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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 seri-

ously disrupt existing employer-sponsored coverage. To the approximately 170 million Americans who have such coverage² 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 ad-

ministrative 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 non-discrimination 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

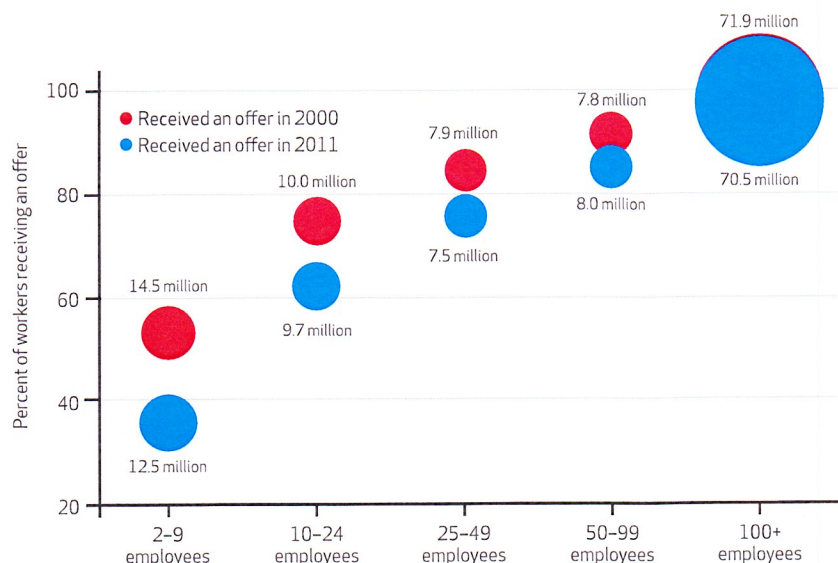
Clearly, the problem is simpler for employers whose workers who are similar to one another in their demand for insurance than for employers with a more diverse workforce. However, depending on the nature of their business, firms may need to hire workers who are diverse in this respect.

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

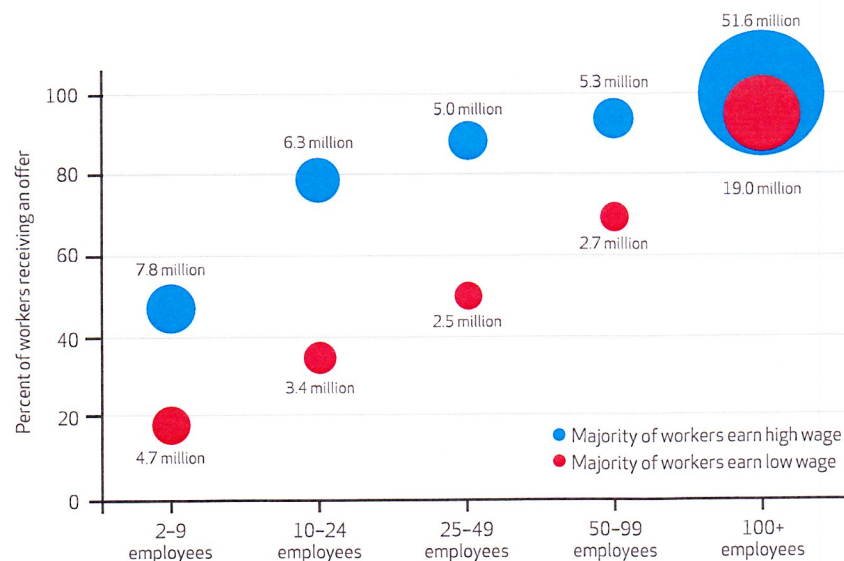


SOURCE Authors' analysis of data from the Medical Expenditure Panel Survey, Insurance Component.
NOTE The size of the bubbles indicates the number of workers.

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

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.

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

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

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 (<i>affordable</i> 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. ^aThis 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 cover-

age 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

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

		Impact (percentage points) according to estimate from:				
Coverage source	Percent covered in 2011	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 coverage 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. ^aNot available. ^bIncludes 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 CBO⁴² 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 2014. 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 per-

cent 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 Act⁴⁶ 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. ■

NOTES

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