 86545CT1230001 Bronze	$182	$232	$493

Monthly Premiums Before and After Tax Credits Connecticut Rating Area 2 (Hartford)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$258	$982	$1,393
Tax Credit	$114	$573	$1,243
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$182	$695	$985
Lowest Cost Bronze Plan After Tax Credit	$69	$122	$0

District of Columbia (Washington, DC)

State Exchange Overview

- 4 insurers participating in exchange (district-wide)
- 10 silver plans offered in Washington, DC*
- 11 bronze plans offered in Washington, DC

**DC has a single rating area that applies to the entire district, but some plans may only be available in certain regions within the district*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Washington, DC			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
CareFirst BlueChoice, Inc.— BlueChoice HSA Silver $1300	$177	$238	$512
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.— KP DC Silver 1750/25%/HSA/Dental	$180	$242	$521
Lowest Cost Bronze Plan			
CareFirst BlueChoice, Inc.— BlueChoice HSA Bronze $6000	$124	$166	$357

Monthly Premiums Before and After Tax Credits Washington, DC			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$180	$845	$1,042
Tax Credit	$36	$435	$892
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$124	$580	$962
Lowest Cost Bronze Plan After Tax Credit	$87	$144	$70

INDIANA (INDIANAPOLIS)

State Exchange Overview

- 4 insurers participating in exchange (statewide)
- At least 2 insurers offering coverage in rating area 10 (Indianapolis) *
- At least 8 silver plans offered in rating area 10 (Indianapolis) *
- At least 15 bronze plans offered in rating area 10 (Indianapolis) *

**One insurer, MDwise, was excluded because its filing did not include rating areas*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Indiana Rating Area 10 (Indianapolis)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Physicians Health Plan of Northern Indiana, Inc.– Silver Copay 2500/70%	$229	$291	$618
Physicians Health Plan of Northern Indiana, Inc.– Silver HSA 3500/100%-E	$232	$295	$626
Lowest Cost Bronze Plan			
Physicians Health Plan of Northern Indiana, Inc.– Bronze HSA 6000/100%-E	$196	$250	$531

Monthly Premiums Before and After Tax Credits Indiana Rating Area 10 (Indianapolis)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$232	$883	$1,253
Tax Credit	$88	$474	$1,103
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$196	$748	$1,062
Lowest Cost Bronze Plan After Tax Credit	$109	$275	$0

MARYLAND (BALTIMORE)

State Exchange Overview

- 6 insurers participating in exchange (statewide)
- 6 insurers offering coverage in rating area 1 (Baltimore)
- Number of silver plans offered in rating area 1 (Baltimore) not available*
- Number of bronze plans offered in rating area 1 (Baltimore) not available*

**Maryland rate tables do not include specific plan details.*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Maryland Rating Area 1 (Baltimore)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
BlueChoice, Inc d.b.a. CareFirst BlueCross BlueShield – BlueChoice Plus Silver $2500	$168	$214	$454
BlueChoice, Inc d.b.a. CareFirst BlueCross BlueShield – BlueChoice HSA Silver $1300	$179	$228	$484
Lowest Cost Bronze Plan			
BlueChoice, Inc d.b.a. CareFirst BlueCross BlueShield – BlueChoice HSA Bronze $6000	$115	$146	$310

Monthly Premiums Before and After Tax Credits Maryland Rating Area 1 (Baltimore)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$179	$683	$968
Tax Credit	$35	$273	$818
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$115	$437	$620
Lowest Cost Bronze Plan After Tax Credit	$80	$164	$0

MAINE (PORTLAND)

State Exchange Overview

- 2 insurers participating in exchange (statewide)
- 2 insurers offering coverage in rating area 1 (Portland)
- 11 silver plans offered in rating area 1 (Portland)
- 7 bronze plans offered in rating area 1 (Portland)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Maine Rating Area 1 (Portland)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Maine Community Health Options – Community Value-0140001	$222	$283	$601
Maine Community Health Options – Community Choice-0040001	$232	$295	$626
Lowest Cost Bronze Plan			
Anthem Healthplans of Maine, Inc. – Anthem Bronze Guided Access – caaa	$185	$235	$499

Monthly Premiums Before and After Tax Credits Maine Rating Area 1 (Portland)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$232	$883	$1,253
Tax Credit	$88	$474	$1,103
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$185	$704	$998
Lowest Cost Bronze Plan After Tax Credit	$97	$230	$0

MONTANA (BILLINGS)

State Exchange Overview

- 3 insurers participating in exchange (statewide)
- 3 insurers offering coverage in rating area 1 (Billings)
- 8 silver plans offered in rating area 1 (Billings)
- 6 bronze plans offered in rating area 1 (Billings)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Montana Rating Area 1 (Billings)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
PacificSource Health Plans – SmartHealth Balance Silver 2500	$197	$251	$533
PacificSource Health Plans – SmartHealth Value Silver 3600	$203	$258	$548
Lowest Cost Bronze Plan			
Montana Health Co-op – Connected Care Bronze	$162	$206	$437

Monthly Premiums Before and After Tax Credits Montana Rating Area 1 (Billings)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$203	$772	$1,096
Tax Credit	$59	$363	$946
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$162	$617	$875
Lowest Cost Bronze Plan After Tax Credit	$103	$254	$0

NEBRASKA (OMAHA)

State Exchange Overview

- 4 insurers participating in exchange (statewide)
- 4 insurers offering coverage in rating area 1 (Omaha)
- 14 silver plans offered in rating area 1 (Omaha)
- 22 bronze plans offered in rating area 1 (Omaha)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Nebraska Rating Area 1 (Omaha)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Blue Cross Blue Shield – Select Blue Plus $1500 HDHP Silver	$201	$256	$544
Coventry – Silver $10 Copay HMO Methodist Health Partners	$213	$271	$576
Lowest Cost Bronze Plan			
Blue Cross Blue Shield – Select Blue Plus $4750 HDHP Bronze	$155	$197	$418

Monthly Premiums Before and After Tax Credits Nebraska Rating Area 1 (Omaha)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$213	$811	$1,151
Tax Credit	$69	$402	$1,001
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$155	$590	$837
Lowest Cost Bronze Plan After Tax Credit	$86	$188	$0

New Mexico (Albuquerque)

