Congressional Research Service
Informing the legislative debate since 1914

The Affordable Care Act and Small Business: Economic Issues

Sean Lowry
Analyst in Public Finance

Jane G. Gravelle
Senior Specialist in Economic Policy

February 25, 2014

Congressional Research Service
7-5700
www.crs.gov
R43181

CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 and P.L. 111-152) contains several provisions to encourage employer-sponsored health coverage, particularly among small businesses. The provisions that most directly relate to small businesses are (1) an employer penalty for not providing health insurance, (2) a tax credit to increase the affordability of health care for the smallest firms, and (3) small business health insurance exchanges designed to increase plan options and lower plan costs.

Several events have altered ACA's implementation since its enactment in 2010. Most notably, the Obama Administration delayed the implementation of the employer penalty and part of the small business health exchanges from 2014 to 2015 to allow for more time for developing these provisions and allowing firms to come into compliance. Subsequently, the Administration suspended the penalty for employers with fewer than 100 full-time equivalents (FTEs) for an additional year (2016). These delays have added to uncertainty over the potential effects of ACA on small businesses.

First, this report explains how employer-sponsored insurance can be used to address concerns about health insurance coverage and cost. Second, it summarizes the three ACA provisions most relevant to small businesses, listed above. Next, it analyzes these provisions for their potential effects on small businesses. Last, this report presents several approaches that could address some concerns associated with these provisions (particularly the employer penalty).

According to analysis of the most recent employer size and insurance coverage data, ACA's employer penalty is structured so that it could exempt approximately 96.2% of employer firms simply because they would be too small, and thus fall below the employer penalty threshold of 50 FTE employees. These exempt firms account for approximately 27.6% of all workers. After accounting for firms that already provide insurance, less than 1% of employer firms could be subject to the employer penalty. Although 72.4% of all employees work for firms that are large enough to be potentially subject to the penalty, only about 1.8% of employees work in firms that do not already offer health insurance.

Less than 4% of small businesses that could have been eligible for the small business health care tax credit in 2010 actually claimed it. According to a report by the Government Accountability Office (GAO), many business owners felt that (1) the credit was too small of an incentive to begin offering insurance; (2) even if these small employers offered health insurance, some employees declined coverage because they could not afford their share of the premium; and (3) the rules were too complex. President Obama has proposed simplifying and expanding the credit.

Small business health exchanges could help to reduce some barriers to accessing relatively affordable health coverage in the small-group market. By pooling risk among multiple businesses and reducing administrative costs, average insurance costs could reduce costs for these firms. On the other hand, firms with relatively healthier employees could see a rise in insurance costs.

One issue of concern is the incentive for firms to reduce part-time employee hours below the 30 that define "full-time" employment (under ACA) as a means to exclude these employees from coverage. Several bills have been introduced (e.g., H.R. 2575) to increase the definition of "full-time" to at least 40 hours per week. Although this change would reduce the incentive at 30 hours

per week, it would introduce an incentive to reduce hours among those that work around 40 hours (a larger share of all workers).

Contents

Tables

Appendixes

Contacts

Introduction

The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 and P.L. 111-152) contains several provisions to encourage employer-sponsored health coverage, particularly among small businesses. The provisions that most directly relate to small businesses are (1) an employer penalty for not providing health insurance, (2) a tax credit to increase the affordability of health care for the smallest firms, and (3) small business health insurance exchanges designed to increase plan options and lower plan costs.

The implementation of the ACA's provisions to encourage employer-sponsored health coverage has been the subject of increasing attention, particularly as they relate to small businesses. The ACA's employer penalty is intended to encourage employers to retain or offer health coverage to their employees.[1] Some maintain that the direct costs of the employer penalty and related compliance costs will be damaging to small businesses.[2] Core issues regarding the employer penalty as related to small businesses include hiring and workforce decisions, as well as their administrative costs. Although the employer penalty may not affect the decisions of employers with few employees (fewer than 50 employees) because they are not subject to the penalty, the penalty could be part of decision-making calculations for employers who are on the margins of the penalty threshold and are considering expanding their business.

Several events have altered ACA's implementation since its enactment in 2010:

- The Supreme Court ruled in 2012 that ACA's requirement that states extend their Medicaid benefits to all adults under the age of 65 with incomes up to the 133% of the federal poverty level was unconstitutional. It is now up to the states to choose whether to expand their respective Medicaid programs and increase health care coverage and affordability among some low-income workers.
- On June 4, 2013, the Department of Health and Human Services (HHS) announced that it is delaying the enforcement of ACA's requirement that the Small Business Health Options Program (SHOP) exchanges offer more than one plan from 2014 to 2015.[3] The SHOP exchanges will still open in 2014, but they are not required to offer more than one plan to employers.
- On July 2, 2013, the Obama Administration announced a delay in implementation of the employer penalty for all applicable firms until 2015, citing the need to simplify administrative complexities for businesses and give

[1] For an analysis of other options to increase health insurance coverage (including some that are part of the ACA), see Jonathan Gruber, *Covering the Uninsured in the U.S.*, National Bureau of Economic Research (NBER), Working Paper 13758, January 2008, http://www.nber.org/papers/w13758.pdf.

[2] This concern derives, in part, from the notion that small businesses are critical to job creation. Recent empirical studies indicate that small business owners have different aspirations concerning the growth of their firm, and small, new firms (i.e., startups) are more likely to expand than small businesses, generally. For further information reviewing the theoretical arguments and empirical literature on small business and job creation, see CRS Report R41392, *Small Business and the Expiration of the 2001 Tax Rate Reductions: Economic Issues*, by Jane G. Gravelle and Sean Lowry; CRS Report RL32254, *Small Business Tax Benefits: Current Law and Main Arguments For and Against Them*, by Gary Guenther; and CRS Report R41523, *Small Business Administration and Job Creation*, by Robert Jay Dilger.

[3] See CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

businesses more time to comply with an appropriate plan.[4] According to the ACA, the employer penalty and the small business health exchanges were supposed to go into effect beginning in 2014.

- On February 10, 2013, the Department of the Treasury issued a final regulation that would delay implementation of the employer penalty for firms with less than 100 "full-time equivalent" (FTE) employees (i.e., 50 to 99 FTEs) from 2015 to 2016.[5]

This report analyzes several ACA provisions that are most relevant to small business.[6] Because there is no single, precise definition of a "small business" in the ACA, this report discusses issues that are relevant to businesses that are sometimes considered to be "small" in more general terms (e.g., fewer than 500 employees). First, an overview of the rationale behind employer-sponsored health insurance is provided. This rationale informs the purpose and design of many of ACA's small-business relevant provisions. Second, a description of the ACA provisions that are most relevant to small business is provided, including the employer penalty, small business health care tax credits, and SHOP exchanges. Third, each provision is analyzed for potential economic effects on small businesses. Lastly, this report presents several approaches that could address some criticisms of ACA's employer penalty, and reduce its effects on small businesses.

The Rationale for Encouraging Employer-Sponsored Health Insurance

From an economic perspective, health insurance and health care markets have fundamental flaws that often lead to an inefficient allocation of resources. This inefficient allocation of resources, also known as a *market failure*, leads to a mismatch between demand and supply for a product because prices fail to accurately reflect the product's costs and benefits. From an economic perspective, the presence of a market failure may provide a justification for government intervention to resolve inefficiencies, unless the cost of correcting the failure is greater than the expected efficiency loss.[7]

Access to health insurance generates *externalities*, or spillover effects to society, that might be difficult for any individual participant in the health insurance market to take into account. For example, more insured individuals decrease the risk that others might contract certain contagious diseases. Also, ill individuals without coverage might use publicly funded resources, especially if their illness becomes serious enough that it depletes their wealth (a negative externality). The net

[4] See Valerie Jarrett, "We're Listening to Businesses About the Health Care Law," White House Blog, July 2, 2013, http://www.whitehouse.gov/blog/2013/07/02/we-re-listening-businesses-about-health-care-law. For more information about the administrative effects of the delay, see CRS Report R43150, *Delay in Implementation of Potential Employer Penalties Under ACA*, by Bernadette Fernandez and Annie L. Mach.

[5] U.S. Department of the Treasury, "Shared Responsibility for Employers Regarding Health Coverage," 79 *Federal Register* 8543-8601, February 12, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-02-12/pdf/2014-03082.pdf.

[6] This report updates and supersedes analysis in the archived CRS Report R40775, *Health Care Reform and Small Business*, by Jane G. Gravelle. For analysis and historical context the alternative proposals put forward during the legislative process that led to the enactment of the ACA, please refer to this archived report.

