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Realizing Health Reform's Potential:

Small Businesses and the Affordable Care Act of 2010

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Abstract: The Patient Protection and Affordable Care Act (ACA) includes several short- and long-term provisions designed to help small businesses pay for and maintain health insurance for their workers, and to allow workers without employer coverage to gain access to affordable, comprehensive health insurance. Provisions include a small business tax credit to offset premium costs for firms that offer coverage starting this taxable year, establishment of state-based insurance exchanges that promise to lower administrative costs and pool risk more broadly, and creation of new market rules and an essential benefit standard to protect small firms and their workers. Analysis shows that up to 16.6 million workers are in firms that would be eligible for the tax credit in 2010 to 2013. Over the next 10 years, small businesses and organizations could receive an estimated $40 billion in federal support through the premium credit program.

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BACKGROUND

Job-based health insurance is the primary way most Americans under age 65 get their health coverage. In 2008, more than 60 percent of the nonelderly population held employer-sponsored insurance.[1] While this system does a good job of providing coverage for many working Americans, it is not a fail-proof approach—some employees and employers fall through the cracks. The new health reform law contains provisions to make coverage more affordable for both businesses and employees.

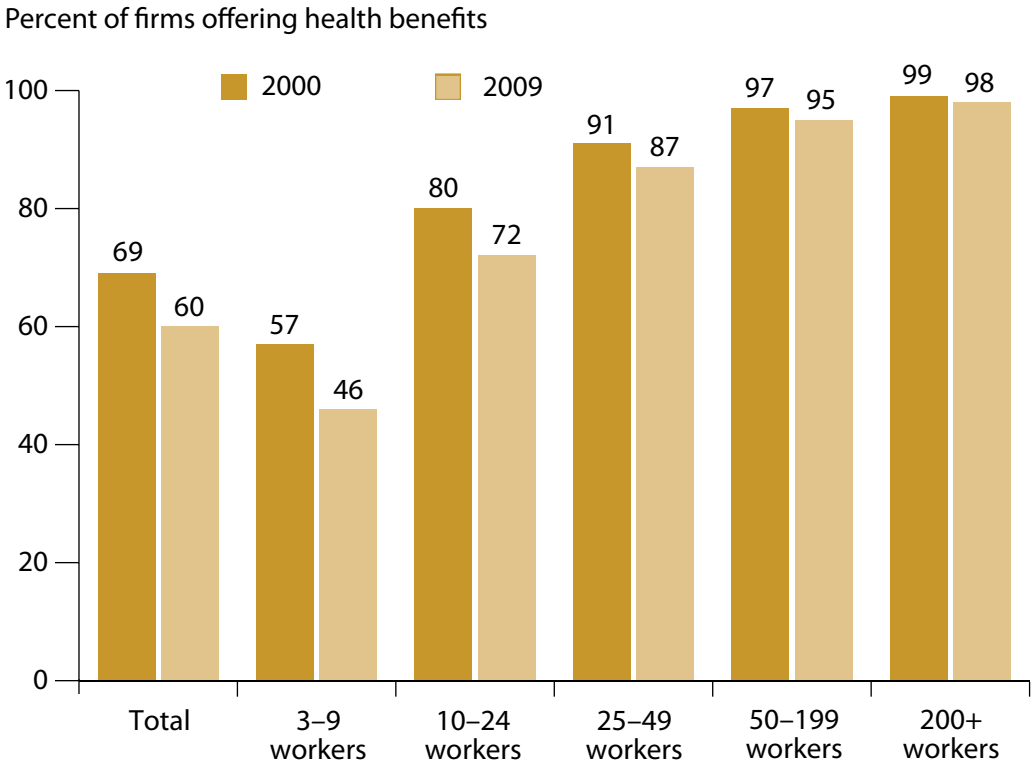
Coverage for employees in small businesses—i.e., those with 50 or fewer employees—has been especially problematic. Small firms face higher premiums than larger firms for comparable benefits.[2] As a result, small firms are less likely to offer coverage. Ninety-eight percent of firms with 200 or more workers report offering health benefits, but less than half of those with fewer than 10 employees do (Exhibit 1).[3] Further, employment-based health insurance has eroded in the past decade, with nearly all the attrition occurring in firms with fewer than 200 employees. An analysis of the 2007 Commonwealth Fund Biennial Health Insurance Survey shows that more than 70 percent of employees working in large

firms had adequate health insurance, compared with less than half of those in small firms (Exhibit 2).[4]

The substantial differential in costs between large and small firms is driven by higher administrative costs, greater per-employee costs of offering coverage, and underwriting in many states that can lead to more costly premiums for sicker, older, or female-dominated workforces.[5] On average, small firms pay up to 18 percent more in premiums than large firms do for the same health insurance policy.[6] In these plans, a higher share of the premiums is used for administration, marketing, insurance broker commissions, underwriting, and other overhead costs of the insurance carrier (Exhibit 3).[7]

