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TECHNICAL REPORT

Establishing State Health Insurance Exchanges

Implications for Health Insurance Enrollment, Spending, and Small Businesses

Christine Eibner, Federico Girosi, Carter C. Price, Amado Cordova, Peter S. Hussey, Alice Beckman, Elizabeth A. McGlynn

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1776 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138
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Summary

Overview

On March 23, 2010, President Barack Obama signed PPACA into law, a policy designed to expand health insurance coverage for U.S. citizens through expanding eligibility for Medicaid, developing new marketplaces for purchasing insurance that are subject to regulatory changes, requiring individuals to have insurance coverage (with subsidies to offset costs for low-income individuals and penalties for those who fail to comply), and imposing fines on employers who do not offer coverage and whose employees obtain government subsidies. This study evaluates the likely effects of the law, with a focus on small businesses and businesses offering coverage through health insurance exchanges. Outcomes assessed include the proportion of nonelderly Americans who have insurance coverage, the number of employers who choose to offer health insurance, premium prices, total employer spending, and total government spending relative to what we would have observed in the absence of the policy change.

We used RAND's Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model, which was updated and refined to analyze how people and firms would respond to a health care reform that would allow businesses to offer health insurance coverage through health insurance exchanges. Behavioral responses to new requirements and the availability of new options in our model are based on utility maximization, in which people and firms weigh economic benefits against economic costs to make choices. The baseline reform considered in our analysis was designed to reflect the main provisions of PPACA, and in scenario testing we analyzed the sensitivity of results to key design features and model assumptions. We also considered the effect of exchange implementation choices that must be made by states, including whether to permit large businesses to offer coverage on the exchanges, and whether to segregate the nongroup and small group markets (risk pools) within the exchanges.

Key Findings

We predict that PPACA will increase insurance offer rates among small businesses. According to model projections, by 2016, offer rates would increase from 53 to 77 percent for firms with ten or fewer workers, from 71 to 90 percent for firms with 11 to 25 workers, and from 90 percent to nearly 100 percent for firms with 26 to 100 workers. Offer rates would also increase at the largest firms (those with more than 100 workers), rising from 93 percent to close to 100 percent. Simultaneously, 35 million people would obtain health insurance, and the uninsurance rate in the United States would fall from 19 to 6 percent of the nonelderly population. The increase in employer offer rates is driven by workers' demand for insurance, which increases

due to an individual mandate requiring all people to obtain insurance policies. The presence or absence of employer penalties incentivizing businesses to offer coverage does not have a meaningful impact on outcomes, such as the total number insured or employer offer rates. Employer penalties have little effect because many firms that would not otherwise offer coverage are induced to offer following the reform solely because of the individual mandate. Firms that do not offer coverage after the reform are primarily small businesses (≤50 workers), which are exempt from employer penalties.

In contrast to the employer penalty results, the total number of people insured following the reform is sensitive to the presence of an individual mandate. Without the individual mandate, the number of newly insured would fall from 35 million to 22 million. Other policies, such as employer eligibility to offer coverage in the exchanges and tax credits for small businesses, have little impact on the number of people who become newly insured. Instead, these policies serve mainly to shift costs between employers and the federal government. For example, federal government spending increases when tax credits are available to small businesses, and federal government revenue increases when employer penalties associated with not offering coverage are high.

Under our baseline assumptions, approximately 60 percent of all businesses opt to offer coverage in the exchange following the reform. A total of 68 million people enroll in the exchanges in the baseline reform, of whom 35 million receive exchange-based coverage through an employer. However, there is significant uncertainty regarding the degree of "inertia" bias that will be present in firm decisionmaking. Inertia bias could lead firms to maintain traditional ESI coverage even if standard utility theory would predict a move into the exchanges. Although inertia bias has been documented in other studies, most prior studies focus on individual rather than firm decisionmaking and are not specific to health care.

Implications for Policy

We analyzed two policies that will be relevant for states as they begin to implement health insurance exchanges. First, we considered the effects of opening health insurance exchanges to all businesses, in comparison with limiting exchange eligibility to businesses with 100 or fewer workers (the eligibility cutoff required by law). Although opening the exchange to large businesses has no effect on overall coverage, our model predicts that this policy will have a significant impact on the number of people enrolled in exchange-based coverage. When the exchanges are open to all, we predict that 139 million people will be enrolled in exchange-based coverage, compared to 68 million when the exchanges are restricted to businesses with 100 or fewer workers. These results, however, are highly sensitive to assumptions about inertia bias in firm decisionmaking.

Opening the exchange to a wider group of employers could have a secondary effect of increasing Medicaid enrollment. Differences in cost-sharing requirements between exchange plans and traditional employer plans may cause some workers who are eligible for both employer coverage and Medicaid to take Medicaid if their firms switch to low actuarial value plans in the exchange. This possibility would have the effect of reducing spending for employers, while increasing spending for states and the federal government.

Second, we analyzed the effect of segregating the nongroup and small group markets within the exchange for the purpose of risk pooling. When these markets are segregated, pre-

miums for small group enrollees fall, while premiums for nongroup enrollees increase. This finding reflects that fact that individual exchange policyholders tend to be less healthy than policyholders enrolled through an employer. Since individual policyholders in the exchanges also tend to be eligible for government subsidies, splitting the exchange market raises the cost to the federal government while lowering the cost to small businesses and their enrollees.

In addition to inertia bias in decisionmaking, another potential source of uncertainty is the administrative cost associated with exchange-based health insurance plans. Estimates from existing literature suggest that these costs could range from 8 to 18 percent of premiums and may vary significantly by state. In sensitivity analyses, we considered the implications of changing assumptions about administrative costs in the exchanges. Although fewer people enroll in exchange-based coverage when administrative costs are high, this effect is secondary to the effect of opening the exchanges to larger employers and the effect of inertia bias. Research to quantify the extent of employer bias toward the status quo could be useful in developing more precise estimates of exchange enrollment.