[7] For more information, see CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford; David Cutler, *Market Failure in Small Group Health Insurance*, National Bureau of Economic Research (NBER), October 1994, http://www.nber.org/papers/w4879.

cost of these externalities to society may not be fully reflected, or *internalized*, by firms and workers, in the cost of health insurance. Therefore, the supply and demand for health insurance in the private market may lead to an undesirable level of insurance from the perspective of society as a whole.

In the private market for health care, individuals typically know more about their health status than insurance firms and those that generally desire more health care tend to seek out health insurance. This market failure is called *adverse selection*. Adverse selection makes it difficult for insurance firms to predict costs and establish prices based on predicted costs.[8] Also, individuals who tend to desire the most health care coverage tend to be the least healthy, while healthier people tend to desire less heath care coverage. Because some healthy people opt to not have health care coverage, the average price of insurance increases, as those now in the insurance pool are less healthy. Rising costs push more people out of the market for health insurance because they believe that the costs of insurance exceed the benefits. The end result is that many individuals, some by choice and some due to cost, will not have health insurance.

In addition, even if both parties are informed about health status, people who have pre-existing conditions or other characteristics that make use of health care more likely (such as old age) may not have, or be able to afford, health insurance.[9] Individuals could be limited in their capacity to pay for health insurance due to low-incomes. In this instance, a lack of individual health care coverage can still impose the same negative spillover effects on society.

Aside from the issues of adverse selection and spillover effects from uninsured individuals, society as a whole can view health insurance not as individual insurance, but as social insurance. From a social insurance perspective, having more insured individuals spreads the risk (and costs) of becoming ill across more individuals including, for example, those born with compromised health, health issues developed during childhood, or those who lose employer health insurance due to a job loss or change in employment.[10]

Various types of risk-pooling mechanisms have been able to reduce the negative externalities associated with the private health care market. The problem of adverse selection and excessive cost has been addressed among the elderly by Medicare and is significantly reduced among the working population by employer-sponsored health insurance (ESI). Some states also limit variations in premium costs. ESI also provides a pooling mechanism that is unrelated to health factors and thus addresses both the adverse selection problem and the problem of being priced out of the market for those with ill health.[11] ESI also tends to reduce administrative costs compared

[8] Before health care reform, insurance companies often counteracted this adverse selection by denying coverage to risky individuals or offering them coverage at higher insurance premium costs. While this helped to address the negative effects of adverse selection for insurance companies, it also led to some individuals not having insurance even if they wanted it.

[9] Prior to the ACA, insurers practices in the individual market for health insurance, such as denial of coverage to high-risk applicants, reduced the effects of adverse selection on risk pools, but also lead to more individuals without insurance. For more information on the ACA's private health insurance market reforms, see CRS Report R43048, *Overview of Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach.

[10] Some say that public policy should not encourage employer-sponsored health coverage, as it may provide incentives for some workers to stay in less-productive jobs in order to retain their health benefits. Under this interpretation, a market failure in the health care market may be the result of a worker's inability to accurately price the benefits of pursuing more productive lines of work, known as *opportunity costs*.

[11] Employer health insurance also benefits from the exclusion of premium contributions by employers from wage (continued...)

with such costs when individuals purchase coverage on their own. These pooling and administrative advantages are lessened for businesses with few employees.

The price of employer-sponsored health care benefits should, according to economic theory, offset wages so that employees as a group are still incurring the cost of insurance, but do not face the difficulties they would with non-group private insurance purchase. Employers with small pools of individuals may experience some of the same types of problems as individuals. If there is one employee who has (or whose family has) a serious health problem, the cost for insuring the group could be relatively high. Further, administrative costs per employee are larger for small firms; one study estimates these costs are 18% higher for small businesses.[12] Perhaps as a result, large firms are more likely than small firms to offer health care plans and to have higher employee participation rates.

Two crucial elements are cited as necessary to address the problems relating to adverse selection and lack of affordability, especially for those with pre-existing conditions: some form of community pooling so that individuals with health problems (including age) would not have to pay a substantially different price, and a provision to require most individuals to have health insurance. Because 55% of workers (as of 2011) are already covered by insurance provided by an employer (even if not their own, such as their spouse's employer), policies to further encourage ESI could be deemed by some to be desirable.[13] The benefits of ESI could induce more low-risk workers to purchase health insurance, thereby lowering overall risk pools and subsidizing the higher price of insuring workers with comparatively higher risk profiles.

Overview of Provisions Relating to Small Business in the Affordable Care Act

This section briefly describes the provisions in the ACA that are especially relevant to small businesses.[14] A "small business" is defined in multiple ways throughout ACA, and differs from

(...continued)

income, which benefits taxpayers with income tax liability. Insurance benefits are also excluded from the payroll tax although there are future benefits that partially offset the cost of the payroll tax.

[12] Executive Office the President, Council of Economic Advisers, *The Economic Effects of Health Care Reform on Small Businesses and Their Employees*, July 25, 2009.

[13] Health care coverage data is available at the U.S. Census Bureau and Bureau of Labor Statistics, HI01- Health Insurance Coverage Status and Type of Coverage by Selected Characteristics, Current Population Survey, http://www.census.gov/hhes/www/cpstables/032012/health/h01_000.htm. For critical analysis of ESI prior to enactment of the ACA, see Thomas C. Buchmueller and Alan C. Monheit, *Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform*, National Bureau of Economic Research (NBER), Working Paper 14839, April 2009, http://www.nber.org/papers/w14839.pdf. Note that the ACA contains provisions to help address some of the authors' criticisms (e.g., access to affordable ESI coverage among small businesses).

[14] Some have voiced concerned that the ACA's 3.8% Medicare tax increase for higher-income tax filers could affect small business owners. Because this provision is targeted toward individuals exceeding a certain threshold based on their modified adjusted gross income, and not business income, it is omitted from analysis in this report. For a description and analysis of this provision, see CRS Report R41413, *The 3.8% Medicare Contribution Tax on Unearned Income, Including Real Estate Transactions*, by Mark P. Keightley; and Tax Policy Center, Table T10-0084, March 1, 2010, http://www.taxpolicycenter.org/numbers/displayatab.cfm?DocID=2679&topic2ID=60&topic3ID=73&DocTypeID=.

other conventional definitions of a small business. Thus the scope of the firms affected by each provision varies.

Employer Penalty

The ACA sets out a two-part calculation for determining which employers are subject to a monthly imposed penalty for not providing health insurance meeting minimum standards of "affordability" and "adequacy" set forth in the ACA.[15] As previously mentioned, implementation of the employer penalty was originally scheduled to begin in January 2014, but the Obama Administration has delayed the penalty until January 2015 (2016 for firms with 50 to 100 "full-time equivalent" [FTE] employees).

First, businesses must employ enough workers to qualify as a "large employer" to be subject to the employer penalty. Small businesses with fewer than 50 FTE employees or less are not subject to the penalty.[16] Total FTEs are calculated by adding the total number of "full-time" workers (who average 30 hours per week or more) plus the number of part-time employees aggregated to FTE employees.[17] Seasonal workers are generally not included in determining employer size.

Second, the penalty will only be levied on large employers that have at least one full-time worker that receives a health insurance premium credit in the individual insurance exchange markets that will begin offering coverage in January 2014. Some large employers could have workers that do not purchase insurance through an employer-sponsored plan, thus those employers would not necessarily face a penalty (these scenarios will be discussed in more depth, later in this report).

For employers subject to the penalty, the amount of the penalty depends on whether an employer offers insurance coverage. Even if an employer offers coverage, it could still be subject to the employer penalty if the health insurance coverage does not meet ACA's standards for being *affordable* and *adequate*. Coverage is considered affordable if the employee's required contribution to the plan does not exceed 9.5% of the employee's household income for the taxable year.[18] A health plan is considered to provide adequate coverage if the plan is a 60% or greater actuarial value (i.e., the share of the total allowed costs that the plan is expected to cover).

If a large employer offers coverage that is not *affordable* and *adequate* and one or more of those employees receives premium credits, the monthly penalty is the lesser of

[15] See CRS Report R41159, *Potential Employer Penalties Under the Patient Protection and Affordable Care Act (ACA)*, by Julie M. Whittaker for a more detailed explanation of the employer penalty.

[16] In other words, even if a business is considered to be a "small business" by other means (e.g., eligible for assistance from the Small Business Administration), they can still be classified as a "large employer" for the purposes of the ACA's employer penalty.

[17] Part-time workers are converted to FTEs by dividing the sum of part-time hours worked in a month by 120. This part-time calculation is then added to the amount of full-time workers to arrive at a total FTE count. With regard to multiple franchises under a single owner, ACA follows the Internal Revenue Service (IRS) aggregation rules governing "controlled groups" (26 USC §414). If one individual or entity owns (or has a substantial ownership interest in) several franchises, all those franchises are essentially considered one entity. In this case, for purposes of the 50-FTE rule under the employer penalty, the employees in each of the franchises must be aggregated to determine the number of FTEs.