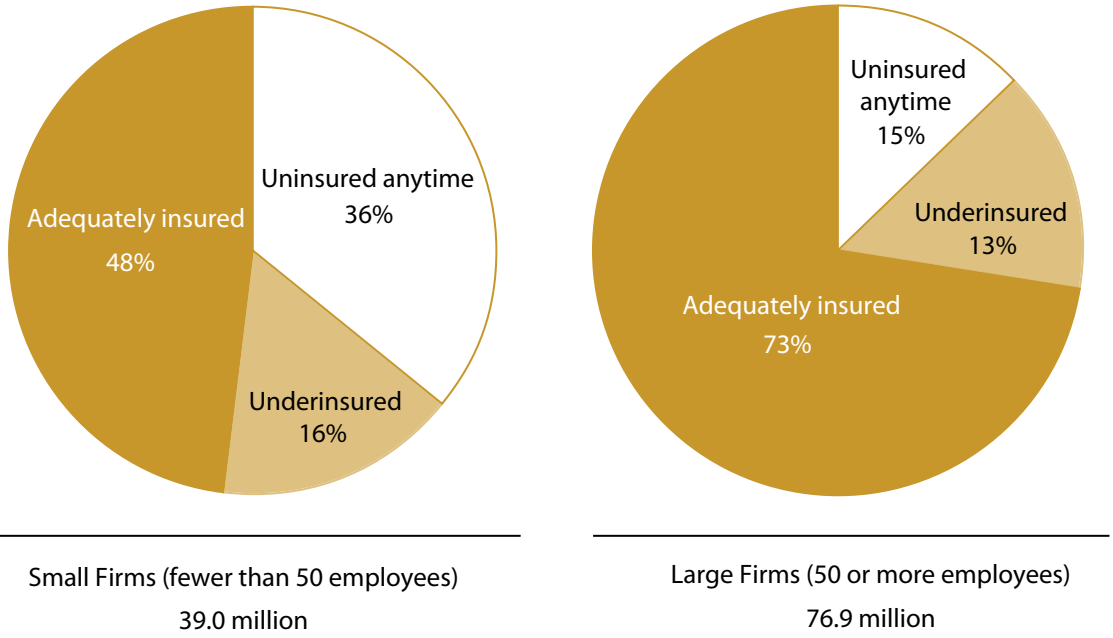
Workers who lack coverage through their jobs have few affordable options for health insurance. Those who look for coverage in the individual market often find it either unavailable or unaffordable. Nearly 70 percent of small-firm workers who attempted to buy coverage on the individual market found it difficult or impossible and never bought a plan (Exhibit 4).[8]

Exhibit 1. Employer Coverage Continues to Be Major Source of Coverage for Employees of Larger Firms



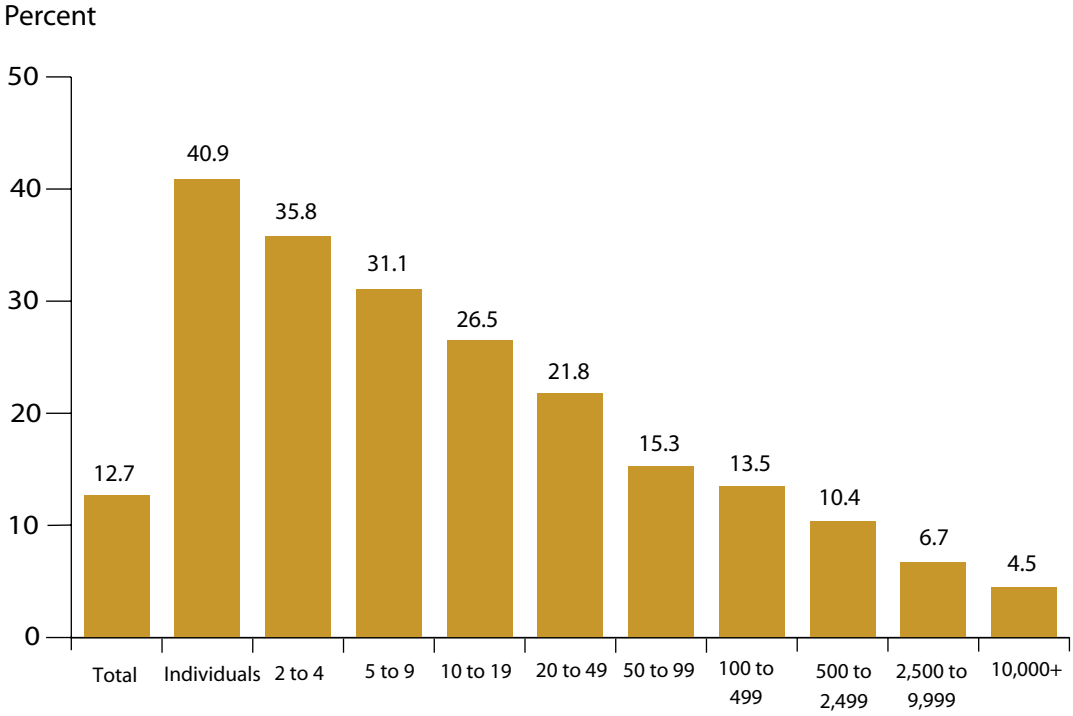
Data: Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits,* 2000 and 2009 Annual Surveys.

Exhibit 2. More Than Half of Working Adults in Small Firms Were Uninsured or Underinsured During the Year, 2007



Notes: Includes both part-time and full-time workers. Underinsured is defined as having continuous health insurance coverage and spending 10 percent or more of income on out-of-pocket health care costs (or 5 percent or more if low income), or having deductibles of 5 percent or more of income.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

Exhibit 3. Cost of Administering Health Insurance as a Percentage of Claims by Group Size



Data: Estimates by The Lewin Group for The Commonwealth Fund.
Source: Commonwealth Fund Commission on a High Performance Health System, *The Path to a High Performance U.S. Health System: A 2020 Vision and the Policies to Pave the Way* (New York: The Commonwealth Fund, Feb. 2009).

Exhibit 4. The Individual Insurance Market Is Not an Affordable Option for Small-Firm Workers

Working adults ages 19–64 in firms with <50 employees:	
Has individual coverage or tried to buy it in past three years	38%
Among those:	
Found it very difficult or impossible to find coverage they needed	44
Found it very difficult or impossible to find affordable coverage	57
Were turned down, charged a higher price, or had a specific health problem excluded from coverage	33
Any of the above	69
Never bought a plan*	69

Note: Includes both part-time and full-time workers.
* Among those who tried to buy a plan.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2007).