State Exchange Overview

- 5 insurers participating in exchange (statewide)
- 5 insurers offering coverage in rating area 1 (Albuquerque)
- 8 silver plans offered in rating area 1 (Albuquerque)
- 7 bronze plans offered in rating area 1 (Albuquerque)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums New Mexico Rating Area 1 (Albuquerque)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Health Care Service Corporation – Blue Community HMO – Silver	$148	$189	$401
Molina Healthcare of New Mexico – HMO Silver	$167	$212	$450
Lowest Cost Bronze Plan			
Health Care Service Corporation – Blue Community HMO – Bronze	$122	$155	$329

Monthly Premiums Before and After Tax Credits New Mexico Rating Area 1 (Albuquerque)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$167	$635	$900
Tax Credit	$22	$225	$750
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$122	$464	$658
Lowest Cost Bronze Plan After Tax Credit	$99	$239	$0

New York (New York City)

State Exchange Overview

- 16 insurers participating in exchange (statewide)
- 11 insurers offering coverage in rating area 4 (NYC)
- Number of silver plans offered in rating area 4 (NYC) not available*
- Number of bronze plans offered in rating area 4 (NYC) not available*

**New York rate tables do not include specific plan details.*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums New York Rating Area 4 (New York City)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Metro Plus – Metro Plus Silver	$359	$359	$359
New York Fidelis – New York Fidelis Silver	$390	$390	$390
Lowest Cost Bronze Plan			
New York Fidelis – New York Fidelis Bronze	$308	$308	$308

Monthly Premiums Before and After Tax Credits New York Rating Area 4 (New York City)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$390	$1,112	$780
Tax Credit	$246	$702	$630
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$308	$878	$616
Lowest Cost Bronze Plan After Tax Credit	$62	$176	$0

OHIO (CLEVELAND)

State Exchange Overview

- 12 insurers participating in exchange (statewide)
- 10 insurers offering coverage in rating area 11 (Cleveland)
- 30 silver plans offered in rating area 11 (Cleveland)
- 27 bronze plans offered in rating area 11 (Cleveland)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Ohio Rating Area 11 (Cleveland)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Kaiser Foundation Health Plan of Ohio – 2014 KP OH Silver HSA $1,750	$185	$235	$499
CareSource – CareSource Just4me Healthcare with Heart 77552OH0010074	$196	$249	$529
Lowest Cost Bronze Plan			
Kaiser Foundation Health Plan of Ohio – 2014 KP OH Bronze HSA $5000/30%	$139	$177	$376

Monthly Premiums Before and After Tax Credits Ohio Rating Area 11 (Cleveland)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$196	$745	$1,058
Tax Credit	$52	$336	$908
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$139	$530	$752
Lowest Cost Bronze Plan After Tax Credit	$88	$194	$0

OREGON (PORTLAND)

State Exchange Overview

- 11 insurers participating in exchange (statewide)
- 10 insurers offering coverage in rating area 1 (Portland)
- 32 silver plans offered in rating area 1 (Portland)
- 27 bronze plans offered in rating area 1 (Portland)

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Oregon Rating Area 1 (Portland)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Moda Health Plan, Inc. – Be Aligned - Rose City	$152	$194	$412
Moda Health Plan, Inc. – Be Aligned	$158	$201	$427
Lowest Cost Bronze Plan			
Moda Health Plan, Inc. – Be Savvy	$130	$165	$350

Monthly Premiums Before and After Tax Credits Oregon Rating Area 1 (Portland)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$158	$602	$854
Tax Credit	$14	$192	$704
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$130	$494	$701
Lowest Cost Bronze Plan After Tax Credit	$116	$302	$0

RHODE ISLAND (PROVIDENCE)

State Exchange Overview

- 2 insurers participating in exchange (statewide)
- 4 silver plans offered in Rhode Island*
- 3 bronze plans offered in Rhode Island*

  ** Rhode Island has a single rating area that applies to the entire state, but some plans may only be available in certain regions within the state*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Rhode Island			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Blue Cross & Blue Shield of Rhode Island – VantageBlue SelectRI Direct 3000	$214	$272	$578
Blue Cross & Blue Shield of Rhode Island – VantageBlue Direct 3000	$230	$293	$622
Lowest Cost Bronze Plan			
Blue Cross & Blue Shield of Rhode Island – BlueSolutions for HSA Direct 5000	$165	$210	$446

Monthly Premiums Before and After Tax Credits Rhode Island			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$230	$877	$1,244
Tax Credit	$86	$468	$1,095
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$165	$629	$892
Lowest Cost Bronze Plan After Tax Credit	$79	$161	$0

South Dakota (Sioux Falls)

State Exchange Overview

- 3 insurers participating in exchange (statewide)*
- 3 insurers offering coverage in rating area 2 (Sioux Falls)
- 24 silver plans offered in rating area 2 (Sioux Falls)
- 6 bronze plans offered in rating area 2 (Sioux Falls)

**Dakotacare is included in the count of insurers and plans but was excluded from rate analysis*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums South Dakota Rating Area 2 (Sioux Falls)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Avera Health Plans – Avera MyPlan HSA $3,500	$198	$252	$535
Avera Health Plans – Avera MyPlan $2,500 / $6,350 Out-of-Pocket	$207	$264	$561
Lowest Cost Bronze Plan			
Sanford Health Plan – Bronze	$188	$239	$508

Monthly Premiums Before and After Tax Credits South Dakota Rating Area 2 (Sioux Falls)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$207	$790	$1,121
Tax Credit	$63	$381	$971
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$188	$716	$1,015
Lowest Cost Bronze Plan After Tax Credit	$124	$335	$44

VIRGINIA (RICHMOND)

State Exchange Overview

- 9 insurers participating in exchange (statewide)
- 7 insurers offering coverage in rating area 7 (Richmond)
- 15 silver plans offered in rating area 7 (Richmond)*
- 20 bronze plans offered in rating area 7 (Richmond)*

** Piedmont Community Healthcare was excluded because its filing did not include metal tiers*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Virginia Rating Area 7 (Richmond)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Coventry Health Care of Virginia, Inc. – Silver $10 Copay POS Bon Secours	$181	$230	$488
HealthKeepers, Inc. – Anthem HealthKeepers Silver Direct Access - cbau	$199	$253	$537
Lowest Cost Bronze Plan			
Coventry Health Care of Virginia, Inc. – Bronze Deductible Only HMO HSA Eligible Bon Secours	$134	$170	$361

Monthly Premiums Before and After Tax Credits Virginia Rating Area 7 (Richmond)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$199	$757	$1,075
Tax Credit	$55	$348	$925
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$134	$509	$722
Lowest Cost Bronze Plan After Tax Credit	$79	$161	$0