[18] IRS has provided a safe harbor for employers to use the employee's W-2 income for this calculation (since most employers do not readily have information on an employee's household income).

- one-twelfth of $3,000 for each of those employees that receive credits for exchange coverage or
- one-twelfth multiplied by $2,000 multiplied by the number of full-time employees minus 30 (i.e., the first 30 full-time workers are exempted from calculations of the penalty amount).

By comparison, a large employer who does not offer *any* coverage will be subject to a penalty equal to

- the number of its full-time employees minus 30 multiplied by one-twelfth of $2,000 for any applicable month.

Part-time workers are not used to calculate the amount of the employer penalty. After 2014, the penalty payment amount will be indexed by a premium adjustment percentage for each subsequent calendar year. Thus a firm with no more than 30 full-time workers would not pay a penalty even if part-time workers caused them to be classified as "large."

Using 50 employees as the point at which the penalty applies and assuming all full-time employees, a firm with 50 employees, would pay an average monthly penalty of $800 per employee ($2,000 * ((50-30)/50)). The average per employee would rise as employee size rose: $800 per employee for a firm with 50 employees, $909 for 55 employees, $1,000 for 60, $1,200 for 75, $1,400 for 100, $1,880 for 500, and so forth, until the average approaches $2,000 at a very large size.

Small Business Employer Health Care Tax Credit

Small businesses with fewer than 25 FTE employees and with average wages less than $50,000 may be eligible for a credit of up to 50% of the employer's payment for two consecutive years, beginning in 2014.[19] From 2010 through 2013, there is a transitional credit of 35% as well. The employer must pay at least 50% of the health plan premium to be eligible for the tax credit. The tax credit is applied against the income tax, so small employers without tax liability will receive no current benefit and small employers with inadequate tax liability will not receive the full current benefit. Credits can be carried backward one year (except in the first year offered) and forward 20 years.

Tax-exempt entities, such as charities, are eligible for a 35% credit (25% during the transition) taken against payroll taxes.

The credit is phased out both by size and average income in an additive fashion. The credit is reduced by the number of FTE employees over 10, divided by 15; the credit is also reduced by average wage over $25,000 divided by $25,000.

For example, a business with 10 or fewer FTE employees and $25,000 or less in average wages will receive a credit of 50% of the employer contributions to health premiums in 2014.[20] Changes

[19] See CRS Report R41158, *Summary of Small Business Health Insurance Tax Credit Under the Patient Protection and Affordable Care Act (ACA)*, by Manon Scales and Annie L. Mach, for a more detailed discussion of the small business credit and detailed calculations of the tax credit.

[20] Ibid., see **Table 4** for calculations.

to the size of the firm or its payroll could affect this firm's maximum tax credit in one of three ways:

1. If the average wage remains at $25,000 or less but FTE employee size rises to 15, the credit is reduced by 33% (15 minus 10, all divided by 15, or approximately one-third or 33%).
2. If average wages rise to $30,000 but size mains at 10 or fewer FTE employees, the credit is reduced by 20% ($30,000 minus $25,000, all divided by $25,000) for a credit of 40% (instead of the maximum of 50%).
3. If both phaseouts are added, so that a firm with 15 employees and an average wage of $30,000, both the 33% and the 20% apply for a reduction of 53%. This combined phaseout would reduce the 50% maximum credit to 23% of employer contributions to health care premiums.

Small Business Insurance Exchanges

Beginning in 2014, small employers seeking health insurance coverage for their employees will be able to use ACA's SHOP exchange.[21] The SHOP exchange is designed to assist small employers and their employees with the purchase of health plans offered in the small group market.[22]

Only qualified small employers and their qualified employees are eligible to obtain coverage through a SHOP exchange health insurance plan. Enrollment in a SHOP exchange begins in October 2013 for the 2014 calendar year. Prior to 2016, states have the option to define "small employers" either as those with 100 or fewer employees or 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees.

A SHOP must allow certain "employer choice" functions, thereby enabling an employer to select from a variety of coverage options to make available to its employees. According to an HHS final rule issued on June 4, 2013, however, a SHOP will not be required to carry out the employer choice function (i.e., offer more than one plan) until 2015.[23]

Potential Effects of Certain ACA Provisions on Small Business

This section of the report analyzes the effects certain ACA provisions could have on small businesses. Specifically, issues related to compliance, hiring, and profits are addressed. Although

[21] Note that small employers are not required to obtain health insurance coverage for their employees through a SHOP exchange; ACA explicitly states that enrollment in exchanges is voluntary, and no individuals or small employers may be compelled to enroll in exchange coverage (§ 1312(d) of ACA).

[22] In general, exchanges will offer comprehensive coverage that meets the standards to be certified as "qualified health plans" (QHPs). For more information about QHPs and exchanges (including SHOP exchanges), see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[23] 78 *Federal Register* 33233, June 4, 2013.

some specific firm size designations are set in the various provisions of the ACA, the effects of these provisions might extend to firms beyond these size thresholds (e.g., those on the margins of growth around the size thresholds).

Employer Penalty

In theory, penalties should help induce firms that are large enough to be subject to the penalty and are not currently providing health insurance to do so, without encouraging other, larger employers to stop providing health insurance. Economic theory suggests the penalty should ultimately be passed through to lower wages, limiting the burden on small business owners.[24] If firms cannot pass on the cost in lower wages, the higher cost of workers may lead firms to reduce output and the number of workers.[25] Individuals with lower incomes, however, should be able to receive insurance premium credits in the community-rated pools, which will increase their welfare while also increasing cost to the federal government for financing coverage to those foregoing ESI. For some firms, paying a penalty may be more feasible than providing insurance that meets ACA's coverage and affordability standards, especially if their employees are lower income and the wage cannot be lowered below the minimum wage.

Any exemption from the employer penalty based on employees could create disincentives for adding workers. As the ACA imposes the full penalty at a specific, discrete level (often referred to as a "cliff"), an additional employee at that point will trigger a significant cost and discourage expansion. By phasing in the penalty as employee size rises, the cost could have risen more gradually and the disincentive at any specific point would be smaller.

The number of small businesses that could be affected by the employer penalty and how they could be affected has been the subject of some misunderstanding among small employers who are not subject to the penalty.[26] A March 2013 survey of very small employers (those with between two to 10 employees) who would not be subject to the employer penalty under ACA found that 56% of respondents misunderstood portions of the ACA's employer penalty, with 32% believing they will be required to provide group health insurance in 2014, regardless of the number of employees, and 24% believe they will have to pay a penalty for failing to provide group coverage.[27]

Data from the Census Bureau's 2011 Statistics of U.S. Business (SUSB) can be used to approximate the number of firms exempt from the employer penalty because they do not have enough employees to put them over the threshold. These data also include information on payroll

[24] In the long-run, the labor supply is relatively fixed (inelastic). With a fixed aggregate labor supply, total payments to labor are fixed at any point in time. The compensation a firm offers a worker is equal to their direct wages plus any fringe benefits (e.g., health care). Thus, firms will respond to any increase in the price of offering those fringe benefits by either reducing the value of the fringe benefits or the value of the wages.

[25] Firms in capital-intensive industries might have less ability to pass any additional costs onto their workers, though.

[26] For more discussion of projections on ACA's effects on health care costs, coverage rates, etc., see Jonathan Gruber, "The Impacts of the Affordable Care Act: How Reasonable are the Projections?" *National Tax Journal* (September 2011), pp. 893-908 and Casey B. Mulligan, "Health Reform, the Reward to Work, and Massachusetts," *New York Times Economix Blog*, March 6, 2013, http://economix.blogs.nytimes.com/2013/03/06/health-reform-the-reward-to-work-and-massachusetts/.

[27] eHealth Inc. Small Business Owners Unaware of Exchanges and Misunderstand Mandates and Tax Obligations Under the Affordable Care Act, 2013, http://news.ehealthinsurance.com/_ir/68/20132/eHealth%20Spring%202013%20Small%20Bus%20Survey.pdf.

and wages that are useful for analysis of ACA employer penalties. There are limitations when using SUSB data to analyze ACA penalties. Specifically, full-time and part-time employees count equally as employees in the SUSB dataset, whereas they are weighed differently in calculations of FTE employees. Thus, estimates based on SUSB of the number and share of firms that could be affected by ACA employer penalties are likely overstated. Because the SUSB data does not disaggregate workers by full-time or part-time status, it is also difficult to determine precisely which firms will be "exempt" from the penalty because they have 20 or fewer full-time workers.

Data from the SUSB suggests that the vast majority of firms will be exempt from the employer penalty simply due to their employment size. As shown in **Table 1**, 96.2% of employer firms in 2011 had fewer than 50 employees and thus are not likely to be affected by the ACA employer penalty simply due to their size.[28] These exempt businesses accounted for 27.6% of all workers. The 3.8% of businesses with 50 or more employees in 2011 which could be potentially subject to the employer penalty (simply based on their size) employed 72.4% of all workers.

