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WILL DIVESTMENT FROM EMPLOYMENT-BASED HEALTH INSURANCE SAVE  
EMPLOYERS MONEY? THE CASE OF STATE AND LOCAL GOVERNMENTS

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Will Divestment from Employment-Based Health Insurance Save Employers Money? The Case of State and Local Governments

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**ABSTRACT**

Reforms introduced by the Affordable Care and Patient Protection Act (ACA) build new sources of coverage around employment-based health insurance. But what if firms find it cheaper to have their employees obtain insurance from these sources, even after accounting for penalties (for non-provision of insurance) and employee bonuses (to ensure the shift is cost neutral for them)? State and local governments (SLGs) have strong incentives to consider the economics of such “divestment”; many have large unfunded benefits liabilities. We investigated whether SLGs would save under two scenarios: (1) shifting all employees and under-65-retirees to alternative sources of coverage; (2) shifting only employees whose household incomes indicate they would be eligible for federally subsidized coverage and all under-65-retirees. Full divestment would cost SLGs more than they currently pay, due primarily to penalty costs. Selective divestment could save SLGs nearly \$119 billion over 10 years at the expense of the federal government.

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An online appendix is available at:  
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## INTRODUCTION

Sweeping national policy reforms often reset the division of fiscal responsibilities between the public and private sectors, and between different levels of government.<sup>1</sup> They may also create strong incentives for cost shifting, particularly in immediate post-reform periods when "loopholes" abound in evolving regulations.<sup>2</sup> The Patient Protection and Affordable Care Act (ACA) is no exception. The federal government's role in healthcare financing expands substantially as it takes on subsidies and cost-sharing for lower income households, as well as the lion's share of the costs of Medicaid expansions.

The enhanced role for federal government financing has the potential to chill employers' willingness to offer health insurance.<sup>3</sup> With coverage for most workers and their families available through the health insurance exchanges or expanded Medicaid programs, it may be appealing for firms to curtail their own offerings. For this to be a cost-saving move, however, any savings from having employees obtain insurance elsewhere would need to exceed penalties levied under the ACA. Such health insurance "divestment" by employers is not what the ACA's architects intended, but the potential financial incentives for it cannot be ignored.

One large group of employers with pressing reasons to consider health insurance divestment is state and local government (SLG). SLGs were hard hit by the financial crisis. Between 2009 and 2012, budget shortfalls among state governments exceeded \$540 billion,<sup>4</sup> prompting deep cuts to spending and services. Although the fiscal position of SLG has generally improved since 2012, many will take years to return to a stable financial position.<sup>4</sup>

Health insurance benefits constitute a substantial component of SLG budgets. In 2013, most SLGs offered health insurance to their employees, and many extended benefits to retirees under age 65, but continuing to do so will be challenging.<sup>5</sup> A 2010 Pew Center report estimated that states' obligations to public sector retiree healthcare benefits exceeded states' assets by \$627 billion.<sup>6-8</sup>

Would SLGs alleviate their budgetary pressures by shifting current and retired employees into federally-subsidized health insurance plans? If so, how much money might they save? We addressed these questions by analyzing data from three national surveys. We began by estimating the costs to SLGs of continuing

to offer coverage in the usual way. Next, we estimated whether SLGs would save by dropping employment-based insurance entirely and supporting employees and retirees to obtain coverage elsewhere. Finally, we estimated potential savings from selectively shifting defined subgroups of beneficiaries to alternative coverage sources. Our findings should provide useful information to SLGs considering their options in the wake of the ACA. Since savings to SLGs are achieved largely by shifting costs to the federal government, our estimates are also relevant to ongoing debates about projected costs of ACA-related reforms to the federal government.

### **The Divestment Calculus**

The ACA does not establish special rules for SLGs; essentially, they are treated like any other employer. Thus, under the ACA's "play-or-pay" regime, if an SLG with at least 50 full-time equivalent workers does not offer at least one coverage option to every full-time employee, and an employee obtains subsidized coverage through an individual exchange, the employer must pay a \$2,000 penalty for each full-time employee above the first 30. Alternatively, if an SLG with 50 full-time equivalent employees offers coverage but employees choose instead to purchase insurance on the exchange, the SLG faces a penalty if the purchase attracts a subsidy. In this case, the SLG faces the lesser of two penalties: \$3,000 per employee who purchases subsidized coverage or \$2,000 for all full-time employees above the first 30.