VERMONT (BURLINGTON)

State Exchange Overview

- 2 insurers participating in exchange (statewide)
- 6 silver plans offered in Vermont*
- 6 bronze plans offered in Vermont*

  ** Vermont has a single rating area that applies to the entire state, but some plans may only be available in certain regions within the state*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Vermont			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
BlueCross BlueShield of Vermont – Non-Standard Plan – Silver	$395	$395	$395
BlueCross BlueShield of Vermont – Standard Plan - Silver High Deductible	$413	$413	$413
Lowest Cost Bronze Plan			
MVP Health Plan Inc. – Bronze Standard Non-High Deductible	$336	$336	$336

Monthly Premiums Before and After Tax Credits Vermont			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$413	$1,161	$826
Tax Credit	$269	$751	$676
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$264	$944	$672
Lowest Cost Bronze Plan After Tax Credit	$0	$193	$0

WASHINGTON (SEATTLE)

State Exchange Overview

- 4 insurers participating in exchange (statewide)*
- 4 insurers offering coverage in rating area 1 (Seattle)*
- 11 silver plans offered in rating area 1 (Seattle)*
- 11 bronze plans offered in rating area 1 (Seattle)*

**Washington is considering approval of additional insurers, not included in this report*

Exchange Premiums

Unsubsidized Lowest Cost Silver and Bronze Monthly Premiums Washington Rating Area 1 (Seattle)			
	Age 25	Age 40	Age 60
Two Lowest Cost Silver Plans			
Group Health Cooperative – Core Silver	$221	$281	$597
Premera Blue Cross – Multi State Plan Premera Blue Cross Preferred Silver 2500 HSA	$222	$283	$601
Lowest Cost Bronze Plan			
Group Health Cooperative – Core Bronze	$167	$213	$452

Monthly Premiums Before and After Tax Credits Washington Rating Area 1 (Seattle)			
	Single Adult 25-Year-Old $25,000 Income (218% FPL)	Family of Four Two 40-Year-Old Adults $60,000 Income (255% FPL)	Couple Two 60-Year-Old Adults $30,000 Income (193% FPL)
Total Premium for Second-lowest-cost Silver Plan	$222	$847	$1,202
Tax Credit	$78	$438	$1,052
Second-lowest-cost Silver Premium After Tax Credit	$144	$409	$150
Lowest Cost Bronze Plan Before Tax Credit	$167	$638	$905
Lowest Cost Bronze Plan After Tax Credit	$89	$200	$0

METHODS

Premium data were collected from health insurer rate filing submitted to state regulators. These submissions are publicly available for the states we analyzed and can be found on the state websites listed below. Most rate information is available in the form of a SERFF filing (System for Electronic Rate and Form Filing) that includes a base rate and other factors that build up to an individual rate. In states where original filings were unavailable, we gathered data from tables released by state insurance departments. With some exceptions, exchange rates presented in this report are final. Nebraska and New Mexico rates available publicly are pending state review. Washington rates included in this report are approved; however, the state is currently considering approval of additional insurers not included in this report.

Filings with sufficient information to calculate premiums were not publicly available in Maryland and New York, and tables provided those states did not provide specific product information. New York rates presented in this report may represent averages of multiple plans offered by the insurer, and the actual rates for the lowest cost bronze and silver plans may be lower than what is presented here. The Maryland Department of Insurance separately provided us with the filings for the three lowest-cost insurers in the Baltimore area (BlueChoice Inc., CareFirst of Maryland Inc., and Group Hospitalization & Medical Services Inc.).

Three insurers were excluded from the rate analysis due to incomplete filing information: Dakotacare in South Dakota did not provide adequate information on the rating areas or metal tiers; MDwise in Indiana did not specify rating areas; and Piedmont Community Healthcare in Virginia did not provide metal tiers. While rates could not be calculated, these carriers were included in the total count of insurers and plans where possible.

SOURCES

State	URL
California	http://wpso.dmhc.ca.gov/ratereview/ https://interactive.web.insurance.ca.gov/apex/f?p=102:4:0::NO
Colorado	http://cdn.colorado.gov/cs/Satellite?c=Page&childpagename=DORA-HealthIns%2FDORALayout&cid=1251643290088&pagename=CBONWrapper http://cdn.colorado.gov/cs/Satellite/DORA-HealthIns/CBON/DORA/1251627738584
Connecticut	http://www.catalog.state.ct.us/cid/portalApps/RateFilingDefault.aspx
District of Columbia	http://disb.dc.gov/sites/default/files/dc/sites/disb/publication/attachments/FinalIndividualRates71913.pdf http://disb.dc.gov/page/health-insurance-rate-review-district
Indiana	http://www.in.gov/idoi/HFAI.htm
Maryland	http://www.mdinsurance.state.md.us/sa/consumer/md-health-connection-plans.html

Maine	http://www.maine.gov/pfr/insurance/ACA/PDF/Individual_Exchange_Plans.pdf http://www.maine.gov/pfr/insurance/PPACA/HFAI.htm#
Montana	http://www.csi.mt.gov/news/2013/08162013_MarketplacePrices.asp
Nebraska	http://www.doi.nebraska.gov/aca/consumer/aca-info/index.html#nebraska-rates-are-online
New Mexico	http://nmhealthratereview.com/attachments/PrintFormat_NMHI_2014.pdf
New York	http://www.dfs.ny.gov/about/press2013/pr1307171_health_rates_2014.pdf
Ohio	http://www.insurance.ohio.gov/Company/Pages/RecordsRequest.aspx
Oregon	http://www.oregonhealthrates.org/files/app_portland_individual.pdf
Rhode Island	http://www.ohic.ri.gov/2013%20Rate%20Factor%20Review.php
South Dakota	http://dlr.sd.gov/insurance/consumers/consumer_documents/exchange_rates_nonsmokers_v2_40.pdf http://apps.sd.gov/applications/CC57SERFFPortal/basicsearch.aspx
Virginia	http://www.scc.virginia.gov/boi/SERFFInquiry/LHAccessPage.aspx
Vermont	http://www.dfr.vermont.gov/insurance/preliminary-rate-filings-vermont-health-connect http://healthconnect.vermont.gov/sites/hcexchange/files/Vermont%20Health%20Connect%20Plan%20Designs%20with%20Final%20Rates_updated%208.23.13.pdf
Washington	http://www.insurance.wa.gov/health-rates/Search.aspx