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: PROVISIONS AFFECTING SMALL BUSINESSES

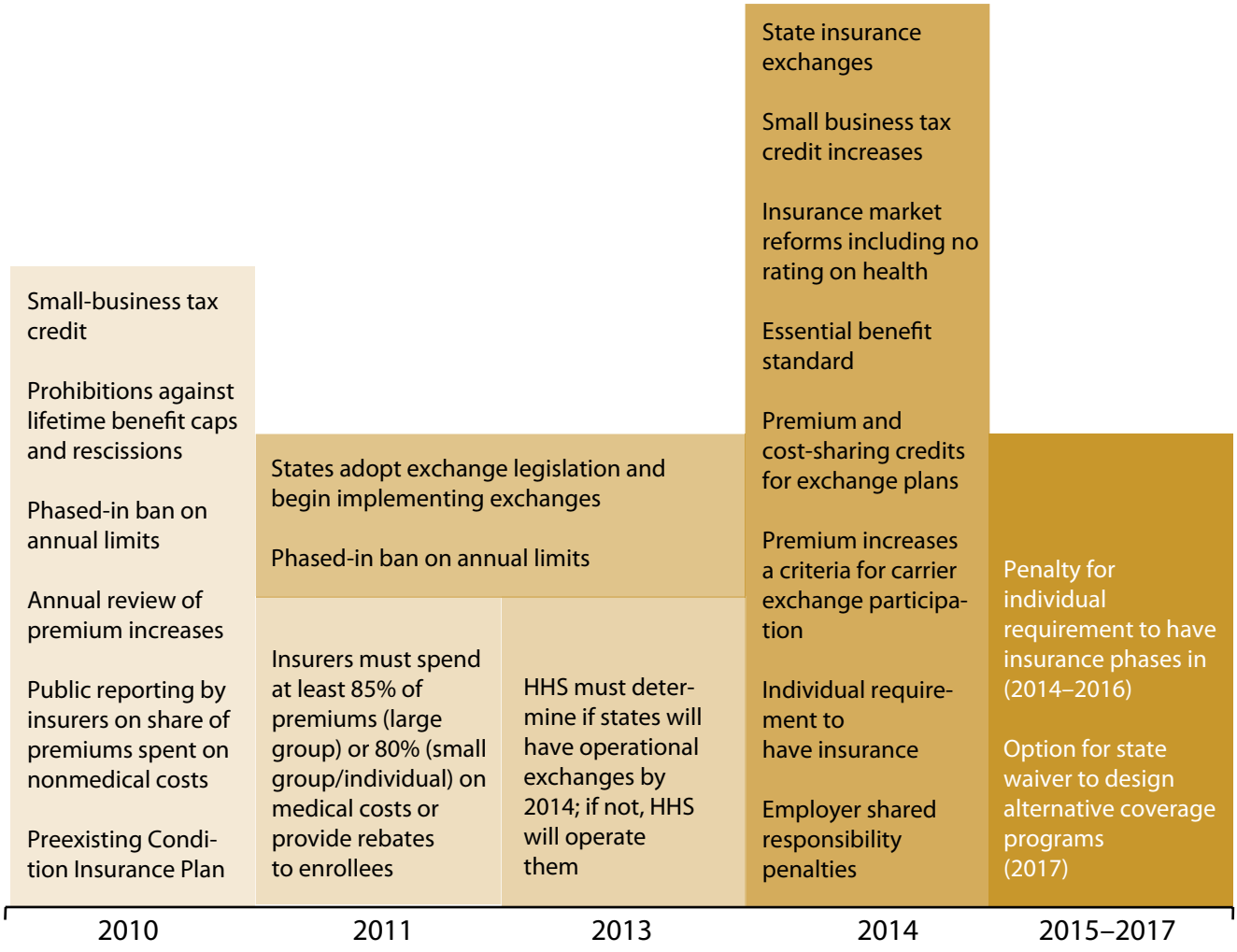
The persistently slow growth in the economy coupled with increasingly high health care costs will likely place further burdens on small businesses in the coming years and leave more workers without access to coverage or with high out-of-pocket costs. The Patient Protection and Affordable Care Act (ACA) includes several provisions designed to help small businesses pay for and maintain health insurance for their workers, and will also allow workers without employer coverage to gain access to affordable, comprehensive health insurance. Small businesses will realize the greatest benefits from the expansion and improvement of insurance coverage beginning in 2014. However, several ACA provisions that will be implemented in 2010, including a tax credit to offset premium costs, will provide important transitional support (Exhibit 5).

Small-Business Tax Credits to Offset Premium Costs (2010)

Beginning with taxable year 2010, small employers that provide health insurance to their employees will be eligible for tax credits to offset their premium costs. Between 2010 and 2013, the legislation provides tax credits for up to 35 percent of the employer premium contribution (which must be at least 50 percent of the full premium) for employers with fewer than 25 employees and average wages below $50,000. The full 35 percent tax credit is available to employers with 10 or fewer full-time employees and average wages of $25,000 or less and phases out for larger firms (Exhibit 6).[9]

Beginning in 2014, the full credit will cover 50 percent of employers' premium contribution for up to two years. This credit will be available to small businesses with fewer than 25 employees and average wages below $50,000. To be eligible for the credits, small employers must offer their employees health plan options through the new insurance exchanges. The full 50 percent credit, like the 2010–2013 credit, will be available to firms with 10 or fewer workers and with average wages of $25,000 or less, and will phase out for larger firms (Exhibit 7).

Exhibit 5. ACA Provisions That Benefit Small Businesses and Their Workers



Source: Commonwealth Fund analysis of the The Affordable Care Act (Public Law 111–148 and 111–152).

Tax-exempt organizations of the same size are eligible for the small business premium credit (as a refundable tax credit) as well, though they receive somewhat lower credits. Tax-exempt organizations will be eligible for a credit equal to 25 percent of their employee premium contribution through 2013, and 35 percent beginning in 2014.

Small businesses that are eligible for the credit but have no taxable income in one year (and are not tax-exempt organizations) may carry the credit forward 20 years. They may also carry the credit back one year (for years other than 2010).

To illustrate how the tax credit might work in practice, a company with 10 or fewer workers and average wages of $25,000 would be eligible for the full tax credit. Assuming that the company has a per-worker family premium of $9,435 and contributes 50 percent of the premium, it would be eligible for a tax credit of $1,651 per worker, or 35 percent of its premium contribution in the years 2010–2013, leaving it with a balance of $3,067 (Exhibit 8).[10] Beginning in 2014, the company would receive 50 percent of its premium contribution or $2,359, leaving it with a balance of $2,359. A tax-exempt organization in that year would receive a slightly lower credit (35% of its premium contribution) of $1,651 per worker.