Nor does the ACA stipulate special rules or exceptions for SLG employees. They may purchase health insurance offered on the exchange, or enroll in Medicaid provided they meet eligibility criteria. Income thresholds for Medicaid eligibility vary by state, but the ACA sets a floor: states implementing the expansions must accept households with incomes below 138% of the Federal Poverty Level (FPL), which in 2013 corresponded to \$15,856 for an individual or \$26,951 for a family of three. Households with incomes between 138% and 400% FPL are eligible for subsidies and cost-sharing for exchange-purchased plans, calculated on a sliding scale.

For SLGs and other employers, shifting employees to Medicaid and exchange-purchased plans may be fiscally attractive. However, the calculus is not straightforward. It depends on several factors – principally, how many employees are Medicaid eligible, how many are eligible for subsidies and cost-sharing (and at what level), and the amount of any applicable penalties. These

factors, and the overall cost equation, are amenable to quantitative analysis.

Other implications of health insurance divestment by SLGs – for example, political and reputational costs – are much more difficult to quantify, and we do not incorporate them directly into our estimates. However, recent developments provide some clues. A 2009 50-state survey by the US Government Accountability Office found that SLGs striving to control unfunded liabilities have introduced a variety of changes to their retiree health benefits, including alterations to plan offerings, employer contributions, and eligibility requirements.<sup>7</sup> In addition, recent media reports describe proposals by several cities and counties – including Chicago, Detroit, Sheboygan County (Wisconsin), and Stockton (California) – to utilize ACA provisions to reduce the costs of health insurance benefits to their retirees.<sup>9-12</sup> (We are not aware of any SLGs actively considering this strategy for current employees.)

Despite signs that SLGs are already moving to constrain health insurance benefits, we recognize that simply ceasing to offer them and pointing workers elsewhere would be an unpalatable option for most SLGs, however parlous their financial situation. This is especially true in relation to current employees. Such a move would be criticized on public policy grounds, and may have adverse effects on the health and wellbeing of the tens of millions of people who currently obtain coverage through SLG-based plans.

For these reasons, all of the health insurance divestment strategies we consider incorporate an income supplement paid by SLGs to their employees or retirees who purchase insurance on the exchanges. The purpose of these supplements is to bridge any cost differences employees may encounter (i.e., the difference between premiums in their employment-based plan and premium costs in products found on the exchange, less any subsidies received). In other words, our calculations are designed to ensure SLG employees who shift to federally-subsidized forms of coverage are no worse off financially than they were under employment-based coverage.

We also recognize that forcing subgroups of employees to shift from employment-based coverage is likely to be unpopular. In the selective divestment scenarios we consider, SLGs need not impose bars on employment-based purchasing. Rather, we imagine a suite of inducements that would lead most or all members of certain

subgroups to seek coverage elsewhere, and if they do, fair income supplements would be provided to make this a cost-neutral move.

Finally, income supplements will have tax consequences. Employer contributions to employees' health insurance costs are not taxable income for employees. Employee contributions are, except for payments that exceed 10% of the employee's Adjusted Gross Income (AGI).<sup>13, 14</sup> Consequently, the tax treatment of any income supplements to SLG employees must also be considered in a divestment calculus that seeks to leave the SLG employees financially no worse off.

## **STUDY DATA AND METHODS**

### **Data**

Our analyses use the Current Population Survey (CPS), Medical Expenditure Panel Survey Household Component (MEPS), and Annual Survey of Public Employment & Payroll (APES).

The CPS is a monthly survey of about 60,000 households conducted by the US Bureau of Labor Statistics and the Census Bureau. It provides information on a wide range of labor and income statistics; and includes data on respondents' demographic and household characteristics. We used the CPS to estimate the size of the study population, and to determine the incomes and household composition of SLG employees and retirees.

The MEPS, conducted by the Agency for Health Care Research and Quality, is a comprehensive source of information on healthcare utilization and costs. We used the household component of the MEPS to estimate healthcare expenditures for our study population.

The APES, conducted by the US Census Bureau, provides comprehensive data on government employment. The survey covers US federal, state and local civilian government employees, and permits reliable estimates of the number of full-time employees and full-time equivalents for each type of government entity. We used APES data to sort SLG employees into government entities of varying sizes, and to validate our estimates of the total number of SLG workers.