ENDNOTES

1 Congressional Research Service "Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)" January 3, 2011, http://assets.opencrs.com/rpts/R41166_20110103.pdf

2 "Reinsurance, Risk Corridors, and Risk Adjustment Final Rule" Center for Consumer Information and Oversight (CCIIO) Centers for Medicare and Medicaid Services (CMS) Department of Health and Human Services (HHS), March 2012, http://www.cms.gov/CCIIO/Resources/Files/Downloads/3rs-final-rule.pdf

3 Kaiser Family Foundation "Why Premiums Will Change for People who have Nongroup Insurance" February 6, 2013, http://kff.org/health-reform/perspective/why-premiums-will-change-for-people-who-now-have-nongroup-insurance/

4 "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act" Congressional Budget Office (CBO) November 30 2009, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf

5 Kaiser Family Foundation "How Competitive are State Insurance Markets?" October 2011, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf

6 Kaiser Family Foundation "Quantifying the Effects of Health Insurance Rate Review" October 2012 http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8376.pdf Kaiser Family Foundation

7 "State Statutory Authority to Review Health Insurance Rates, Individual Plans" Kaiser Family Foundation http://www.kff.org/other/state-indicator/rate-review-individual/

8 Catastrophic plans will be sold on the exchanges, but will only be available to people who are under 30 years old or would have to spend more than 8 percent of their household income on a bronze plans.

9 "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision" Congressional Budget Office (CBO) July 2012

10 The methods for arriving at this estimate can be found on the Kaiser Family Foundation Subsidy Calculator, (available here: http://www.kff.org/interactive/subsidy-calculator/). The calculator is based on Congressional Budget Office (CBO) projections from July 2012 (Available here: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf)

By Thomas Buchmueller, Colleen Carey, and Helen G. Levy

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ANALYSIS & COMMENTARY

Will Employers Drop Health Insurance Coverage Because Of The Affordable Care Act?

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ABSTRACT Since the passage of the Affordable Care Act, there has been much speculation about how many employers will stop offering health insurance once the act's major coverage provisions take effect. Some observers predict little aggregate effect, but others believe that 2014 will mark the beginning of the end for our current system of employer-sponsored insurance. We use theoretical and empirical evidence to address the question, "How will employers' offerings of health insurance change under health reform?" First, we describe the economic reasons why employers offer insurance. Second, we recap the relevant provisions of health reform and use our economic framework to consider how they may affect employers' offerings. Third, we review the various predictions that have been made about those offerings under health reform. Finally, we offer some observations on interpreting early data from 2014.

Since the passage of the Affordable Care Act, there has been much speculation about how many employers will stop offering health insurance to their workers once the major coverage provisions of the act—health insurance exchanges, premium tax credits for low-income families, individual and employer mandates, and the Medicaid expansion—take effect. Speculation has only increased since the recent announcement by the Department of the Treasury that the implementation of the employer penalty for not offering insurance will be delayed until 2015.[1]

The response of employers to health reform is important for several reasons. First, a reduction in employer coverage might increase federal outlays if it led to more workers' receiving premium tax credits in the exchanges or enrolling in Medicaid. Second, if the employers that dropped coverage had relatively less healthy workers, that change would worsen the exchange risk pool and drive up average premiums as a result. Finally, the Affordable Care Act was presented to the American public as a reform that would not seriously disrupt existing employer-sponsored coverage. To the approximately 170 million Americans who have such coverage[2] and are for the most part satisfied with it,[3] a large-scale dropping of coverage by employers would be an unwelcome surprise.

Some observers predict that health reform will have relatively little aggregate effect on employer-sponsored coverage. Others believe that 2014 will mark the beginning of the end for our current system of employer-sponsored health insurance. This disagreement, which we describe more fully below, is driven at least in part by fundamental differences in assumptions about employers' behavior. To put it more simply, what you think about how health reform will affect employer-sponsored coverage depends on why you think employers provide insurance in the first place.

We will soon have early data on employers' health insurance offerings for 2014. Making sense of these data—determining whether it is business as usual or the beginning of the end—will require an underlying model of how employers respond to incentives in choosing a menu of

employee benefits.

We address the question, "How will employers' offerings of health insurance change under health reform?" from multiple perspectives. First, we briefly describe economic models of why employers offer insurance and how they might respond to the changes that health reform brings. Second, we recap the relevant provisions of health reform and use our economic framework to consider how they are likely to affect employers' offerings. Third, we review the various predictions that have been made about employers' behavior. Finally, we offer some observations on what to look for as early data for 2014 begin to come in.

The Economics Of Employer Health Insurance

Employers are not currently required to provide health insurance, yet most of them do: Nearly 80 percent of full-time workers are eligible for employer-sponsored coverage.[4] The economic explanation for this is threefold: Employers have a comparative advantage in providing health insurance; workers bear the cost of health insurance through lower wages; and employers' benefit offerings reflect, albeit imperfectly, workers' demand for coverage.

EMPLOYERS' COMPARATIVE ADVANTAGE IN PROVIDING HEALTH INSURANCE There are three reasons why employer-sponsored insurance tends to be a better deal than coverage in the individual market. First, employer-sponsored health insurance premiums are not subject to federal or state income taxes or the Social Security payroll tax. For a typical worker in the 15 percent tax bracket, the tax exclusion reduces the cost of insurance by roughly one-third.[5] For higher-income workers, the subsidy is even greater. Research has shown that this subsidy increases the likelihood that small firms will offer insurance and leads employers of all sizes to provide more generous coverage than they would otherwise do.[6,7]

Second, employers' provision of insurance mitigates adverse selection. Workers at a large firm constitute an effective risk pool, with premiums from the healthy subsidizing expenditures on the sick and aggregate medical claims that are fairly predictable from one year to the next. In contrast, adverse selection in the individual market greatly limits the availability of coverage.