Exhibit 6. Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums, For-Profit Firms (2010–2013) and Nonprofit Firms (2014+)

	Average Wage				
Firm Size	**Up to $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**
Up to 10	35%	28%	21%	14%	7%
11	33%	26%	19%	12%	5%
12	30%	23%	16%	9%	2%
13	28%	21%	14%	7%	0%
14	26%	19%	12%	5%	0%
15	23%	16%	9%	2%	0%
16	21%	14%	7%	0%	0%
17	19%	12%	5%	0%	0%
18	16%	9%	2%	0%	0%
19	14%	7%	0%	0%	0%
20	12%	5%	0%	0%	0%
21	9%	2%	0%	0%	0%
22	7%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%

Source: C. L. Peterson and H. Chaikind, Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (PPACA), Congressional Research Service, April 20, 2010.

Exhibit 7. Small Business Tax Credit as a Percent (Maximum of 50%)of Employer Contribution to Premiums, For-Profit Firms (2014+)

	Average Wage				
Firm Size	**Up to $25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**
Up to 10	50%	40%	30%	20%	10%
11	47%	37%	27%	17%	7%
12	43%	33%	23%	13%	3%
13	40%	30%	20%	10%	0%
14	37%	27%	17%	7%	0%
15	33%	23%	13%	3%	0%
16	30%	20%	10%	0%	0%
17	27%	17%	7%	0%	0%
18	23%	13%	3%	0%	0%
19	20%	10%	0%	0%	0%
20	17%	7%	0%	0%	0%
21	13%	3%	0%	0%	0%
22	10%	0%	0%	0%	0%
23	7%	0%	0%	0%	0%
24	3%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%

Source: C. L. Peterson and H. Chaikind, Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (PPACA), Congressional Research Service, April 20, 2010.

Up to 16.6 million workers are estimated to be currently working in firms that will be eligible for these tax credits.[11] The Internal Revenue Service has sent postcards to more than 4 million small businesses and organizations informing them of their potential eligibility. [12] Ultimately, the take-up of the credit will depend on its size for each eligible firm. Jonathan Gruber of the Massachusetts Institute of Technology estimates that about 3.4 million workers are in firms that will take up the tax credit between 2010 and 2013.[13]

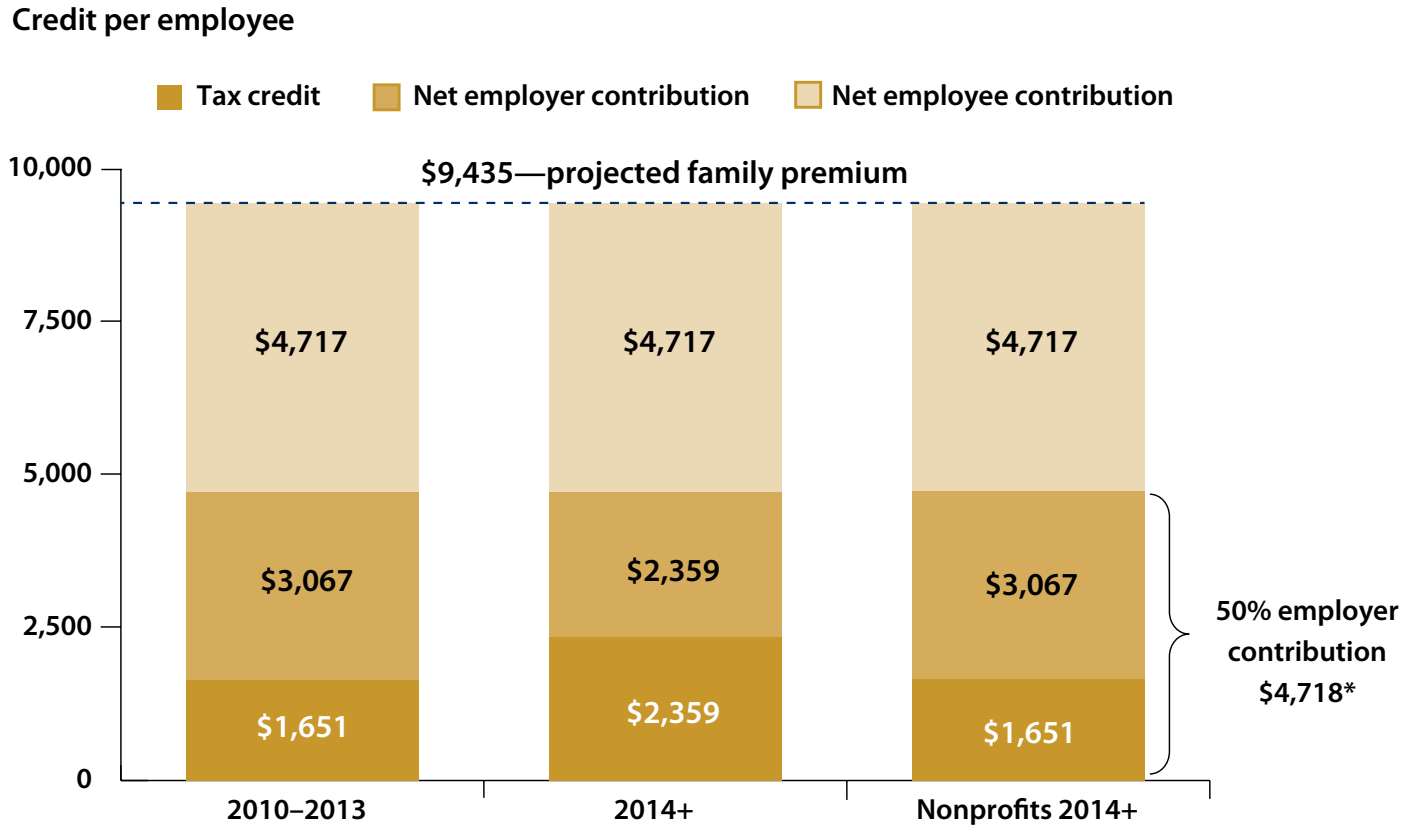
The Congressional Budget Office estimates that over the next 10 years, 2010–2019, the federal government will provide $40 billion in support to small businesses and organizations through the premium credit program.[14]