Table 1. Employment and Payroll Characteristics of Employer Firms, 2011

Enterprise Employment Size	Number of Employer Firms	Cumulative Share of All Firms	Average Annual Payroll Per Employer Firm	Number of Employees	Cumulative Share of All Employees	Average Annual Salary Per Employee
45-49	34,003	96.2%	$1,481,970	1,263,505	27.6%	$39,882
50-74	26,979	97.6%	$7,021,135	4,677,761	31.7%	$40,494
75-99	77,777	98.3%	$1,731,250	3,199,218	34.5%	$42,089
100-149	37,335	98.9%	$4,869,629	4,260,619	38.3%	$42,672
150-199	35,212	99.2%	$3,616,965	2,992,069	40.9%	$42,566
200-299	17,372	99.5%	$10,146,307	4,025,425	44.4%	$43,787
300-399	16,637	99.6%	$7,041,336	2,635,522	46.8%	$44,449
400-499	7,641	99.7%	$11,508,051	1,953,802	448.5%	$45,006
500+	17,671	100.0%	$169,517,511	58,427,653	100.0%	$51,269
Total	5,684,424	100.0%	$908,605	113,425,965	100.0%	$45,535

Source: CRS analysis of U.S. Census Bureau, Statistics of U.S. Business Annual Data for 2011, http://www2.census.gov/econ/susb/data/2011/us_state_naicssector_small_emplsize_2011.xls.

Note: An enterprise is an employment or a business consisting of one or more domestic establishments that were specified under common ownership or control. The enterprise and the establishment are the same for single establishment firms. Each multi-establishment company forms one enterprise. Employment is defined as paid employment and consists of full and part-time employees, including salaried officers and executives of corporations, who were on the payroll in the pay period including March 12. Employment is measured in March, thus some employer firms (e.g., start-ups created after March, closures before March, and seasonal firms) will have zero employment and some annual payroll.

[28] For a table containing data analysis of all employer firms, see the **Appendix**. As discussed earlier in this report, the SUSB dataset does not include non-employers (i.e., self-employed individuals). These self-employed individuals are excluded from analysis in this report because they could be working part-time as a side job (and possibly covered under an employer-sponsored plan or a spouse's group plan) or working full-time (and not subject to the employer penalty). If self-employed individuals are included among the number of "total firms" in the United States, then the share of businesses potentially subject to the employer penalty would be smaller.

When accounting for health insurance offer rates, the number of smaller firms that could be subject to the employer penalty decreases, as the larger the firm, the more likely it is to offer health insurance coverage.[29] **Table 2** shows data on health insurance offer rates by firm size from the Kaiser Family Foundation's 2013 Annual Employer Survey.[30] Firms with between three and nine employees were less likely to offer insurance coverage than firms with more employees.[31] In 2012, 85% of firms with fewer than 50 workers offered health benefits to their employees compared with 91% of firms with 50-199 workers, and 99% of firms with 200 workers or more.

Table 2. Percentage of Firms Offering Health Benefits, by Firm Size, 2013

Year	3-9 Workers	10-24 Workers	25-49 Workers	50-199 Workers	200+ Workers
2013	45%	68%	85%	91%	99%

Source: Kaiser Family Foundation (KFF), *Employer Health Benefits Annual Survey*, 2013, p.33, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf.

Note: The KFF survey does not report data for firms with 1-2 workers.

Assuming that the firms offering health care benefits in 2014 continue to do so after the penalty begins in 2015, less than 0.2% of all employer firms could be subject to the full employer penalty (assuming the coverage provided by employers meet ACA's standards for being "affordable" and "adequate"), with the vast majority of these firms having between 50 and 199 employees.[32] Although the firms with more than 50 employees account for 72.4% of all employees (as shown in **Table 1**), only about 1.8% of all employees work in larger firms that do not already offer health insurance.[33] Note though, that some analysts' simulations indicate that ACA will have an effect on small business health care coverage rates.[34] In its February 2014 Budget Outlook, the

[29] Note that these health care offer rates are not the same as employee take-up rates. For simplicity, the analysis in this report assumes that employees take-up employer-sponsored coverage rather than seek individual coverage in health exchanges or choose to pay ACA's individual penalty rather than a regular health care premium. This latter assumption might not hold for some workers (e.g., younger, healthier workers).

[30] Kaiser Family Foundation (KFF), *Employer Health Benefits Annual Survey*, 2013, at http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf. In the past, the share of employers that offer health insurance have been higher than the share of the workers that take-up their employer's plan. KFF's reported offer rates are used in this analysis instead of employee take-up rates because a number of decisions affect the latter statistic. For example, some employees may not take-up their employer's health plan because they can obtain cheaper or more comprehensive coverage through a spouse's or family plan, they cannot afford to or choose not to pay for their share of their insurance premiums, etc. It is uncertain how the full implementation of ACA will affect these statistics. While some employees might be affected by the other ACA provisions that are set to begin in 2014 and 2015 (e.g., the individual mandate, insurance premium subsidies for low-income workers in individual health exchanges), these effects will probably not have a major effect on the number of firms that could be subject to the employer penalty.

[31] The KFF survey does not report data for firms with 1-2 workers.

[32] This calculation is computed by multiplying the share of employer firms (as shown in **Table 1**) times the share of firms that don't offer health benefits to their employees (as indicated by the 2013 KFF Employer Survey data), and then summing these numbers for firms with 50-199 workers and 200+ workers to arrive at a total estimate. In numerical terms, this is: (0.021*0.09) + (0.008*0.01) = 0.00197, or approximately 0.2% of all employer firms.

[33] This calculation is computed by multiplying the cumulative share of employees by employer size (as shown in **Table 1**) times the health care offer rates for the respective firm size found (as shown in **Table 2**), and then summing these numbers for firms with 50-199 workers and 200+ workers to arrive at a total estimate. In numerical terms, this is: (0.133*0.09) + (0.591*0.01) = 0.01788, or approximately 1.8% of all workers.

[34] For example, see Linda J. Blumberg et al., *Implications of the Affordable Care Act for American Business*, The Urban Institute, October 2012, http://www.urban.org/UploadedPDF/412675-Implications-of-the-Affordable-Care-Act-(continued...)

Congressional Budget Office (CBO) also estimated that the employer penalty could have a minor effect on the aggregate demand for labor in the short run (as they bear the cost of the penalty or providing health insurance coverage) until businesses can adjust by offering lower wages over time.[35] In the long run, however, CBO says that workers will choose to reduce their labor supply (hours or participation in the labor market), based on their own preferences for leisure or consumption, as wages fall.

These long-run effects would likely be minor. CBO projects penalties of about $14 billion for 2016.[36] Comparing that number with labor compensation in 2012, the percentage change in wages is only 0.16%.[37] CBO has indicated that the labor response to a change in wages (an elasticity, which is percentage change labor supply divided by a percentage change in wages) is approximately 0.25. Thus the employer penalty would produce a reduction of 0.04% of the labor force, only 2% to 3% of their total.

The CBO report discusses the effects of the penalty on part-time work but concludes there is little evidence of an effect or that it would affect total labor. The report also does not estimate the effect of a benefit from cheaper insurance by small business, which one study concludes indicates the employer penalty will benefit wages and increase labor supply.[38]

Small Business Employer Health Care Tax Credit

The credit is intended to encourage coverage to benefit very small firms (not subject to the employer penalty) and very low-income workers. The Joint Committee on Taxation (JCT) and the CBO initially estimated that taxpayers would claim up to $2 billion in credits for the 2010 tax year.[39] Despite informing approximately 4.4 million taxpayers that were potentially eligible for credits, the Internal Revenue Service (IRS) reported that 228,000 taxpayers claimed the credit for a total of $278 million in 2010.[40] A 2012 report by the Government Accountability Office (GAO) said that the number of firms that benefited from the credit was even smaller than the IRS's 2011 report: 170,300 small businesses claimed a total of $468 million in health care credits in 2010.[41]

(...continued)

for-American-Business.pdf.

[35] See Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, February 2014, p. 122, http://cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014.pdf.

[36] Penalty estimates can be found in Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's February 2014 Baseline," February 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-02-ACAtables.pdf.

[37] Labor compensation was $8.7 trillion, as of the end of 2012. See Council of Economic Advisors, *Economic Report of the President,* Table B-29, http://www.whitehouse.gov/sites/default/files/docs/erp2013/ERP2013_Appendix_B.pdf.

[38] Linda J. Blumberg, Matthew Buettgens, Judy Feder, and John Holahan, Implications of the Affordable Care Act for American Business, Urban Institute, October 2012, http://www.urban.org/UploadedPDF/412675-Implications-of-the-Affordable-Care-Act-for-American-Business.pdf.

