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Alternatives to the ACA's Affordability Firewall

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Key findings

- Under the affordability firewall, workers and their families are precluded from receiving Marketplace subsidies if the worker's share of the single ESI premium is less than 9.5 percent of the household income.
- Researchers modeled two scenarios that represent alternatives to the ACA affordability firewall. Relative to the ACA, they estimate that nongroup enrollment will increase by 4.1 million for an "entire family" scenario and by 1.4 million for a "dependents only" scenario. However, the number without insurance only declines by 1.5 million in the "entire family" scenario and by 0.7 million in the "dependents only" scenario.
- The difference between the increase in nongroup enrollment and the decrease in uninsurance is primarily due to ESI crowd-out, which is more pronounced for the "entire family" option.
- Researchers estimate that about 1.3 million families who have ESI and unsubsidized nongroup coverage under current ACA policy would receive Marketplace subsidies under the alternative affordability firewall scenarios.
- For these families, health insurance coverage would become substantially more affordable; the risk of spending at least 20 percent of income on health care would drop by more than two-thirds.
- Federal spending would increase by $8.9 billion for the "entire family" scenario and $3.9 billion for the "dependents only" scenario, relative to the ACA.

The Affordable Care Act (ACA) was designed to increase health insurance coverage while limiting the disruption to individuals with existing sources of insurance coverage, particularly those with employer-sponsored insurance (ESI). Medicaid expansion and the establishment of Marketplaces where individuals can receive subsidies for purchasing insurance were designed to reduce the number of uninsured. To limit disruption to those with coverage, the ACA implements the employer mandate, which requires firms with more than 50 employees to offer health insurance or face penalties, and the individual "affordability firewall," which limits subsidies to individuals lacking access to alternative sources of coverage that are "affordable." While the employer mandate has received considerable attention in the ongoing debate on health reform, the affordability firewall has received comparatively little attention. In this report, we study the policy impacts of the affordability firewall and investigate two potential modifications.

The affordability firewall is one of the key policy tools for limiting disruption to the ESI market. Based on experiences with previous public insurance expansions (Cutler and Gruber, 1996), lawmakers were concerned about the possibility of "crowd-out" of ESI. That is, in addition to helping the uninsured afford coverage, the availability of subsidies might also encourage those with existing plans to abandon them and enroll in the nongroup Marketplace. Crowd-out could have several important implications. Most notably, the federal government would incur a significant expense to provide subsidies to those who already had insurance. Assuming firms pass the savings associated with reduced health insurance enrollment back to workers in the form of wages, this expense would be partially offset by the reduction in tax-excluded compensation for those who had ESI. However, there would be no offset for those who had unsubsidized nongroup insurance. High levels of crowd-out could also encourage employers to drop coverage,

causing many of those who previously had access to ESI plans to search for a new plan or go uninsured.

Although the affordability firewall may provide a strong defense against crowd-out, its construction will also cause certain individuals and families to pay more for health insurance than they would if they had access to Marketplace subsidies. Under the affordability firewall, all members of a family are ineligible for subsidies if at least one worker in the family has an ESI offer in which the employee's contribution for a *single* premium is less than 9.5 percent of the worker's household income. However, the employee contribution for a family ESI plan may be substantially higher than the single contribution. In contrast, families who are eligible for premium subsidies on the Marketplaces pay no more than 9.5 percent of their income for a *family* premium, and many will pay considerably less, depending on their family's income. As a consequence of the ACA's affordability firewall, many households facing onerous employee contributions to ESI family premiums do not qualify for subsidies for purchasing coverage in the Marketplaces. For example, we estimate that the average employee contribution for a single ESI plan in 2015 is $1,256, while the average employee contribution for a family plan is about $4,672.[1] For a family of four making $36,375, which is 150 percent of the federal poverty level (FPL), the employee contribution for the single plan is only 3.5 percent of the family's income; according to the ACA affordability firewall criteria, this means the family does have access to affordable health insurance, and is therefore unable to obtain subsidized coverage on the Marketplace. However, the family's contribution to the family ESI insurance plan is 12.8 percent of its income. In contrast, if that family had access to Marketplace subsidies, the premium contribution could be no more than 4.02 percent of its income (CFR, Title 26, Section 601.105).