Limits on Share of Premiums Insurers Spend on Nonmedical Costs (2010)

The costs of insurance administration in the U.S. health care system totaled nearly $160 billion in 2008, and that figure is expected to double to $320 billion by 2018.[15,16]

The administrative cost component of private insurance premiums runs from 5 percent to 40 percent, depending on the market and state in which the insurance policy is purchased. Insurance carriers currently sell polices in three different markets—large-employer group, small-employer group (typically firms with fewer than 50 employees), and individual—in each of the 50 states and the District of Columbia. Administrative costs and profits consume an estimated 25 percent to 40 percent of premiums in the individual

Exhibit 8. Small Business Tax Credits Under Affordable Care Act for Family Premiums



* To be eligible for tax credits, firms must contribute 50% of premiums. For-profit firms receive 35% and later 50% of their contribution in tax credits.
Note: Projected premium for a family of four in a medium-cost area in 2009 (age 40). Premium estimates are based on actuarial value = 0.70. Actuarial value is the average percent of medical costs covered by a health plan.

Source: Commonwealth Fund analysis of Affordable Care Act (Public Law 111–148 and 111–152). Premium estimates are from Kaiser Family Foundation Health Reform Subsidy Calculator, http://healthreform.kff.org/Subsidycalculator.aspx.

market, 15 percent to 25 percent of premiums in the small-employer group market, and 5 percent to 15 percent of premiums in the large-employer group market.[17] The costs of commissions alone in the small-group market, where brokers play a key role in identifying pertinent insurance policies, run from 4 percent to 11 percent of premiums.[18]

The ACA may help reduce the sizeable share of premiums that are attributed to administrative costs. Beginning in 2010, health plans are required to report the proportion of premiums spent on items other than medical care. The secretary of the Department of Health and Human Services (HHS) will make these reports available on the HHS Web site. Generally, medical care includes clinical services, activities to improve quality of care, and all other nonadministrative costs. The secretary of HHS will issue regulations that explicitly define medical care, especially in the area of quality improvement activities, in addition to standardized methodologies for calculating the share of premiums spent on medical care. Beginning January 1, 2011, health plans in the large-group market that spend less than 85 percent of their premiums on medical care, as well as health plans in the small-group and individual markets that spend less than 80 percent on medical care, will be required to offer rebates to enrollees. These percentages may be even higher under state regulation. The secretary may also adjust the small-group or individual market standard.[19]

Annual Review of Premium Increases (2010)

Small-business premiums may also be driven lower by a new state-by-state review of premiums that begins this year. Beginning in 2010, the HHS secretary and states are required by the ACA to establish a process for annual review of "unreasonable" premium increases. HHS has issued a request for comments on this provision to help clarify what constitutes an unreasonable premium increase. Health insurers will be required to submit to the secretary and the relevant state a justification for an unreasonable increase prior to implementation of the increase, and the information will be posted on the insurer's Web site. The bill appropriates

In 2008, a total of $783.2 billion was paid to private health insurance companies in premiums. Of that, $691.2 billion was spent by carriers on medical benefits (or on medical claims).[20] The difference ($92 billion) between premiums collected and the amount paid out in claims was spent on nonmedical costs, including advertising, sales commissions, underwriting, and other administrative functions; net additions to reserves; rate credits and dividends; premium taxes; and profits.[21]

$250 million to the secretary for grants (of $1 million to $5 million each) to states from 2010 to 2014 to review and approve carrier premium increases. In August, HHS awarded grants of $1 million each to 45 states and the District of Columbia to begin implementing the review process.[22] As a condition of receiving a grant, state insurance commissioners are required to provide the secretary with information on trends in premium increases in the state and make recommendations to the state insurance exchanges beginning in 2014 on whether particular insurance carriers should be excluded from participating in the exchanges, based on a pattern or practice of excessive or unjustified premium increases.

Preexisting Condition Insurance Plan (2010)

Some employees of small businesses who do not have coverage through their employers and who have been unable to secure health insurance because of a health condition will benefit from new Preexisting Condition Insurance Plans (PCIPs). Now available in most states,

PCIPs will be open to people who have been uninsured for at least six months and who have a health problem that has made it difficult for them to gain health insurance. Premiums will be set for a standard population in the individual insurance market and cannot vary by more than a factor of four, based on age (i.e., 4:1 age bands). The PCIPs will be required to cover, on average, no less than 65 percent of medical costs (actuarial value) and to limit out-of-pocket spending to that which is defined for health savings accounts (HSAs), or $5,950 for individual policies and $11,900 for family policies. They also cannot impose preexisting condition exclusions.

The federal government invited states to submit applications to form their own PCIPs, supported by federal subsidies to cover the difference between premiums and the cost of claims. Twenty-seven states and the District of Columbia applied to run their own plans and most are now accepting applications for enrollment.[23] States have some flexibility in setting the size of the deductible, the level of other cost-sharing, and the scope of benefits, so there is variation in PCIPs from state to state.