[39] Letter from Douglas Elmendorf, Director of the Congressional Budget Office to Honorable Nancy Pelosi, Speaker of the U.S. House of Representatives, May 25, 2010, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf.

[40] Treasury Inspector General for Tax Administration, Affordable Care Act: Efforts to Implement the Small Business Health Care Tax Credit Were Mostly Successful, but Some Improvements Are Needed, 2011-40-103, September 19, 2011, http://www.treasury.gov/tigta/auditreports/2011reports/201140103fr.pdf.

[41] U.S. Government Accountability Office, *Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity*, GAO-12-549, 2012, http://www.gao.gov/assets/600/590832.pdf. GAO's independent audit was lower than (continued...)

According to GAO, the average tax credit claimed by small businesses that applied for and received the health care credit in 2010 was $2,748.

GAO found that the amount of small businesses that applied for the credit was limited by three factors. First, many business owners felt that the credit was too small of an incentive to begin offering insurance. Most small businesses that would otherwise be eligible for the credit (83% by one estimate) did not offer health insurance.[42] In addition, 67% of employers who could be eligible for the partial credit did not offer insurance in 2010.[43] Second, even if these small employers offered health insurance, some employees declined coverage because they felt that they could not afford their share of the premium. Third, many small businesses felt that claiming the credit was too complex.[44]

Small Business Insurance Exchanges

The health exchanges associated with ACA, notably the SHOP exchanges, are intended to address some of the inherent disadvantages for small businesses to improve access to affordable health care plans.[45] The 2013 Kaiser Family Foundation Annual Employer Survey reported that among small firms (defined as having 3 to 199 workers) not offering health benefits, 50% cited high cost as "the most important reason" for not doing so.[46] If the ACA programs (including SHOP exchanges) contain the costs of health insurance premiums, more of the smaller firms could offer health insurance coverage.

As with individuals, very small firms that have individuals or families whose health care is relatively more costly will be able to purchase insurance more easily through the SHOP exchanges. For some small firms, the ability to buy insurance through the SHOP exchanges could enable them to offer health coverage at a lower cost than they would have been offered in the private small-group market. This is particularly the case for small businesses that employ workers with a higher risk profile. The cost of these plans are lower because the additional costs of insuring relatively riskier firms will be spread across many other firms. Thus, they should reduce

(...continued)

the U.S. Department of the Treasury's Inspector General for Tax Administration's 2011 claim that 228,000 small businesses applied for the health care credit.

[42] This estimate is based on GAO's methodology of data from the Medical Expenditure Panel Survey. See U.S. Government Accountability Office, *Small Employer Health Tax Credit: Factors Contributing to Low Use and Complexity*, GAO-12-549, 2012, p. 10, http://www.gao.gov/assets/600/590832.pdf.

[43] Ibid., p. 12.

[44] Ibid., p. 13. Some tax preparers said that it takes their clients from two to eight hours, or possibly longer, to gather the necessary information to calculate the credit and that the tax preparers spent, in general, three to five hours calculating the credit. If a small business tax accountant charges approximately $122 an hour, then a small business owner would likely need to project a tax credit of at least $350 to $600 just to cover the cost of hiring an accountant to calculate the credit—in addition to the cost of the time spent gathering any necessary information. GAO used this figure from a 2008 National Society of Accountants survey that estimated the hourly tax preparer fee to be $122 an hour.

[45] For more information on SHOP exchanges and current status of implementation, see CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[46] Kaiser Family Foundation, *Employer Health Benefits Annual Survey*, 2013, p.43, http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf.

the problem of adverse selection.[47] Firms with healthier employees, however, could see a rise in cost. In any case, the SHOP exchange should also reduce premium costs because of reduced administrative costs from pooling more businesses under a single policy.

Potential Revisions to Address Criticisms of the Employer Penalty

Aside from concerns about compliance and administration, some have charged that the employer penalty creates incentives for some employers to take undesirable actions. Some of these possible actions include encouraging firms to avoid hiring or to reduce employment to fall below the limit, significantly increasing the cost of hiring low wage workers, and encouraging firms to reduce the hours of employees to schedule them to work part-time.[48]

Still, an argument could be made that there is no need to make revisions given the small share of firms that would be affected. As noted earlier, the circumstances in which these effects are likely to occur are limited to less than 1% of firms (after adjusting for firms that already offer health insurance coverage). One forecaster has observed that projected employment effects leading up to implementation have not been very large, which may reflect the limited effect of the penalty.[49]

Also, options to liberalize exemptions will increase federal budgetary costs due to lost revenue from the penalty. According to CBO, the employer penalty is expected to raise about $130 billion over 10 years (after accounting for the Obama administration's one-year implementation delay).[50] In addition, if the exemption caused firms to forego offering health insurance, government outlays for health insurance premium credits for individuals would likely increase. This effect would be offset by a reduced cost (i.e., increased revenue), at least in part, from the tax exclusion of health insurance from the income of the employer.

Nevertheless, some may still feel inclined to make revisions to the employer penalty in order to reduce or moderate potential issues. This section of the report analyzes several possible revisions and provides some examples of legislation proposed in the 113th Congress, but it is not meant to reflect an exhaustive list of possible options or suggest that changes are needed.

---

[47] These issues are discussed in Executive Office the President, Council of Economic Advisers, *The Economic Effects of Health Care Reform on Small Businesses and Their Employees*, July 25, 2009, http://www.whitehouse.gov/assets/documents/CEA-smallbusiness-july24.pdf.

[48] Some of these concerns are summarized in Testimony of Larry Schuler on behalf of the National Restaurant Association, in U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, Obamacare's Impact on Jobs, 112th Cong., 1st sess., March 30, 2011, http://www.restaurant.org/Downloads/PDFs/advocacy/20130313_hc_energycommerce_nra_testimony; and Testimony of Tom Boucher on behalf of the National Restaurant Association, in U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, Obamacare's Impact on Jobs, 113th Cong., 1st sess., March 13, 2013, http://www.restaurant.org/Downloads/PDFs/advocacy/20130313_hc_energycommerce_nra_testimony.

[49] See comments of Mark Zandi indicating the predicted employment effects were lower than expected and appear to be modest in Danielle Kurtzleben, "Businesses Applaud Affordable Care Act," *U.S. News and World Report*, July 3, 2013, http://news.yahoo.com/businesses-applaud-affordable-care-act-delay-135819141.html;_ylt=A2KJ2UbEatRRW3oAENDQtDMD.

[50] Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Honorable Paul Ryan, Chairman, House of Representatives Committee on the Budget, July 30, 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44465-ACA.pdf.

Eliminate the Employer Penalty

Opposition to the employer penalty is most often centered on its disincentives to hiring on the margins, other possible labor market distortions (e.g., firms choosing to hire part-time to full-time workers), and compliance costs to employers. Some critics have called for a repeal of the current employer penalty, arguing that its repeal would have little effect on health insurance coverage.[51] In contrast, some bills in the 113th Congress seek to eliminate the employer penalty with no replacement provision that would penalize firms for not offering health insurance of a particular quality or cost level.[52]

As previously mentioned, the employer penalty is designed to encourage employers to either begin offering health insurance to their employees or to maintain coverage.[53] For employers that already offer coverage, the employer penalty serves to reinforce that practice and provide disincentives for firms to decrease the range of coverage or to increase an employee's share of the premium costs.

Change the Definition of "Full-Time" to 40 Hours Per Week

Multiple bills introduced in the 113th Congress propose changing ACA's definition of "full-time" from 30 hours per week to 40 hours per week.[54] Proponents of this revision argue that the current, 30-hour per-week definition is unusually low compared with "traditional standards" of a full-time worker in many industries, thus increasing employer's calculations and compliance costs.[55] In addition, proponents of the revision argue that the 30-hour definition encourages employers to reduce the number of hours allotted to each worker (thereby reducing their pay) in order to reduce the number of "full-time" workers and reduce their compliance costs with ACA (or the size of their employer penalty, because the penalty is only based on full-time workers).[56] Note, as discussed below, that the incentive for firms paying the penalty could be eliminated by imposing the penalty to apply to FTEs.

---

[51] For example, see Linda J. Blumberg, John Holahan, and Matthew Buettgens, *It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than the Individual Mandate*, Urban Institute, July 15, 2013, http://www.urban.org/publications/412865.html; Ezra Klein, "Obamacare's employer mandate shouldn't be delayed. It should be repealed," *The Washington Post Wonkblog*, July 2, 2013, http://www.washingtonpost.com/blogs/wonkblog/wp/2013/07/02/obamacares-employer-mandate-shouldnt-be-delayed-it-should-be-repealed/; and Tyler Cowan, "Repeal the employer mandate altogether," Marginal Revolution Blog, July 3, 2013, http://marginalrevolution.com/marginalrevolution/2013/07/repeal-the-employer-mandate-altogether.html.