In this paper, we consider two potential policy options for modifying the affordability firewall. Option 1, which is the "entire family" scenario, involves allowing an exception to the firewall for anyone in a family where the family ESI premium contribution exceeds 9.5 percent of the worker's household income. In Option 2, the "dependents only" scenario, only dependents (and not the worker) become eligible for Marketplace subsidies when the ESI premium contribution exceeds 9.5 percent of the worker's household income. Lawmakers have proposed this second option (U.S. Senate, 2014). Using the Comprehensive Assessment of Reform Efforts (COMPARE) microsimulation model, an economic model developed by RAND researchers to predict the impact of health policy reforms, we find that modifying the affordability firewall could have both desirable and undesirable effects. Both options would result in moderate crowd-out of the ESI market and increased net government spending. Conversely, the alternative options would decrease the number of uninsured relative to the ACA by 1.5 million and 0.7 million people, respectively, and substantially reduce health spending for families newly able to access subsidies for purchasing insurance in the Marketplaces. Hence, policymakers will need to consider these trade-offs in assessing whether to modify the ACA's affordability firewall.

METHODS

A complete description of the COMPARE microsimulation model can be found in Cordova et al. (2013). Briefly, we created a synthetic population of individuals, families, health expenditures, and firms using data from the April 2010 cross-section of the 2008 Survey of Income and Program Participation (SIPP) (U.S. Census Bureau, 2008), the 2010 and 2011 Medical Expenditure Panel Survey (MEPS) (AHRQ, 2010), and the 2010 Kaiser Family Foundation Annual Survey of Employer Benefits (Kaiser Family Foundation, 2010). These datasets are linked together using statistical matching on key demographic characteristics, such as self-reported health status and income. We assign each individual in the SIPP a spending amount using the spending of a similar individual from the MEPS; we then augment spending imputations with data on aggregate spending levels from the National Health Expenditures Accounts, as well as data on high-cost claims from the Society of Actuaries. To model individual and family decisions, we use a utility maximization approach, in which decisionmakers weigh the costs and benefits of available options. This framework accounts for the tax penalty for not purchasing insurance, the value of health care consumption, premium costs, subsidies for purchasing insurance on the Marketplace (if applicable), expected out-of-pocket health care spending, and financial risk associated with out-of-pocket spending. We scale each of these components of utility to dollars and assume that they are additively separable, following Goldman, Buchanan, and Keeler (2000). Insurance enrollment choices in the model include employer coverage, Medicaid/ Children's Health Insurance Program (CHIP), Medicare, an ACA-compliant individual market plan (including plans available on and off the Marketplaces), or "other" sources of coverage.[2] Individuals can also choose to forgo insurance.

To forecast enrollment and premiums under the ACA, we calibrate COMPARE to approximate the pre-ACA health insur-

ance market that existed in 2010 as a basis for estimating the impact of reforms under the ACA. Calibration is a process by which we adjust the algorithms in the model so that estimates of the pre-ACA insurance market match health insurance enrollment data collected before the provisions of the law took effect. For each firm in our model, we impute the percentage of the single and family ESI premiums that the employee contributes for coverage using a regression based on data from the 2010 Kaiser Family Foundation Annual Survey of Employee Benefits. The regression includes firm-level characteristics such as firm size, geographic region, and firm sector. A key feature of COMPARE is that premiums in the ACA-compliant market are calculated dynamically. Premiums are computed endogenously using the imputed expenditure of modeled enrollees. Individuals sort into health insurance plans by choosing their preferred option. Next, premiums are recalculated based on the profile of the enrolled pool. If premiums are too high, some enrollees will opt to drop an insurance option, while if premiums are low, additional individuals may enroll. This iterative process continues until an equilibrium is achieved in which premiums and enrollment decisions are sufficiently stable between model iterations.

To model the effects of Options 1 and 2, we used the COMPARE framework and changed the rules for those who were excluded from getting premium and cost-sharing subsidies on the Marketplaces. Tables 1–3 present the COMPARE microsimulation results from three scenarios: the ACA as enacted, Option 1, and Option 2. All modeling results are for the year 2017. Our model assumes perfect compliance with the affordability firewall. That is, no individuals in our model who are not allowed access to Marketplace subsidies by law receive those subsidies. In addition, we assume that the affordability criteria used to determine the employer mandate penalties are unchanged so that employers face no new penalties under the alternative firewall options we consider. Finally, we assume that workers bear the cost of their employer's contribution to their ESI plans through reduced compensation. We note that this suggests that even those low-wage workers with relatively low employee premium contributions (for example, less than 9.5 percent of income) could be better off with access to Marketplace subsidies and with compensation in the form of increased wages rather than their ESI health insurance offer. When ESI takeup decreases, we assume that the firm's savings are passed back to workers in the form of increased wages. We do not assume that employers are able to target the passback to those workers no longer taking an ESI offer, but rather that the costs are distributed to all workers in the firm in proportion to their compensation.