The federal government began operating PCIPs in the remaining 23 states on July 1. The plans in these states feature a $2,500 deductible, $25 copayment for doctor visits, 20 percent coinsurance for other covered in-network benefits, prescription drug coverage with $4 to $30 copayments for most drugs for the first two prescriptions and 50 percent of the cost of the prescriptions after that, no cost-sharing for preventive services, no lifetime limit on benefits, and a $5,950 out-of-pocket maximum for in-network services.[24]

The HHS secretary will have $5 billion to use to subsidize the gap between premiums collected for the PCIPs and claims costs between 2010 and 2013. The CBO estimates that the PCIPs will be able to cover about 200,000 people over their three-and-half years of operation.[25]

Essential Health Benefit Standards (2014)

Starting in 2014, all health plans sold through the new state insurance exchanges and in the individual and small-group markets will be required to provide a federally determined essential benefit package. Plans that have been in existence since March 23, 2010, however, will be grandfathered in and will not have to comply with the standard. The benefit package will be similar to those offered in employer plans and will include, at a minimum: ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services, including behavioral health; prescription drugs; rehabilitative services and devices; laboratory services; preventive services, including services recommended by the Task Force on Clinical Preventive Services and vaccines recommended by the director of the Centers for Disease Control and Prevention; and chronic disease management. In addition, the plans must cover pediatric services, including vision and oral care.

Small Firms May Offer Coverage to Employees Through State Health Insurance Exchanges (2014)

Beginning in 2014, small businesses will be able to purchase plans for their employees through the exchanges. States can either open the exchanges to companies with 100 employees or limit participation to companies with 50 or fewer employees. But by 2016, states must open the exchanges to firms with up to 100 employees. In 2017, states have the option to open the exchanges to companies with 100 or more employees. Plans offered through the exchanges will have the essential benefit package with no lifetime or annual limits and will vary only by the degree of cost-sharing.

Small businesses offering insurance to their employees through the exchanges will have better information about what health plans cover than businesses do today. They can select health plans with the essential benefit package with a choice of four different levels of cost-sharing: bronze (covering an average of 60% of an enrollee's medical costs), silver (70% of medical costs), gold (80% of medical costs), and platinum (90% of medical costs). For all plans, out-of-pocket costs are limited to $5,950 (single policies) and $11,900 (family policies). Deductibles for

small businesses can be no greater than $2,000 for a single policy or $4,000 for a family policy. Employers may provide premium support for a level of coverage (bronze, silver, gold, or platinum) and employees may choose a plan within the designated level.

The Congressional Budget Office estimates that by 2019 about 5 million workers will gain their employer-based coverage through the insurance exchanges.[26]

Prohibitions on Insurance Carriers from Denying Health Insurance or Charging Higher Premiums (2014)

Underwriting activities in both the individual and small-group insurance markets are costly and can prevent small businesses from offering coverage to their employees. Because carriers selling policies in the small-group and individual insurance markets do not have complete information about their potential customers' health, they invest significant capital in attempting to identify risk and in designing underwriting models to determine whether premium revenues will exceed expected costs.[27] Some states have prohibited or limited underwriting. In these cases, carriers have developed other mechanisms for weeding out applicants likely to incur high medical costs. These strategies include refusing to write a policy; selling to niche, potentially profitable markets, such as small firms of lawyers and other professionals; avoiding industries, such as taxi driving, that carry higher health risks; excluding coverage for individuals with preexisting conditions; and offering policies with differentiated benefits as a way of eliciting information about the health status of potential clients.[28]

Beginning in January 2014, premiums charged by a health insurance carrier offering insurance coverage in the exchanges or the individual or small-group markets may vary only by certain factors: 1) whether an individual or family is covered; 2) the geographic or "rating area" in which the coverage is offered, as established by each state or HHS; 3) age, although age rating cannot vary by a ratio of more than 3-to-1 for adults (i.e., the highest premium rate for adults can be no more than three times the lowest premium rate); and 4) tobacco use, where the highest premium rate may be no more than 1.5 times the premium rate for a nonsmoker. The provision does not apply to grandfathered plans that existed when the ACA was signed into law in March 2010.[29]

Health plans may not impose any exclusions for preexisting conditions, beginning in 2010 for children and 2014 for everyone else. The restriction applies to both employer plans, including self-insured plans, and plans sold in the individual and small-group markets and the exchanges. It applies to grandfathered group plans but not grandfathered plans sold on the individual market.

Small Employers Exempt from Shared Responsibility Payments (2014)

The ACA does not include an employer mandate for health insurance, but it does require payments from large employers that either do not offer health insurance to their workers or offer health insurance that is expensive to employees or of poor quality. Under the law, small businesses (i.e., those with fewer than 50 employees) are exempt from the payments.

If employers with 50 or more full-time equivalent workers do not offer health insurance, the legislation will require a payment of $2,000 per full-time employee (i.e., those working more than 30 hours per week) if an employee becomes eligible for a premium subsidy through the exchanges. The penalty does not apply to the first 30 full-time workers in a company. If a firm offers coverage and has 50 or more full-time equivalent workers and a full-time worker is determined to be eligible for premium subsidies through the exchange either because that worker's premium contribution exceeds 9.5 percent of income or his or her coverage does not meet the minimum creditable benefit standard, the company must pay the lesser of $3,000 for each full-time worker who receives such a premium subsidy through the exchange or $2,000 for each full-time employee, not counting the first 30 employees.[30]

ESTIMATED IMPACT

The ACA provisions are designed to lower the cost of premiums to both employers and employees and reduce the number of people who are uninsured. In addition, the essential benefit standard and limits on cost-sharing, along with the bans on underwriting and lifetime limits, should reduce the burden of uncovered out-of-pocket expenses and the resulting numbers of underinsured people.

Estimated Effects of Health Reform on Premiums for Small Employers

In November 2009, the Congressional Budget Office (CBO) estimated the potential effect of the provisions in the Senate bill on health insurance premiums in the individual market (including the new insurance exchange), small-group market, and large-group market, compared with trends under current law.[31] While the version CBO analyzed was somewhat different than the legislation ultimately passed in March, the effects on premiums would likely be very similar, according to the CBO.[32]

CBO estimates that the overall effect of the law on premiums for companies with fewer than 50 workers would range from an increase of 1 percent to a decrease of 2 percent in 2016, relative to current law. This does not include the effects of the small business tax credit, which CBO estimates would further reduce premiums by 8 percent to 11 percent for eligible firms.