[52] For example, see the Small Business Health Relief Act of 2013 (H.R. 1558, S. 24) and the American Job Protection Act (S. 399). None of these bills have been reported out of committee.

[53] Much of this logic is based on research pertaining to the use of coverage mandates in the health insurance market. For example, see Jonathan Gruber, *Covering the Uninsured in the U.S.*, National Bureau of Economic Research (NBER), Working Paper 13758, January 2008, http://www.nber.org/papers/w13758.pdf.

[54] For example, see the Save American Workers Act of 2013 (H.R. 2575), the Forty Hours is Full Time Act (S. 1188), and Generating Real Opportunities for Workers and Transitional Help Act (H.R. 3885). On February 4, 2014, the Committee on Ways and Means favorably reported H.R. 2575 to the House of Representatives.

[55] Sen. Joe Donnelly and Sen. Susan Collins, "ObamaCare's Definition of Full-Time Job Needs Revising," *Wall Street Journal*, July 18, 2013, http://online.wsj.com/article/SB10001424127887323309404578611490682767344.html.

[56] For example, see Mark Peters and Douglas Belkin, "Health Law Pinches Colleges," *Wall Street Journal*, January 18, 2013, http://online.wsj.com/article/SB10001424127887323635504578213502177768898.html.

As shown in **Table 3**, 2012 Census data indicates that the majority (67.8%) of workers usually work 40 hours or more per week. The average work week for people who typically work "full time" is 42.5 hours per week—more than the 30-hour definition of an "FTE" in ACA. However, the data in **Table 3** does not provide much behavioral insight into the responses of firms to ACA, as they were collected prior to the initial measurement period for ACA's employer penalty that began in January 2013.

Table 3. Persons at Work, by Average Hours Worked Per Week, 2012

Hours of Work	Distribution of Workers Across All Industries
1 to 14	5.0%
15 to 29	12.5%
30 to 34	7.6%
35 to 39	7.1%
40	42.8%
41+	25.0%
Average Hours, Total at Work	38.5 hours
Average Hours, Persons Who Usually Work "Full Time"[a]	42.5 hours

Source: U.S. Census Bureau, 2012 Current Population Survey, "Household Data – Annual Averages – 19. Persons at work in agricultural and nonagricultural industries by hours of work," http://www.bls.gov/cps/cpsaat19.htm.

a. The Census Bureau defines a "full-time worker" as someone working 35 hours or more per week.

Several employer surveys indicate that most respondents are not reducing their employees' hours in response to ACA's definition of a full-time worker. According to a 2013 survey conducted by the International Foundation of Employee Benefits Plans, a non-profit foundation, 16% of the 966 employers surveyed said they have adjusted or plan to adjust hours so that fewer employees qualify for full-time.[57] According to a 2012 survey of 1,203 employers conducted by Mercer, a global business consulting firm, 68% of survey respondents indicated that they will begin offering health coverage to all employees working 30 or more hours per week.[58] Other surveys with fewer respondents support these findings.[59]

In addition to surveys (which could or could not be representative of the firms that could be affected by the employer penalty), some researchers have conducted empirical analysis of broad, public-use data. A 2013 study conducted by the U.C. Berkeley Labor Center estimated that

[57] International Foundation of Employee Benefit Plans, *2013 Employer-Sponsored Health Care: ACA's Impact*, 2013, http://www.ifebp.org/pdf/research/2103ACAImpactSurvey.pdf. For more details on the survey methodology, see the report's introduction.

[58] Mercer, *Health Reform Poses Biggest Challenge to Companies with the Most Part-Time and Low Paid Employees*, August 8, 2012, http://www.mercer.us/press-releases/1472805. Details about the survey's methodology and summary statistics of the respondents are not included in this press release.

[59] For example, see Towers Watson, *Nearly Half of U.S. Employers Contemplating Changes to Reward Programs in Light of Health Care Reform*, June 13, 2013, http://www.towerswatson.com/en/Press/2013/06/Nearly-Half-of-US-Employers-Contemplating-Changes-to-Reward-Programs-in-Light-of-Health-Care-Reform; and Challenger, Gray & Christmas, Inc., *Majority of Employers Plan to Maintain Health Coverage*, June 26, 2013, http://www.challengergray.com/press/PressRelease.aspx?PressUid=275.

approximately 2.3 million workers in firms with 100 or more employees (representing 3.1% of all workers) were most vulnerable to a reduction in their payroll hours from above 30 hours per week to below 30 hours per week.[60] These workers were mostly concentrated in the restaurant industry. In contrast, a 2013 study conducted by Helen Jorgensen and Dean Baker of the Center for Economic and Policy Research (CEPR) found that less than 1% of all workers in 2013 fall just below ACA's full-time threshold (26-29 hours per week).[61] Jorgensen and Baker's study uses more recent data and is probably a more reliable study to forecast future conditions. Unlike the U.C. Berkeley Labor Center's study, Jorgensen and Baker's study likely captured any initial employers' responses to shifting workers below the 30 hour per week cutoff because, according to ACA, the baseline measurement period for measuring a firm's FTE employees begins in 2013. Also, Jorgensen and Baker's study better captures more recent improvements in the labor market; there are likely to be more "underemployed" workers (working under 40 hours) in the older data because the macroeconomy was in an earlier stage of recovery.

Changing the cutoff from 30 hours per week to 40 hours per week would not eliminate the incentive for employers to shift more workers to part-time status, and could actually provide a greater incentive for firms not to offer health insurance to their employees. In theory, changing the definition of a full-time worker to 40 hours per week would shift, not eliminate, the incentive for employers to reduce workers' hours. Additionally, more employers could be inclined to shift more workers to "part-time" status (in terms of the ACA) under a 40-hour definition, because the disruption to their workforce is smaller from 40 to 39 hours than 40 to 29 hours. If the incentive to retain their workers on full-time status is diminished, then fewer firms could be compelled by the employer penalty to offer health care coverage relative to current law. As shown in **Table 3**, more workers are also clustered around the 40-hour per-week threshold than the 30-hour threshold.

Exempt More Firms with Low-Income Employees

Some are concerned that the effects of the employer penalty could be concentrated among smaller firms in certain industries that are large enough to be over the 50-FTE threshold and that primarily employ low-income workers (who are less likely to be able to afford out-of-pocket premium costs of an employer-sponsored health plan). Low-income workers tend to be liquidity constrained in their household budgets. Faced with reducing their take-home paycheck to obtain health insurance coverage, many low-income workers would likely prefer wages to benefits.[62] With the option to receive a government subsidy for health care premiums, an increasing number of lower-income workers could look to the individual exchanges (beginning in 2014) if their employer does not offer affordable coverage. In some cases, this could trigger a penalty for their employer.

The extent to which the interactions between low-income workers and the employer penalty pose a problem to small businesses is unclear at this time. So far, many of these concerns have been

[60] U.C. Berkeley Labor Center, *Data Brief: Which Workers are Most at Risk of Reduced Work Hours Under the Affordable Care Act?*, February 2013, http://laborcenter.berkeley.edu/healthcare/reduced_work_hours13.pdf.

[61] Helene Jorgensen and Dean Baker, *The Affordable Care Act: A Hidden Jobs Killer?*, Center for Economic and Policy Research, July 2013, http://www.cepr.net/documents/publications/aca-job-killer-2013-07.pdf.

[62] See Quantria Strategies LLC for the Small Business Administration's Office of Advocacy, *Health Insurance in the Small Business Market: Availability, Coverage and the Effect of Tax Incentives*, September 2011, p. 28, http://www.sba.gov/sites/default/files/386tot.pdf.

voiced by some industry groups (e.g., the restaurant industry). The age of the workers in these industries could have a large effect on whether low-income workers will lead to a higher likelihood of their employers paying the ACA penalty. According to the Bureau of Labor Statistics, the median ages of workers in these industries are over 26.[63] If so, then many of the workers in these industries would not be eligible for extension of dependent coverage. However, some of the workers in these industries, such as food service or retail, could be young enough to be covered as a dependent in a family group plan, covered through an expansion of Medicaid in certain states, or they could find it cheaper to pay the individual penalty than regular health insurance premiums—all of which would not trigger the employer penalty. According to testimony by the National Restaurant Association, 43% of employees are under the age of 26 in the industry.[64] Media reports indicate that previous estimates of the cost of compliance with the employer penalty among some industries (particularly the restaurant industry) have been revised downward in light of more recent analysis of ACA.[65]

To help increase insurance coverage among lower-income workers, ACA includes an option for states to expand Medicaid to households with incomes up to 133% of the Federal Poverty Line (FPL).[66] As shown in **Table 4**, this would include families with household income (defined as modified adjusted gross income, or MAGI) up to $15,521 for an individual to $37,120 for a family of five (in 2014).