HEALTH INSURANCE COVERAGE CHANGES

In this section, we present 2017 COMPARE estimates of coverage under the ACA as enacted and under the two alternative scenarios (Table 1). As noted, coverage categories include ESI, nongroup or individual coverage, Medicaid/CHIP, Medicare, uninsured, and other.

Under Options 1 and 2, 10.2 million and 4.2 million people gain access to Marketplace subsidies,[3] respectively.

Table 1.Projected Health Insurance Coverage and Premiums in 2017 Under the ACA and Two Alternatives to the Affordability Firewall (millions of individuals)

		Nongroup (Including Marketplace)						
	ESI	Subsidized	Unsubsidized	Medicaid/ CHIP	Medicare	Uninsured	Other	Silver Marketplace Premium (40-year-old nonsmoker)
ACA	156.8	15.2	9.3	57.2	44.4	27.5	12.1	$3,626
Option 1: Entire Family, difference from ACA	–2.9	4.7	–0.6	0.3	0.0	–1.5	0.0	–$193
Option 2: Dependents Only, difference from ACA	–1.1	2.3	–0.9	0.4	0.0	–0.7	0.0	–$35

Because of the expansion in Marketplace subsidies, we observe increased Marketplace enrollment, as shown in Table 1. This increased nongroup enrollment comes from individuals shifting from ESI and individuals becoming insured. Option 1 results in a larger decrease in the number of uninsured than Option 2. We see a larger decrease in ESI for Option 1 than for Option 2 because entire families become eligible for subsidies in Option 1, whereas, in Option 2, at least one family member is not eligible and is likely to enroll in a single ESI plan. Therefore, in Option 1, families who switch from ESI to Marketplace coverage pay only the subsidized Marketplace premium, while those who switch in Option 2 pay both a subsidized Marketplace premium as well as the employee contribution for a single ESI plan. This makes leaving ESI a generally less attractive choice for families in Option 2 compared with Option 1.

Finally, we find a net decrease in the number of unsubsidized individuals in the nongroup market. Underlying this net change are two main transitions. First, some individuals shift from unsubsidized to subsidized nongroup coverage as they newly gain access to subsidies. A second, smaller shift involves some previously uninsured individuals entering the unsubsidized nongroup market as premiums decrease. The net shift is smaller in Option 1 than in Option 2 because the larger decrease in premiums brings more newly insured into the unsubsidized nongroup market, offsetting decreases in this market from those who became newly subsidized.

The shift from unsubsidized to subsidized nongroup coverage may be surprising initially because it means that some families with access to an ESI family plan had previously decided to cover one or more family members on the unsubsidized nongroup market. However, there are many cases where covering some family members on the nongroup market may be less expensive than covering all family members on ESI. For example, in COMPARE, we project that the annual (unsubsidized) cost of insuring a nonsmoking dependent under age 21 on a bronze (60-percent actuarial value) nongroup plan in 2017 will be $1,482. In contrast, we project that the average employee contribution for a plan covering an employee and a dependent will be $2,086 more than the employee contribution for the single plan in 2017.[4]

We see a larger decrease in nongroup premiums in Option 1, where workers gain access to Marketplace subsidies, than in Option 2, where only dependents gain access. This suggests that the premium decreases we observe are largely driven by healthy workers with relatively low medical costs shifting from the ESI to the nongroup market.

We also see small increases in Medicaid/CHIP enrollment. This is because we predict that in a family where some dependents have access to Medicaid/CHIP and others do not under the ACA,[5] the family may chose ESI coverage for everyone. However, if some family members become eligible for subsidies in the Marketplace, those eligible for Medicaid/CHIP enroll in the program.

GOVERNMENT SPENDING AND REVENUE

Next, we consider the impact of alternatives to the affordability firewall on government spending. We consider budgetary impacts of changes to spending on Marketplace subsidies and Medicaid. Because we forecast a decrease in the number of uninsured, we also consider uncompensated care payments (payments made by federal governments to hospitals to offset costs of treating the uninsured), and changes in revenue from the individual mandate penalty, which is levied on individuals with access to an affordable insurance offer who do not enroll in an insurance plan that provides "minimum essential coverage." In addition, the alternative affordability firewall options we consider reduce ESI enrollment and therefore reduce compensation that employees receive from employers in the form of health insurance. We assume that employers would make up for this loss of compensation by increasing employees' wages, which, unlike health insurance, would be subject to payroll and income tax, resulting in increased federal tax revenue.