For workers in small firms who will be buying health insurance on their own, CBO estimates that premiums for coverage purchased either through the new insurance exchanges or the individual market will be a net of 10 percent to 13 percent higher in 2016 than they would have been under current law. The increase is attributable to the fact that the essential benefit package makes health plans more comprehensive and protective from out-of-pocket costs than those currently available in the individual market. However, the increase in premiums is substantially offset by changes in the individual market that result from the ACA: lower administrative costs and an influx of younger and healthier enrollees. In addition, 57 percent of those in exchange and individual market plans would receive a premium subsidy, which CBO estimates would reduce their premiums by 56 percent to 59 percent relative to premiums under current law.

Other analysts have attributed greater savings from the establishment of exchanges and the new market rules against underwriting that will reduce administrative costs and increase competition among insurers. CBO estimates that a reduction in administrative costs would reduce premiums between 1 percent and 4 percent for small companies, but sees no savings for large groups, for an average reduction of about 0.4 percent.[33] Cutler, Davis, and Stremikis estimate that this translates into about $27 billion in administrative cost savings.[34] But the authors assume additional savings in administrative costs totaling $184 billion over 2010–2019. These savings stem from broader risk-pooling, a reduction in costs associated with underwriting, and greater transparency of information for consumers and businesses searching for health plans that will reduce costs of marketing and insurance broker commissions.[35] When combined with greater estimated savings from health system modernization and reform of payment methods, these savings become quite significant over time. Prior to the passage of the ACA, family premiums were expected to increase from $13,305 in 2010 to $21,458 in 2019.[36] Under reform, premiums will increase only three-quarters as much. By 2019, the authors estimate that family premiums will be nearly $2,000 lower as a result of the ACA.

Estimated Effects of ACA on Coverage of Workers

Provisions of the ACA will affect the coverage of workers in small and large firms. It will cover those currently without coverage, stabilize the coverage of those with insurance, and shift some workers to the insurance exchanges or to Medicaid. For example, the small business tax credit is estimated to provide new coverage or stabilize existing coverage for about 3.4 million workers and family members employed in small firms by 2013.[37] Small firms eligible to offer their employees health insurance through the insurance

exchanges will provide new coverage or stabilize existing coverage for about 5 million workers and their families by 2019.[38] The combination of the individual requirement to health insurance and the employer penalties for not offering coverage are expected to provide employer-based health insurance to 6 million to 7 million people who are currently without employer health insurance.[39]

Still, a large number of small firms with lower-wage workforces may decide to stop offering health insurance if their workers can gain subsidized, comprehensive coverage through the exchanges and Medicaid in 2014. The CBO estimates that 8 million to 9 million workers—mostly in small, lower-wage firms—will lose their employer coverage but are expected to gain health insurance through the exchanges and Medicaid.[40]

Small-Firm Employees and Low-Wage Workers Without Employer Coverage Will Have New Options

Small-firm employees who do not have health insurance through their jobs will, depending on their income, have new affordable options either through Medicaid or the health insurance exchange. Eligibility for Medicaid will increase to 133 percent of the federal poverty level (i.e., $29,327 for a family of four). New insurance regulations will ensure that people buying coverage through the exchange will not be charged higher premiums or denied coverage based on health status. All health plans sold through the exchange will be required to meet standards for an essential benefit package, which will ensure transparency of benefit packages. People will have far more information when choosing which package best meets their needs than what is currently available in the individual market. Plans will also be prevented from imposing annual or lifetime limits.

For the first time, workers in small firms who must buy coverage on their own will be eligible for a federal subsidy to help pay for the cost of premiums for plans sold through the exchanges. Premium credits will be tied to the silver plan and will cap premium contributions for individuals and families from 2 percent of income up to 133 percent of poverty ($14,404 for a single adult or $29,327 for a family of four). The cap will gradually increase to 9.5 percent at 300 percent to 400 percent of poverty ($43,320 for a single person and $88,200 for a family of four).

Workers with low and moderate incomes will also benefit from cost-sharing credits that effectively reduce out-of-pocket costs under the silver plan from 30 percent of total medical costs to 6 percent for those with incomes up to 150 percent of poverty. Costs will drop to 13 percent of total costs for those with incomes up to 200 percent of poverty and to 27 percent for incomes up to 250 percent of poverty. In addition, out-of-pocket expenses will be capped for people earning between 100 percent and 400 percent of poverty from $1,983 for individuals and $3,967 for families, up to $3,967 for individuals and $7,933 for families.

CONCLUSION

The ACA will provide both immediate and long-term relief for millions of small businesses that have long struggled to provide health insurance to their workers and who are now coping with a severely weakened economy. Starting for tax year 2010, tax credits will be available to small businesses with fewer than 25 employees and average wages of less than $50,000. These are the first direct subsidies provided to Americans under the new health care law. An estimated 16.6 million workers are employed in firms that will be eligible for the credits.

Beginning in 2014, the ACA will create new insurance exchanges with standardized and comprehensive health benefits, new market rules, and greater federal and state oversight of the individual and small-group markets. In addition, the value of the small business tax credit will increase to half of an employer's premium contribution, starting in 2014. The CBO estimates that the credits will reduce premiums for eligible small firms by 8 percent to 11 percent, providing savings of up to $40 billion over the next 10 years. In addition, broader risk-pooling for small businesses through the exchanges, bans on underwriting, limits on nonmedical costs charged to employers by insurance

carriers, and greater transparency of information about benefits that may reduce the need for insurance brokers also promise to reduce the cost of insurance over time.[41] Ultimately, the ability of small firms to offer high-value health benefits to their workers will reduce the considerable disadvantage that small businesses have had in the labor market, allowing them to compete with larger businesses for high-quality workers.

The ACA will also benefit millions of workers in small firms who have lost their health benefits over the past decade and have been unable to buy affordable coverage on the individual market. For the first time, workers buying coverage on their own will be eligible for a subsidy to help pay the cost of premiums for plans sold through the exchanges and will not face the risk of being denied coverage or charged a higher premium on the basis of their health or gender. The requirement that all plans sold through the exchanges and the individual and small-group markets provide an essential benefit package with limits on cost-sharing as well as bans against lifetime and annual limits also means that individuals will know precisely what their plans cover, will have coverage for critical preventive health services like colonoscopies and mammograms, and will never be exposed to catastrophic health care costs. Just as the ACA promises to level the playing field between small and large businesses, it also promises to equalize access to comprehensive insurance coverage for all American workers regardless of their health, economic circumstances, or employment status.