Third, since administrative and marketing costs are relatively fixed, employers enjoy significant economies of scale. For a large group, the "loading factor" per enrollee—which includes profits and any risk premium in addition to administrative and marketing costs—may be as little as half of what it would be for individually purchased insurance.[8]

WORKERS' FORGONE WAGES FUND HEALTH INSURANCE Economists are in near-unanimous agreement that workers ultimately pay for health insurance through lower wages,[9–11] unless minimum wages are a binding constraint.[12] The logic is that employers care about the cost of total compensation, not how compensation is split between wages and benefits; therefore, they will offer insurance only if they can adjust wages to keep total compensation constant. Because of the cost advantages just described, workers who want health insurance will find this trade-off to be a good deal, particularly if the marginal tax rate on earned income is high. There is considerable empirical evidence of a compensating wage differential for health insurance.[13–16]

EMPLOYERS' OFFERINGS REFLECT WORKERS' PREFERENCES Not all workers want health insurance so much that they are willing to trade off the amount of wages required to pay for it. And even among workers who do want insurance enough to make that trade-off, some will want more generous coverage than others. Because of both practical considerations and federal nondiscrimination rules, employers generally cannot tailor health benefits to the preferences of each individual worker.[17,18] Instead, they must balance the preferences of workers who have a strong demand for insurance against those of workers who are less willing to trade wages for benefits, although it is not entirely clear how employers do this.[19–21] Firms may also tailor employees' premium contribution requirements or the scope of benefits in response to diversity in workers' demand for insurance.[22]

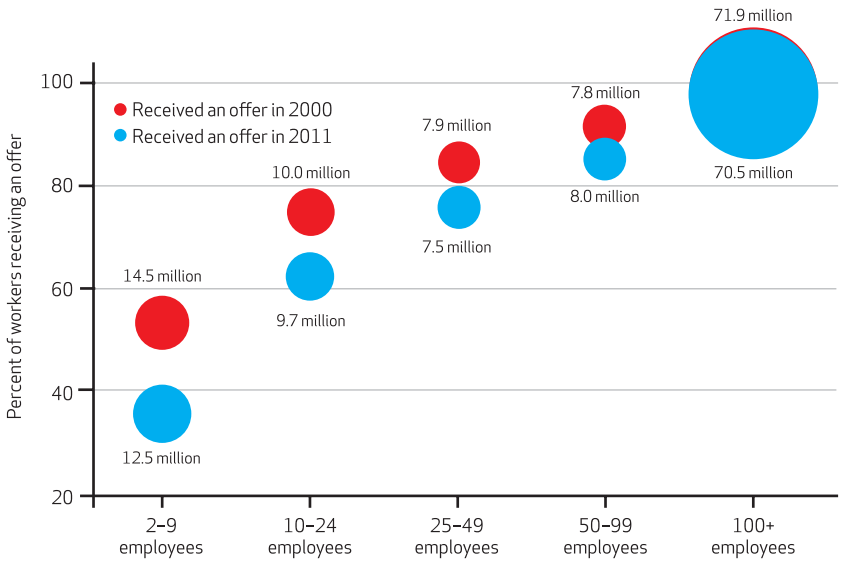
Clearly, the problem is simpler for employers whose workers who are similar to one another in their demand for insurance than for employers with a more diverse workforce. However, depending on the nature of their business, firms may need to hire workers who are diverse in this respect.

The advantages afforded to employer-sponsored insurance explain why most Americans receive their health coverage through the workplace. Nonetheless, as increases in health care costs have outpaced wage and price inflation, employer-sponsored coverage has declined.[23]

Exhibits 1 and 2 illustrate three features of the current insurance market landscape that are important for understanding the potential impact of the Affordable Care Act on employer-sponsored coverage. First, the size of the circles highlights a fundamental feature of the labor market: Although most firms are very small—roughly 60 percent of all private-sector employ-

EXHIBIT 1

Percentage Of Private-Sector Workers Receiving Offers Of Health Insurance, By Firm Size, 2000 And 2011



SOURCE Authors' analysis of data from the Medical Expenditure Panel Survey, Insurance Component.
NOTE The size of the bubbles indicates the number of workers.

ers have fewer than ten employees—nearly two-thirds of private-sector workers are employed at firms with more than a hundred employees. This means that the aggregate effect of the Affordable Care Act on employer-sponsored insurance will depend disproportionately on the decisions made by large employers and their workers.

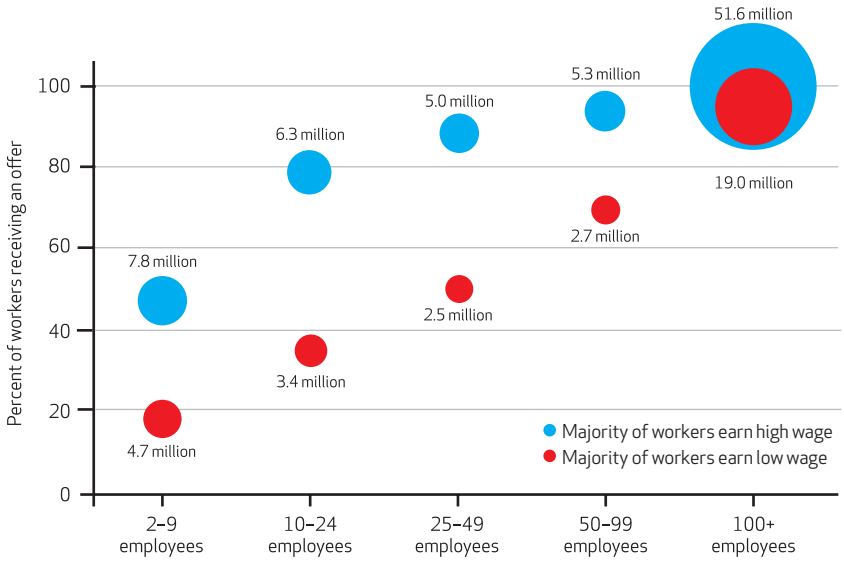
Second, because both administrative economies of scale and the benefits of risk pooling increase with group size, there is a strong positive relationship between a firm's size and whether it offers insurance. Only 36 percent of workers in firms with fewer than ten employees are offered coverage, compared to more than 96 percent of workers in firms with fifty or more employees (Exhibit 1). Part of this difference is likely due to the fact that small employers do not enjoy the economies of scale and risk pooling that large employers do: In these respects, the market for small-group coverage is characterized by some of the same problems as the market for individual coverage. Exhibit 1 also shows that although large firms' rates of offering insurance have been stable, the rates have dropped for small firms.

Third, if firm size is held constant, there is a strong relationship between employees' wages and whether employers offer insurance (Exhibit 2). For all firms except those in the largest size category, workers at high-wage firms are much more likely to be offered coverage than those working at low-wage firms.

The relationship between wages and whether an employer offers insurance is driven in part by the tax exclusion for employer premiums, which offers greater tax savings to higher-income workers. Other work has documented the regressive nature of this tax expenditure.[24]

EXHIBIT 2

Percentage Of Private-Sector Workers Receiving Offers Of Health Insurance, By Firm Size And Majority Wage Level, 2011



SOURCE Authors' analysis of data from the Medical Expenditure Panel Survey, Insurance Component.
NOTES The size of the bubbles indicates the number of workers. High wage is $11.50 per hour or more. Low wage is less than $11.50 per hour.