Table 2 shows that government spending on Marketplace subsides increases by $12.4 billion under Option 1 and by $4.6 billion in Option 2 compared with the ACA baseline. Medicaid spending also increases, while uncompensated care (at the federal level) decreases. We find that revenue from the individual mandate decreases by $0.4 billion in Option 1 and is unaffected in Option 2. Revenue from the individual mandate does not decrease in Option 2 because all dependents affected by the changes to the firewall are exempt from the individual mandate penalty. This is because the affordability criteria for the purposes of the individual mandate are less stringent than the affordability criteria for the firewall. In 2017, dependents will be exempt from the individual mandate penalty if a family's contribution for an ESI family plan is greater than 8.5 percent of family income. We do see some decrease in individual mandate revenue under Option 1 because some of the newly insured include workers who are not exempt from individual mandate penalties because

Table 2. Changes to Federal Spending Under Alternative Affordability Firewall Options in 2017 (billions of 2017 dollars)

	Marketplace Subsidies	Medicaid Spending	Uncompensated Care (Federal)	Budgetary Impact of Change to Individual Mandate Revenue[a]	Budgetary Impact of Increase in Tax Revenue Due to Increased Worker Wages[b]	Total Impact
Option 1: Entire Family, difference from ACA	12.4	1.0	–0.3	0.4	–4.6	8.9
Option 2: Dependents Only, difference from ACA	4.6	1.5	–0.2	0	–2.0	3.9

[a] Figures in this column represent revenue decreases, which increase the total budgetary impact of the scenarios.
[b] Figures in this column represent revenue increases, which decrease the total budgetary impact of the scenarios.

their exemption status is based on their single, rather than family, ESI premium contribution. Newly insured individuals in Option 1 also include individuals who do not have a change in firewall status, but who become newly insured when nongroup premiums decrease.

Option 1 increases payroll and income tax revenue of $4.6 billion and Option 2 increases tax revenue by $2.0 billion. The net effect of these changes is that government spending increases by $8.9 billion when the firewall exception is based on the family premium and by $3.9 billion when only the workers are firewalled.

The total amount of Marketplace subsidies is lower for Option 2. In Option 1, entire families get subsidies, whereas in Option 2 only dependents do (including many children). Since children have lower medical expenses than adults, subsidizing their premiums is less expensive.

FAMILY SPENDING

In this section, we examine how modifications of the affordability firewall could affect family spending on health care. For policymakers, it might be undesirable to extend subsidies to those who had health insurance coverage through ESI or the unsubsidized nongroup market under the ACA. We refer to those individuals who were insured without access to Marketplace subsidies under the ACA and who receive Marketplace subsidies under our alternative options as "previously insured, newly subsidized." It is also important to consider the health care spending implications for these previously insured, newly subsidized families. Table 3 shows average premium spending, out-of-pocket (OOP) spending, and risk of spending at least 10 percent or 20 percent of total income on health care for the 1.3 million previously insured, newly subsidized families where at least one family member switches from unsubsidized insurance to subsidized insurance in either of our two scenarios. This allows us to examine spending changes for a single population of families. The average ESI premium contribution, average Marketplace premium contribution, and average OOP spending are averages over all 1.3 million families included in this analysis, even if they have zero spending in a particular category. Therefore, average Marketplace premium contributions are larger under Options 1 and 2 than under the ACA because many families in this analysis have ESI coverage only, and no Marketplace coverage, in the ACA scenario. Similarly, average ESI premium contributions decline relative to the ACA in both Options 1 and 2 as families cover fewer individuals on an ESI plan.

We find that total spending on health care falls by $2,274 per year in Option 1 and by $2,080 per year in Option 2, relative to the ACA for the previously insured, newly subsidized families included in our analysis. We also find that the risk of spending at least 10 or 20 percent of income on health care falls dramatically for these families. Most of them—87.3 percent—spend at least 10 percent of their income on health care under the ACA. This falls to 46.7 percent under Option 1 and 57.6 percent under Option 2. In both options, the risk of previously insured, newly subsidized families spend-

Table 3. Annual Spending in 2017 for Previously Insured, Newly Subsidized Families (1.3 million families)

	Average ESI Premium Contribution (2017 Dollars)	Average Marketplace Premium Contribution (2017 Dollars)	Average OOP Spending (2017 Dollars)	Average Total Health Care Spending (2017 Dollars)	Percent Spending More Than 10% of Income on Health Care	Percent Spending More than 20% of Income on Health Care
ACA	$4,166	$1,422	$977	$6,564	87.3	33.7
Option 1: Entire Family	$534	$2,846	$910	$4,290	46.7	9.8
Option 2: Dependents Only	$1,655	$2,156	$672	$4,484	57.6	9.2

ing at least 20 percent of income on health care falls by more than two-thirds. Note that in Table 3, the second column refers to the family's contribution to ESI premium and the third column to the subsidized Marketplace premium. We did not model potential changes to subsidy eligibility that would result from any increased wages workers might receive in ESI takeup decreases in firms. Marketplace premium contributions and average OOP spending would change slightly had we considered these potential wage impacts.