Notes

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[8] Doty, Collins, Rustgi et al., *Out of Options*, 2009.

[9] The small business tax credit phases out for businesses with 10 to 25 employees and wages of $25,000 to $50,000 in the following way. If the number of full-time equivalent workers (FTEs) exceeds 10, the reduction is determined by multiplying the full credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10 and the denominator of which is 15. If average annual wages exceed $25,000, the reduction is determined by multiplying the full credit amount by a fraction, the numerator of which is the amount by which average annual wages exceed $25,000 and the denominator of which is $25,000. In both cases, the result of the calculation is subtracted from the full credit amount to determine the credit to which the employer is entitled. For an employer with both more than 10 FTEs and average annual wages exceeding $25,000, the total reduction is equal to the sum of the two reductions. This may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual wages of less than $50,000. See http://www.irs.gov/newsroom/article/0,,id=220839,00.html.

[10] This is the estimated premium for a family of four with parents of age 40 for a "silver" level health plan that will be offered through the health insurance exchanges in 2014 in a medium-cost area of the country. The silver level plan has an actuarial value of .70, or covers an average of 70 percent of total medical costs. See Kaiser Family Foundation Health Reform Subsidy Calculator: http://healthreform.kff.org/Subsidycalculator.aspx.

[11] Estimates are from Jonathan Gruber and Ian Perry of the Massachusetts Institute of Technology using the Gruber Microsimulation Model for The Commonwealth Fund.

[12] See http://www.ustreas.gov/press/releases/reports/additional background on the small business health care tax credit.pdf.

[13] Estimates from Gruber and Perry of MIT.

[14] Congressional Budget Office, Letter to the Honorable Harry Reid, Dec. 19, 2009, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers.pdf; Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010. The estimate includes both direct spending on the program ($37 billion) and lower tax revenues from changes in taxable compensation as result of the credit.

[15] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, National Health Expenditures by Source of Funds and Type of Expenditure, 2003–2008.

[16] C. J. Truffer, S. Keehan, S. Smith et al., "Health Spending Projections Through 2019: The Recession's Impact Continues," *Health Affairs*, March 2010 29(3):522–29.

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[18] R. C. Chu and G. R. Trapnell, *Study of the Administrative Costs and Actuarial Values of Small Health Plans, Small Business Research Summary No. 224* (Washington, D.C.: U.S. Small Business Administration, Jan. 2003).

[19] The rebates will be equal to the percentage difference between the minimum required by law and what a plan actually spends, multiplied by the total amount of premium revenue.

[20] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, Private Health Insurance Premiums, Benefits, and Net Cost, 1960–2008.

[21] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Expenditures Accounts: Definitions, Sources, and Methods, 2008, https://www.cms.gov/NationalHealthExpendData/downloads/dsm-08.pdf; and S. R. Collins, R. Nuzum, S. D. Rustgi, S. Mika, C. Schoen, and K. Davis, *How Health Care Reform Can Lower the Costs of Insurance Administration* (New York: The Commonwealth Fund, July 2009).

[22] U.S. Department of Health and Human Services, "$46 Million in Grants to Help States Crack Down on Unreasonable Health Insurance Premium Hikes" (news release, Aug. 16, 2010), http://www.hhs.gov/news/press/2010pres/08/20100816a.html.

[23] These are: Alaska, Arkansas, California, Colorado, Connecticut, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, Washington, D.C., and Wisconsin. See http://www.pcip.gov/StatePlans.html for more information on state-run PCIPs.

[24] These are: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia and Wyoming. See http://www.pcip.gov/StatePlans.html for more information about the federal PCIP.

[25] Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010.

[26] CBO, Letter to Pelosi, 2010.

[27] K. Swartz, *Reinsuring Health: Why More Middle Class People Are Uninsured and What Government Can Do* (New York: Russell Sage Foundation, 2006).

[28] Ibid.

[29] See S. R. Collins, "Grandfathered vs. Non-Grandfathered Health Plans Under the Affordable Care Act: Striking the Right Balance," Commonwealth Fund Blog, June 22, 2010; and Department of the Treasury, Department of Labor, Department of Health and Human Services, "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," http://www.hhs.gov/ociio/regulations/grandfather/index.html.

[30] To meet the minimum creditable standard, a plan must cover at least 60 percent of a person's medical costs, on average.

[31] Congressional Budget Office, Letter to the Honorable Evan Bayh, Nov. 30, 2009.

[32] CBO, Letter to Reid, Dec. 19, 2009, p. 19. According to CBO, the substitution of the public health plan with the multistate health plans under contract with OPM would likely make little difference in premiums. The new provision limiting medical loss ratios would tend to lower premiums somewhat, while the restrictions on insurers' ability to place annual limits on what plans will pay might slightly increase premiums.

[33] CBO, Letter to Bayh, 2009.

[34] D. Cutler, K. Davis, and K. Stremikis, *The Impact of Health Reform on Health System Spending* (New York: The Commonwealth Fund, May 2010).

[35] Cutler, Davis, and Stremikis, *The Impact of Health Reform*, 2010.

[36] C. Schoen, J. L. Nicholson, and S. D. Rustgi, *Paying the Price: How Health Insurance Premiums Are Eating Up Middle-Class Incomes—State Health Insurance Premium Trends and the Potential of National Reform* (New York: The Commonwealth Fund, Aug. 2009).

[37] Estimates from Gruber and Perry of MIT.

[38] CBO, Letter to Pelosi, 2010.

[39] Ibid.

[40] Ibid.

[41] Commonwealth Fund Commission, *Path to a High Performance U.S. Health System* (New York: The Commonwealth Fund, Feb. 2009).

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