Relevant Provisions Of The Affordable Care Act

With these facts in mind, we now consider which provisions of the Affordable Care Act are likely to affect employers' decisions about whether or not to offer insurance. First, however, we note that employers may respond to these provisions in other ways. Firms may change employees' premium contribution requirements, adjust how generous the plan or plans they offer are, offer more or fewer plans, or change their policies about which workers are eligible for coverage. We have not attempted to consider these relatively marginal decisions here, focusing instead on the bottom-line decision—whether or not to offer insurance at all—which has been the focus of most policy attention.

Exhibit 3 presents the provisions of the Affordable Care Act that are most relevant to employers' health insurance offerings. Although we do not attempt to predict the impact that all of these provisions will have on employer offering—that would, in effect, replicate the work of

EXHIBIT 3

Major Affordable Care Act Provisions Affecting Employers' Health Insurance Offerings

Provision	Effect
AFFECTING EMPLOYERS DIRECTLY	
Employer penalty: Employers with 50 or more full-time workers face a penalty if any of their full-time workers qualifies for a premium tax credit. If the firm does not offer coverage at all, the penalty is $2,000 for each full-time worker beyond the first 30. If the firm offers coverage that is not affordable, the penalty is the lesser of (1) $3,000 for each full-time worker who receives a credit or (2) $2,000 for each full-time worker in the firm beyond the first 30.[a]	More offerings from large firms
Small business exchange: Small employers (those with fewer than 50 full-time workers) can get coverage through the Small Business Health Options Program (SHOP exchange). Between 2014 and 2016, states may choose to allow employers with 50 to 100 workers to get coverage in the SHOP exchange; in 2017 and later, they may choose to allow employers of any size to get coverage in the SHOP exchange. As of 2014 in some states and 2015 in others, a small employer may designate a menu of insurance options for employees.	More offerings from small firms
Small business tax credit: Employers with fewer than 25 employees and average annual wages below $50,000 are eligible for a premium tax credit to offset the cost of coverage for up to 2 years. The maximum credit is now 35 percent; it will rise to 50 percent in 2014. In 2014 and later, coverage must be purchased through a SHOP exchange.	More offerings from small, low-wage firms
AFFECTING DEMAND FOR EMPLOYER-SPONSORED INSURANCE	
Health insurance exchanges with community rating and guaranteed issue: Exchanges should, in theory, provide a viable alternative to employer-sponsored insurance since they capture the "economies of scale" and "risk pooling" advantages that employers have. In practice, this will depend on what the exchange risk pool looks like.	Fewer offerings from firms with many low-income workers
Premium tax credits: Premium tax credits are available to workers without access to affordable employer-sponsored coverage (*affordable* meaning that the worker's share of the premium for single coverage does not exceed 9.5 of the worker's income).	Fewer offerings from firms with many low-income workers
Medicaid expansion: In some states all people with incomes below 138% of the federal poverty level will become eligible for Medicaid.	Fewer offerings from firms with many low-income workers
Individual mandate: Individuals who lack coverage for more than 3 months in a year face a penalty that is phased in between 2014 and 2016. The penalty is the greater of $285 or 1% of family income in 2014, $975 or 2% of family income in 2015, and $2,085 or 2.5% of family income in 2016 and after. Exemptions apply in the case of hardship, families with incomes below the tax filing threshold, Indians, and certain religious groups.	More offerings

SOURCE Authors' analysis. [a]This penalty was originally scheduled to take effect in 2014, but the Department of the Treasury recently announced that it will not be implemented until 2015 (see Note 1 in text).

the microsimulation models discussed in the next section—some general observations come from the simple economic understanding of firms' behavior that is outlined above.

We begin by noting that the provisions affecting employers directly—some of which affect only large firms (those with fifty or more full-time employees) and some of which affect only small firms—all increase the likelihood that firms will offer coverage. Consider first the effect of requiring large employers to offer affordable coverage to their full-time workers. As noted above, nearly all firms large enough to face this penalty already offer coverage. The small minority of large firms that do not currently offer it will face a choice of either offering coverage (and presumably reducing wages to compensate for their added costs) or paying the penalty.

For a typical full-time employee (working forty hours per week, fifty weeks per year) a $2,000 penalty raises the employer's cost by $1 per hour (although the per employee cost is reduced by the fact that the penalty does not apply to an employer's first thirty employees). Some large employers that do not now offer insurance may decide that it is worthwhile to do so. Others will decide to pay the penalty instead. Still others will find ways to appear to be small employers in order to avoid the penalty, perhaps by reducing their workers' hours below the Affordable Care Act's definition of *full time* (thirty hours per week) or by converting employees to contractors.

For small employers, who face no penalty for not offering coverage, the cost of offering it is reduced by both the small business tax credit and the Small Business Health Options Program, which creates insurance marketplaces—called SHOP exchanges—intended to give small employers the administrative efficiencies and risk pooling long enjoyed by large employers.

Offsetting these incentives for employers to offer insurance is the fact that with one exception—the individual mandate—the indirect pro-

visions listed in Exhibit 3 largely decrease workers' demand for employer-sponsored coverage. The provisions have this effect because they create viable alternatives to such coverage that cost low-income workers less.

The net effect of these new alternatives on employers' incentive to offer coverage depends on the characteristics of a given firm and its workforce.[25] In particular, for low-income workers, the benefit of exchange coverage subsidized by premium tax credits will exceed the value of the tax exclusion associated with employer-sponsored coverage, while for high-income workers the opposite will be true. Linda Blumberg and coauthors have identified 250 percent of the federal poverty level as the threshold at which the value of this tax credit will (on average) exceed the value of the tax exclusion for employer-sponsored insurance,[26] although the calculation will depend on household circumstances, employee contributions, and plan parameters.

Since subsidized exchange coverage will be available only for lower-income workers without access to affordable employer-sponsored coverage, some lower-income workers who wanted employer coverage in the past will prefer not to be offered it, since it would stand between them and a generous tax credit. For employers that are already balancing the varied demands of different workers in deciding whether or not to offer coverage, this may tip the balance and lead them to decide against offering coverage. Or it may not.