CONCLUSIONS

In this paper, we used the COMPARE microsimulation model to estimate the impact of two potential policy options for modifying the ACA's affordability firewall. Under the affordability firewall, workers and their families are precluded from receiving Marketplace subsidies if the worker share of the single ESI premium is less than 9.5 percent of the household income. Both policy options we considered use the family contribution instead of the single contribution in determining affordability. The first allows all individuals in such families to access Marketplace subsidies, while the second option allows only dependents, not workers, to access these subsidies. Relative to the ACA, we estimate that nongroup enrollment will increase by 4.1 million for Option 1 and by 1.4 million for Option 2. However, the number without insurance declines by only 1.5 million in Option 1 and 0.7 million in Option 2. The difference between the increase in nongroup enrollment and the decrease in uninsurance is primarily due to ESI crowd-out, which is more pronounced for Option 1. Furthermore, we estimate that about 1.3 million families that have ESI and unsubsidized nongroup coverage under current ACA policy would receive Marketplace subsidies under the alternative affordability firewall scenarios. For these families, health insurance coverage would become substantially more affordable; we estimate that these families' risk of spending at least 20 percent of income on health care would drop by more than two-thirds. We additionally estimated that federal spending will increase by $8.9 billion and $3.9 billion for Options 1 and 2, respectively, relative to the ACA.

Modifying the affordability firewall involves a set of trade-offs. Increasing the number of individuals with access to subsidies could lead to ESI crowd-out, as well as increased government spending. However, the expansion of subsidies would reduce the number of uninsured and lower health care costs for many families. As policymakers evaluate alternatives for modifying the ACA's affordability firewall, they will need to consider these economic trade-offs.

Notes

[1] These estimates are based on the 2014 Medical Expenditure Panel Survey, Insurance Component (AHRQ, 2015), inflated to 2015 levels using health care cost inflation factors from CBO (2015a and 2015b).

[2] Other sources of coverage include Medicare for the nonelderly with qualifying conditions and military-related sources of coverage, such as TRICARE.

[3] These numbers reflect the number of people whose firewall status changes, so they can access subsidies even though not all of them do.

[4] Estimate based on 2014 MEPS (AHRQ, 2015); inflated to 2017.

[5] For example, one or more children have access to CHIP while one parent has an ESI offer and the other does not.

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AHRQ—*See* Agency for Healthcare Research and Quality.

CBO—*See* Congressional Budget Office.

CFR—*See* Code of Federal Regulations.

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About This Report

The Affordable Care Act (ACA) was designed to increase health insurance coverage while limiting the disruption to individuals with existing sources of insurance coverage, particularly those with employer-sponsored insurance. To limit disruption to those with coverage, the ACA implements the employer mandate, which requires firms with more than 50 employees to offer health insurance or face penalties, and the individual "affordability firewall," which limits subsidies to individuals lacking access to alternative sources of coverage that are "affordable." This report examines the policy impacts of the affordability firewall and investigates two potential modifications. Option 1, which is the "entire family" scenario, involves allowing an exception to the firewall for anyone in a family where the family ESI premium contribution exceeds 9.5 percent of the worker's household income. In Option 2, the "dependents only" scenario, only dependents (and not the worker) become eligible for Marketplace subsidies when the ESI premium contribution exceeds 9.5 percent of the worker's household income. Relative to the ACA, RAND researchers estimate that nongroup enrollment will increase by 4.1 million for Option 1 and by 1.4 million for Option 2. However, the number without insurance only declines by 1.5 million in Option 1 and 0.7 million in Option 2. The difference between the increase in nongroup enrollment and the decrease in uninsurance is primarily due to ESI crowd-out, which is more pronounced for Option 1. Researchers also estimated that about 1.3 million families who have ESI and unsubsidized nongroup coverage under current ACA policy would receive Marketplace subsidies under the alternative affordability firewall scenarios. For these families, health insurance coverage would become substantially more affordable; these families' risk of spending at least 20 percent of income on health care would drop by more than two-thirds. We additionally estimated that federal spending will increase by $8.9 billion and $3.9 billion for Options 1 and 2, respectively, relative to the ACA.

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