Table 4. Annual Income by 2014 Federal Poverty Level and Family Size

(for the 48 contiguous states and the District of Columbia)

Federal Poverty Line (FPL)	Family Size				
	1	2	3	4	5
100%	$11,670	$15,730	$19,790	$23,850	$27,910
133%	$15,521	$20,921	$26,321	$31,721	$37,120
150%	$17,505	$23,595	$29,685	$35,775	$41,865
200%	$23,340	$31,460	$39,580	$47,700	$55,820

Source: CRS calculations using U.S. Department of Health and Human Services (HHS), "2014 Poverty Guidelines," http://aspe.hhs.gov/poverty/14poverty.cfm.

Notes: The poverty guidelines are updated annually for inflation. For space considerations, this chart was limited to households with five people, but the FPL can be calculated for larger households by adding $4,060 for each

[63] For example, the median age for a worker in "food services and drinking places" was 28.8 in 2012 and 37.9 in "retail trade." This data does *not* control for firm size. See Bureau of Labor Statistics, "Labor Force Statistics from the Current Population Survey (2012)," http://www.bls.gov/cps/industry_age.htm.

[64] See Testimony of Tom Boucher on behalf of the National Restaurant Association, in U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, Obamacare's Impact on Jobs, 113th Cong., 1st sess., March 13, 2013, http://www.restaurant.org/Downloads/PDFs/advocacy/20130313_hc_energycommerce_nra_testimony.

[65] Tom Gara, "Obamacare and Restaurants: Less Pain than Feared," *The Wall Street Journal,* Corporate Intelligence Blog, May 14, 2013, http://blogs.wsj.com/corporate-intelligence/2013/05/14/obamacare-and-restaurants-less-pain-than-feared/.

[66] See CRS Report R41997, *Definition of Income for Certain Medicaid Provisions and Premium Credits in ACA*, coordinated by Christine Scott; and CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

additional person to the 100% FPL base. The poverty guidelines for Alaska and Hawaii, which are greater than those for the 48 contiguous states and DC, are available on the HHS website.

However, not all states are expected to expand Medicaid.[67] For those who do not expand, those workers with household income between 100% and 133% of the FPL would be eligible for premium credits in the exchange.[68]

Firms with workers just above the FPL have several options, particularly in those states that do not plan to expand Medicaid. Some employers could find other alternatives to minimize any costs of compliance with the ACA or minimize the size of the penalty that they would face. Even if an employer is limited by ACA in its ability to adjust the scope of coverage and insurance cost-sharing, some could limit more general forms of labor costs. Examples of these options could include reducing the number of current or new hires (or shifting to more capital-intensive modes of production, if possible), reducing the hours allotted to each worker (e.g., moving some workers from full-time to part-time status), or reducing its workers' wages.[69] Reducing the number of employees as well as reducing the average hours worked per employee could have an effect on an employer's potential ACA penalty. Anecdotal media reports indicate that some businesses could provide a low-cost, health plan that does not meet ACA's coverage as a means to reduce the severity of their employer penalty (i.e., pay the reduced penalty rather than the full penalty).[70]

However, the options for employers to pass these costs onto low-income workers are limited in two ways. First, downward pressure on wages is limited in two respects: the minimum wage provides a floor for wages (particularly in industries that require fewer advanced skills), and lower income reduces a firm's ability to attract the best workers (which could become a larger concern as the economy grows).[71] As a result, small employers with low-income employees are less likely to voluntarily offer health insurance coverage as compared to large employers with low-income employees (see **Table 4**). Second, ACA limits the extent that businesses could require their workers to "pay" for a larger share of employee health benefits. Specifically, the criteria for *affordability* under the ACA limit the amount that workers pay in premiums to 9.5% of their household income (approximately $2,272 for a full-time worker earning minimum wage).[72]

[67] In its 2012 decision in *National Federation of Independent Business v. Sebelius*, the Supreme Court held that the federal government cannot terminate current Medicaid program federal matching funds if a state refuses to expand its Medicaid program. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules, but, based on the Court's opinion, it appears that a state can refuse to participate in the expansion without losing any of its current federal Medicaid matching funds. See CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead.

[68] For the latest status of states' decisions to participate in the ACA Medicaid expansion, see Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision*, http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[69] See Testimony of Diana Furchtgott-Roth, Senior Fellow at the Manhattan Institute, U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, *Obamacare's Impact on Jobs*, 113th Cong., 1st sess., March 13, 2013, http://docs.house.gov/meetings/IF/IF14/20130313/100443/HMTG-113-IF14-Wstate-Furchtgott-RothD-20130313.pdf.

[70] For example, see Avik Roy, "Employers Can Minimize Their Exposure To Obamacare's Penalties By Offering Low-Cost 'Skinny' Coverage," *Forbes (Online)*, May 21, 2013, http://www.forbes.com/sites/theapothecary/2013/05/21/employers-can-minimize-their-exposure-to-obamacares-health-insurance-mandate-by-offering-low-cost-skinny-coverage/.

[71] See Testimony of Linda Blumberg, Senior Fellow at the Urban Institute, U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, *Obamacare's Impact on Jobs*, 113th Cong., 1st sess., March 13, 2013, http://docs.house.gov/meetings/IF/IF14/20130313/100443/HMTG-113-IF14-Wstate-BlumbergL-20130313.pdf.

[72] This was computed assuming $11.50 an hour for someone working 40 hours per week (totaling $23,920 a year).

If insurance coverage for low-income workers still remains a concern, then the employer penalty could be modified. Possible modifications include an alternative payroll size exemption and a higher exemption for employers in certain industries.

Create an Alternative Payroll Size Exemption

A dollar-level exemption as an option could exempt more firms with low-income employees where it is more difficult to pass on the costs. One example is the food service industry, whose workers often earn their income in the form of tips rather than wages. Given these claims, an additional exemption could be established based on total firm payroll (either in general or for firms within specific industries) to target these smaller firms.

For example, a $2 million payroll cap could provide an exemption to certain firms, with lower average wages, that would otherwise be subject to ACA employer penalties (because they have too many employees to be exempt). **Table 5** provides data on the number of firms in certain industries that have an average payroll of under $2 million but are large enough to be potentially subject to the employer penalty.[73] A full-time worker earning the federal minimum wage would make a gross salary of approximately $15,080.[74] A dollar-level exemption for firms with total payrolls less than $2 million would apply to firms that hired roughly 132 workers at minimum wage ($2 million/$15,080).

Table 5. Illustration of Firms that Could Be Eligible for an Additional $2 Million Payroll Exclusion for Employer Penalties Under the Affordable Care Act

Employee Size Range	Number of Employer Firms	Industry	Total Employment	Average Worker Salary
50-74	174	Agriculture, Forestry, Fishing, and Hunting	7,999	$34,393
50-74	7,606	Retail Trade	429,219	$34,410
50-74	2,760	Educational Services	162,975	$30,201
50-74	2,190	Arts, Entertainment, and Recreation	128,123	$22,617
75-99	1,118	Arts, Entertainment, and Recreation	91,369	$24,033
50-74	12,874	Accommodation and Food Services	751,105	$15,893
75-99	4,732	Accommodation and Food Services	388,762	$16,780
100-149	3,634	Accommodation and Food Services	416,805	$16,485
50-74	5,280	Other Services (Except Public Administration)	302,258	$28,064
Total	40,368	All Eligible Industries	2,678,615	$21,979

Source: CRS analysis of U.S. Census Bureau, Statistics of U.S. Business Annual Data for 2011, http://www2.census.gov/econ/susb/data/2011/us_state_naicssector_small_emplsize_2011.xls.

[73] Determinations whether a firm was eligible under the $2 million payroll cap were based on average payroll calculations per firm within an industry. The $2 million cap is simply an illustration.

[74] This is calculated by: (the minimum wage of $7.25)*(40 hours per week)*(52 weeks in a year) = $15,080. Note that this definition of a "full-time" worker is 40 hours per week, whereas the statutory definition in ACA is 30 hours per week.

Notes: Estimates reflects the number of firms that could be exempt from employer penalties under the Affordable Care Act (ACA) under a policy of a $2 million payroll cap, based on the average payroll size of firms within a particular industry. Because ACA employer penalties are not scheduled to take effect into 2015 (2016 for firms with 50 to 99 full-time equivalent workers), the number of firms and employees that could be affected by this option may vary. These calculations do not take into effect current coverage rates among firms in the above industries, thus the actual amount of firms that could be exempted would likely be lower. The $2 million cap is simply an illustration. Average worker salary for "all eligible industries" is weighted by the share of employment among eligible firms.