The individual mandate, as noted above, should increase workers' demand for employer-sponsored coverage. Indeed, the fact that employers' offerings actually increased after reform was implemented in Massachusetts has largely been credited to the fact that workers want to avoid paying tax penalties.[27–30] This "crowd in" effect for some workers potentially offsets the reduction in others' demand for employer-sponsored coverage.

Projected Effect Of Health Reform On Employers' Offerings

These competing incentives make it difficult to predict how employers and employees will respond to health reform. It is particularly hard to predict how small employers will respond to the new incentives under the Affordable Care Act. On the one hand, the factors just described reduce small employers' cost of offering coverage relative to what it is now. On the other hand, these employers will not face penalties for not offering coverage, and to the extent that their workers will be able to obtain affordable coverage through the exchanges, they do not necessarily need to offer coverage to attract workers. As noted above, however, the decisions of large employers will drive the aggregate impact of the Affordable Care Act on the offering of employer-sponsored insurance.

In light of this theoretical uncertainty, two main approaches have been used to estimate how the number of Americans with employer-sponsored insurance will change after the Affordable Care Act has been fully implemented. The most widely cited estimates—including that of the Congressional Budget Office (CBO), which calculates the legislation's budgetary "score"—are based on a microsimulation methodology.[31,32] The second approach is to ask employers directly about how, if at all, their decisions concerning health insurance are likely to change in 2014 and beyond.

MICROSIMULATIONS Microsimulation models combine data from nationally representative surveys with the best evidence from the research literature to predict how families, employers, and insurers will respond to policies that alter their incentives.[33,34] The models used to simulate the effects of health reform are based on the conventional economic theory summarized above, although details vary across models.

Employers are assumed to set their compensation policies to attract and retain the desired number and type of employees, who implicitly pay for employer-sponsored insurance through reduced wages. Employers' and employees' behavior is modeled in the context of key institutional features of the system, such as federal nondiscrimination rules that essentially prohibit firms from offering benefits to some full-time workers but not others. Insurance premiums, which are a key input in these decisions, are assumed to depend on the expected medical costs of the people who are insured and on market regulations, such as those concerning guaranteed issue and community rating.

In addition to the CBO, organizations that have conducted microsimulation analyses include the Urban Institute,[35,36] the RAND Corporation,[37] the Lewin Group,[38] and the Office of the Actuary of the Centers for Medicare and Medicaid Services.[39] Given the number of assumptions that must be made and the complexity of the models, it is not surprising that different models yield different results. However, it is clear that even with different assumptions, the various models tell a similar story (Exhibit 4).

Consistent with the economic logic discussed above, the models predict that the Affordable Care Act will cause little change in the number of Americans covered by employer-sponsored health insurance. The estimates range from a

EXHIBIT 4

Estimates Of The Impact Of The Affordable Care Act On Health Insurance Coverage For Nonelderly Americans

Coverage source	Percent covered in 2011	Impact (percentage points) according to estimate from: CBO/JCT	RAND	Urban Institute	Lewin Group	CMS
EMPLOYER						
Traditional	58.3	—[a]	−10.1	−7.9	−4.7	—[a]
SHOP	0.0	—[a]	13.0	7.7	3.7	—[a]
Total	58.3	−1.8	2.9	−0.2	−1.0	−0.5
INDIVIDUAL						
Traditional	7.1	−1.1	−6.1	−4.3	−2.8	−5.6
Exchange	0.0	8.4	11.9	8.6	10.0	11.3
Total	7.1	7.3	5.8	4.3	7.1	5.7
OTHER						
Medicaid/CHIP	17.6	5.8	4.3	6.2	4.9	7.3
Other insurer[b]	6.9	—[a]	0.0	0.0	0.0	0.0
Uninsured	17.9	−11.3	−12.3	−10.4	−10.9	−11.7

SOURCES (1) Congressional Budget Office. CBO and JCT's estimates of the effects of the Affordable Care Act on the number of people obtaining employment-based health insurance (Note 32 in text). (2) Buettgens M, et al. America under the Affordable Care Act (Note 36 in text). (3) Eibner C, et al. Establishing state health insurance exchanges: implications for health insurance enrollment, spending, and small businesses (Note 37 in text). (4) Lewin Group. Patient Protection and Affordable Care Act (PPACA) (Note 38 in text). (5) Foster RS. Estimated financial effects of the "Patient Protection and Affordable Care Act," as amended (Note 39 in text). (6) DeNavas-Walt C, et al. Income, poverty, and health insurance coverage in the United States (Note 2 in text). **NOTES** Each microsimulation compared the situation under implementation of the Affordable Care Act to continuation of the status quo. However, the studies simulate the act's effect in different years. The exhibit shows estimates for 2019 for Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) and the Office of the Actuary in the Centers for Medicare and Medicaid Services CMS), which presented estimates for several years. Different assumptions governed how quickly the act's effects were realized and how coverage trended in the status quo. Although all microsimulations included the major market reforms and coverage incentives of the act, they differed somewhat in their inclusion of smaller provisions, such as the extension of parents' policies to adult children up to age twenty-five. Although the Congressional Budget Office (Note 42 in text) and the Urban Institute (Note 43 in text) have issued new estimates reflecting updated policies, we used their older estimates because those are more comparable to the policy assumptions used by RAND, the Lewin Group, and CMS. The Lewin Group and CMS simulated insurance coverage for the full US population, including the elderly, but we attributed all changes to the nonelderly population. The changes by type of coverage do not add up to the reduction in uninsured because some people will have more than one type of coverage. SHOP is Small Business Health Options Program. CHIP is Children's Health Insurance Program. [a]Not available. [b]Includes Medicare and military-related insurance.

1.8-percentage-point decline to a 2.9-percentage-point increase. These estimates represent the net effect: Some workers and their dependents will gain coverage, while others will move from employer-sponsored coverage to other categories.

These modest effects stand in contrast to a prediction by the American Action Forum that forty-three million workers will lose access to employer coverage.[40] We believe that a critical assumption drives this difference: Most microsimulation models assume that in deciding whether or not to offer coverage, employers aggregate their workers' demand for health insurance as described above.

In contrast, the estimate of the American Action Forum appears to assume that employers offer insurance to those who want it and withhold it from those who do not. That withholding could happen only if employers ignored federal nondiscrimination regulations or dramatically restructured themselves so that workers with low demand for employer-based insurance were isolated in separate firms or in part-time or temporary jobs. In addition, the forum's estimate overstates the number of workers with incomes of less than 250 percent of the federal poverty level who currently have employer-sponsored coverage, and it fails to include any offsetting increases in employer coverage as a result of factors such as the individual mandate.

Because there is substantial uncertainty associated with projecting the effects of any policy, especially one as far-reaching as health reform, modelers typically conduct sensitivity analyses, varying key behavioral assumptions. For example, in a 2012 report the CBO discussed how alternative assumptions about employers' responsiveness to employees' preferences and employers' willingness to restructure their firms affected the CBO's results.[32]

The most important finding that has emerged from this sensitivity testing is that even when alternative assumptions yield divergent estimates of the number of workers with employer-sponsored insurance, they produce similar esti-

mates of overall insurance coverage and of the federal budgetary cost of the coverage provisions. The main reason for this latter result is that greater enrollment in the exchanges entails greater spending on premium tax credits along with both lower tax expenditures for premiums and increased revenue from employer penalties.

The estimates summarized in Exhibit 4 pertain to the Affordable Care Act as enacted in March 2010. Recent developments—such as states' declining to expand Medicaid eligibility and the one-year delay in the enforcement of the employer mandate—are not reflected in them, since most researchers have not released updated estimates. As of this writing, only the CBO has released updated estimates to reflect the fact that not all states will expand Medicaid: The CBO assumed that 30 percent of those otherwise eligible for Medicaid would reside in states that do not fully expand eligibility and would instead enroll in the exchanges or be uninsured.[41]

Both the CBO and the Urban Institute recently modeled the impact of the delay in implementing the employer mandate. The CBO[42] expects that approximately one million fewer people will be in employer-sponsored insurance in 2014 than if the employer mandate had gone into effect in January 20014. In contrast, the Urban Institute finds "almost no" effect on rates of coverage.[43] These findings reinforce our view that rates of employer-sponsored coverage are driven by the business case for benefits for the firm's workers.

SURVEYS OF EMPLOYERS Two caveats apply to interpreting survey evidence on firms' behavior. First, because most firms are small but most employees work for large firms, it can be difficult to translate estimates of the number of firms that will add or drop coverage into corresponding numbers of individuals affected. Second, surveys of employers currently offering insurance—the sampling frame of the surveys described below—will miss offsetting increases from firms just beginning to offer benefits and therefore cannot predict net changes in coverage.

With those caveats noted, we found that the results of a number of surveys were consistent with the predictions from microsimulation models. Most surveys suggest that most employers offering health insurance now will continue to offer it in 2014 and that the vast majority of people enrolled in employer-sponsored insurance will continue to use that coverage next year.

In one 2012 survey, 9 percent of large firms currently offering insurance—representing 3 percent of the workforce—said that they anticipated dropping coverage in the next three years, which is an estimate consistent with the microsimulation estimates of gross flows from employer-based coverage.[44] In a 2013 survey, 98 percent of very large firms (those with more than 1,000 employees, which account for about half of the workforce) said that they expected health benefits to be an important component of compensation three to five years from now.[45]

These survey results suggest that reports of the demise of employer-sponsored coverage soon after the passage of the Affordable Care Act[46] may have reflected a lack of awareness of its true effects on employers' incentives. The International Foundation of Employee Benefit Plans has surveyed plans repeatedly since the act became law.[47,48] During the past two years, the foundation reports, fewer employers have taken "a 'wait-and-see' approach," and more employers have "modeled the financial impact of reform."[48] In the same period, the share of employers reporting that they will definitely offer coverage in 2014 jumped from 46 percent to 69 percent.

At the same time, employers continue to report uncertainty about various provisions of the Affordable Care Act. In March 2013, 84 percent of employers reported that they were still studying the act.[48] Only two-thirds of large employers said that they were "familiar" with the shared-responsibility penalty.[44] As firms see the act's provisions in action, they may explore new health insurance options. Among firms with 50–100 employees, 71 percent reported that they would be more likely to participate in the SHOP exchanges if a large choice of plans were available at the employer's targeted benefit level.[44]

Summing Up And Looking Ahead

For an employer, deciding whether or not to offer health insurance already requires a complex calculus that takes into account a host of factors—including employees' preferences, wages, taxes, and regulations. The Affordable Care Act throws new taxes, subsidies, requirements, and insurance markets into the mix. But it does not fundamentally change the economics of the firm's decision. Microsimulation models built on sound economic principles have for the most part predicted relatively small declines in employer-sponsored coverage as a result of health reform, and we believe that these predictions are likely to be correct.

If we are wrong, though, how will we know? Inevitably, reports will come in that some employers are dropping coverage. Although it will be tempting to attribute such reported changes to the Affordable Care Act, it is important to interpret new data on employer-sponsored coverage in the context of the basic economics of firms' behavior and preexisting trends. The combination of rising health care costs and stagnant

earnings for middle-income workers has for decades led to a gradual but steady decline in employer-sponsored insurance. This trend is the appropriate baseline against which to measure the impact of health reform.

It is, perhaps, stating the obvious to add a caution against reading too much into anecdotal reports. But for reasons described above, even surveys with large samples can produce results that are difficult to interpret. Fortunately, there are several high-quality data sources that will be useful for monitoring changes in employer-sponsored insurance and drawing inferences about the effect of health reform.

We expect that the earliest data on rates of coverage will come in September 2014, when both the National Health Interview Survey and the Current Population Survey should report on individuals' sources of coverage in early 2014. If historical patterns hold, the Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey will be published the same month. In September 2015 the American Community Survey will provide state and metropolitan-area estimates of individual-level coverage patterns, and in July 2015 the Medical Expenditure Panel Survey will provide further information on employer offerings.

Of course, effects in early 2014 will not be the last word, as individuals and employers may take a wait-and-see approach. And since the employer penalty for not offering coverage will not take effect until 2015, it may be several years before the true effects of health reform on employer-sponsored insurance become evident.

However, these data will begin to answer the question posed in the title of our article. Given the historical importance of employer-sponsored insurance, the attention that is paid to this question is understandable. However, it is not a question of great economic significance. There is no efficiency argument for preferring private insurance facilitated by employers to private insurance facilitated by the state or any other mechanism that could be used to pool risk and achieve administrative economies of scale.

It is also important to remember that relying on firms as a mechanism for pooling insurance risk generates efficiency costs because it distorts the labor market. A better-functioning individual health insurance market has the potential to improve labor-market efficiency by reducing job lock, and thus eliminating a barrier to entrepreneurship and making it easier for workers to find a job and an insurance plan that matches their preferences. If the shift from employer-sponsored insurance to individual coverage is greater than projected, these labor-market gains may be substantial. ■

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