Most, *but not all*, of the workers in employer firms that could be exempt under the $2 million cap have a lower average salary than larger firms within their industry. Also, some of these workers have an average salary above 133% of the FPL (as defined in **Table 4**). Although this is just one possible variation of this policy, these estimates illustrate that an efficient payroll-based exclusion might be easier to design in theory rather than in practice.

As previously mentioned, some workers in the industries in **Table 5** might not seek a premium credit in the insurance exchanges for various reasons. More information could be necessary given the limitations of Census data for the purposes of analyzing ACA's employer penalty.

Increase Exemption Limits for Certain Industries

This option would set limits by industry and allow higher FTE-equivalent limits or payroll amounts in certain industries, such as the restaurant industry. Estimates to inform dollar-based exclusions by industry could be conducted to target firms that are below a specific employee-size threshold or below a specific firm payroll or average employee salary.[75]

This option could be more administratively complicated for some firms that, arguably, fall into multiple industry categories. For example, if restaurants were given beneficial treatment, would a doughnut shop that sold for take-away but also served customers at tables be included? Would a micro-brewery with an attached restaurant be included? Similar administrative complications have been encountered with the production activities business tax deduction, which only applies to some industries.[76] For example, an expanded exemption could be based on the North American Industry Classification System (NAICS), as reported on tax filings with business income.[77]

Increase the Exemption for the Employer Penalty to the First 50 Full-Time Workers

Currently, the ACA employer penalty is triggered by the hiring of the 50th FTE worker but the first 30 full-time workers (30+ hours per week) are exempt from the calculation of the penalty size. In other words, a firm that employed 49 full-time workers and then hired a 50th full-time worker would be subject to a penalty based (in part) on 30 full-time workers. This 30-worker exemption could be increased to reduce the "cliff" that firms could face at the hiring of their 50th

[75] For example, the Census Bureau's Statistics of U.S. Business Annual Data can be used to calculate analysis similar to **Table 5**, by North American Industry Classification System (NAICS) code.

[76] 26 U.S.C. 199. See U.S. Congress, Senate Committee on the Budget, *Tax Expenditures: Compendium of Background Material on Individual Provisions*, committee print, prepared by the Congressional Research Service, 112th Cong., 2nd sess., December 2012, S. Prt. 112-45 (Washington: GPO, 2012), pp. 509-512.

[77] NAICS classifications are one test that a tax filer can use, in part, to claim a Section 199 production activities tax deduction.

FTE worker, thereby reducing the marginal disincentive to hire around the employer penalty threshold.

On the other hand, reducing the sheerness of this "cliff" could reduce the marginal incentive that an employer has to begin offering health care to its employees. If fewer firms offer employer-sponsored health plans, then more workers could rely on government subsidies for coverage in individual insurance exchanges.

This option could also reduce the revenue raised by the employer penalty. These revenue losses could be offset, at least in part, by changing the calculation of the penalty from "full-time" workers to "FTE employees" as discussed below. The latter definition would change the calculation of the penalty to include uninsured part-time workers. Although this change might impose a larger compliance burden on some firms, it would also eliminate the incentive for firms to hire part-time workers instead of full-time workers (or reduce the hours of existing full-time workers) in an attempt to reduce their exposure to the employer penalty.

This rule could also be applied if an option based on payroll size were included to eliminate that cliff as well.

Modify the Exemption to the First 30 FTE Employees in Calculating the Penalty

The employer penalty exemption could be revised such that it was based on FTE employees in order to reduce the incentive for firms to hire more part-time workers or change full-time workers to part-time status. In this case, hiring two part time workers to substitute for one full time worker would not change the calculation of the penalty.

This option could be combined with the exemption increase option, below, to offset for at least some of the revenue loss associated with increasing the exemption. For example, the employer penalty could be revised to exempt the first 50 FTE employees, instead of the current exemption of the first 30 full-time employees.

Expand the Small Business Health Care Tax Credit

Although not directly related to the employer penalty, the current small business health care tax credit could be expanded to encourage more small businesses to offer health care coverage (and potentially avoid the employer penalty).

The Obama Administration and some lawmakers have proposed to amend the small business tax credit to encourage and expand its use to more businesses. President Obama's FY2014 budget proposes expanding and simplifying the credit. The budget recommends increasing the eligibility cut-off from 25 to 50 workers, changing the phase-out formula so more firms will qualify for at least part of the credit, and simplifying the calculation of the credit (by removing a requirement that an eligible employer pay a uniform percentage of the premium for each employee and also eliminating a cap on the credit based on the average health insurance premium in the employer's

state).[78] The Department of Treasury estimated that this provision would reduce revenue $10.5 billion between FY2014 and FY2023.[79]

In the 113th Congress, the Small Business Health Care Tax Credit Improvement Act of 2013 (H.R. 3046) would amend the tax credit to increase the maximum number of FTEs from 25 to 50, modify the phaseout of the credit, and repeal the limitation based on state health insurance premium averages. Specifically, H.R. 3046 would increase the allowable average annual salaries paid to employees from $25,000 to $28,500 to claim the full credit. Although a cap of $28,500 on average wages would fall below the lower bound average worker wages for all firms with 45 to 49 employees (see **Table 1**), firms in certain industries listed in **Table 5** might be eligible (e.g., arts and entertainment, accommodation and food service). In contrast, the Small Business Tax Credits Improvement Act (S. 1325) would also increase the maximum number of FTEs to 50, increase the maximum wages cap to $37,500, among other provisions to increase the number of firms that could be eligible for the credit and the possible benefits awarded. None of these bills have been reported out of committee as of the date of publication of this report.

[78] Department of the Treasury, *General Explanations of the Administration's Fiscal Year 2014 Revenue Proposals*, April 2013, p.30, http://www.treasury.gov/resource-center/tax-policy/Documents/General-Explanations-FY2014.pdf.

[79] Ibid., p. 242.

Appendix. Employment and Payroll Characteristics of Employer Firms, 2011

Table A-1. Employment and Payroll Characteristics of Employer Firms, 2011

Enterprise Employment Size	Number of Employer Firms	Cumulative Share of All Firms	Average Annual Payroll Per Employer Firm	Number of Employees	Cumulative Share of All Employees	Average Annual Salary Per Employee
0-4	3,532,058	62.1%	$65,237	5,857,662	5.2%	$39,337
5-9	978,993	79.4%	$222,765	6,431,931	10.8%	$33,907
10-14	391,469	86.2%	$412,807	4,581,725	14.9%	$35,271
15-19	201,494	89.8%	$608,706	3,379,556	17.9%	$36,292
20-24	137,714	91.9%	$717,988	2,655,453	20.2%	$37,235
25-29	121,765	93.4%	$678,218	2,182,127	22.1%	$37,845
30-34	81,321	94.4%	$885,044	1,867,376	23.8%	$38,542
35-39	58,592	95.2%	$1,065,061	1,610,941	25.2%	$38,738
40-44	43,724	95.8%	$1,275,775	1,423,620	26.4%	$39,183
45-49	34,003	96.2%	$1,481,970	1,263,505	27.6%	$39,882
50-74	26,979	97.6%	$7,021,135	4,677,761	31.7%	$40,494
75-99	77,777	98.3%	$1,731,250	3,199,218	34.5%	$42,089
100-149	37,335	98.9%	$4,869,629	4,260,619	38.3%	$42,672
150-199	35,212	99.2%	$3,616,965	2,992,069	40.9%	$42,566
200-299	17,372	99.5%	$10,146,307	4,025,425	44.4%	$43,787
300-399	16,637	99.6%	$7,041,336	2,635,522	46.8%	$44,449
400-499	7,641	99.7%	$11,508,051	1,953,802	448.5%	$45,006
500+	17,671	100.0%	$169,517,511	58,427,653	100.0%	$51,269
Total	5,684,424	100.0%	$908,605	113,425,965	100.0%	$45,535

Source: CRS analysis of U.S. Census Bureau, Statistics of U.S. Business Annual Data for 2011, http://www2.census.gov/econ/susb/data/2011/us_state_naicssector_small_emplsize_2011.xls.

Notes: An enterprise is an employment or a business consisting of one or more domestic establishments that were specified under common ownership or control. The enterprise and the establishment are the same for single-establishment firms. Each multi-establishment company forms one enterprise. Employment is defined as paid employment and consists of full- and part-time employees, including salaried officers and executives of corporations, who were on the payroll in the pay period including March 12. Employment is measured in March, thus some employer firms (e.g., start-ups created after March, closures before March, and seasonal firms) will have zero employment and some annual payroll.

Author Contact Information

Sean Lowry

Analyst in Public Finance
slowry@crs.loc.gov, 7-9154

Jane G. Gravelle

Senior Specialist in Economic Policy
jgravelle@crs.loc.gov, 7-7829