### **Study Population**

We used the CPS to identify two groups: 1) current SLG employees under the age of 65 who have health insurance coverage provided by their employer; 2) SLG retirees under the age of 65 who report

an SLG as their primary source of retirement income. The CPS's representative design permitted extrapolation of national estimates of the size of both groups (**Exhibit 1** and **Appendix Tables 1**). We also extracted data on the number of persons under 65 in the households of each member of each group, as well as their demographic information (e.g., age and sex). Values for all CPS measures were based on averages derived from surveys conducted between 2010 and 2013.

Results of analyses of both CPS and MEPS data were weighted to represent the civilian non-institutionalized US population. We express all monetary outcomes in 2013 dollars, adjusting inflation for non-healthcare quantities (e.g., income) using the consumer price index (CPI) and adjusting healthcare costs using the medical component of the CPI.<sup>15</sup>

### **Health Insurance Costs**

Estimated household healthcare costs were used as a proxy for the cost of health insurance for members of the study population, whether they obtained it through employment-based plans or on the exchanges. Healthcare costs are generally lower than the actual costs of premiums because they do not include insurers' administrative costs and profit margins. However, the healthcare costs we estimate should closely resemble the costs of health benefits for SLGs that self-insure. It is also worth noting that the costs we estimate appear to exceed the premiums charged for silver plans in every state; they are closer to the cost of gold plans (**Appendix Table 2**). Thus, the most likely effect of the proxy we use is an upward bias on the income supplements we calculate, and resultantly a downward bias on any estimated savings to SLGs from divestment.

We predicted healthcare costs for SLG plan enrollees using MEPS data on average annual healthcare expenditures (including pharmaceuticals). For every worker, retiree, and family member identified in the CPS analyses, we predicted an average annual healthcare expenditure, based on the individual's age, sex, and geographical region. The prediction model used an ordinary least squares regression applied to MEPS data with restricted cubic splines for age, with knots starting at 0 and then in 15-year increments. The regression specification was a fully interacted model between the splines and indicators for sex and for region (**Appendix Figure 1**). Predicted expenditures were then aggregated at the household level, and expenditures on family members aged 65 years or older were excluded from the tallies.

### **Ledger Losses to SLGs from Divestment**

*Penalties.* The penalty regime prescribed under the ACA fines firms that do not offer insurance options or that offer "unaffordable" options to current employees (with unaffordability defined as premiums that exceed 9.5% of an employee's household income). However, there are two necessary conditions for penalty imposition: the employer must have more than 50 full-time equivalent workers, and at least one employee must have purchased a policy on the exchange and attracted a subsidy and/or cost-sharing. Our analysis had to account for how often these conditions were met.

Because the CPS does not identify specific SLGs, we could not directly link the profiles of individuals in our study population to characteristics of their SLGs, such as workforce size (although 2011 APES data showed that more than 99% of SLG employees worked in entities with more than 30 full-time equivalent employees). We therefore made a conservative pair of assumptions: all SLGs had enough employees to expose them to penalties, and all SLGs would have at least one employee who qualified for exchange subsidies or cost-sharing. Hence, for the scenario in which SLGs cease to offer coverage entirely, we set the penalty at \$2,000 per full-time employee above the first 30 full-time employees. For scenarios in which SLGs selectively shift employees away from employment-based options, we set the penalty at \$3,000 per shifted employee eligible for a federal subsidy and/or cost-sharing. We chose the \$3,000 formulation over the \$2,000 one because, for most SLGs, it is likely to produce the lesser total penalty. Finally, we used APES data to compute the per-capita penalties according to size of SLGs' full-time workforce (**Appendix Table 3**).

One important caveat to the penalty calculations outlined above is that the "lesser penalty" provisions are designed to apply in situations in which the employer has offered health insurance to all full-time employees. This bears upon the question of what firms may do to selectively divest. Stripping a subset of employees of any opportunity to purchase employment-based policies would immediately trigger the \$2,000 version of the penalty. It may also be illegal. For these reasons, selective shifting strategies are likely to be most advantageous if they are pursued through inducements that preserve employees' voluntary choices about where to purchase their health insurance. We assume such inducements, coupled with the income supplements described below, drive shifts away from employment-based coverage options. However, our calculations do not consider the costs of such inducements.



*Income Supplements.* To calculate the size of income supplements required of SLGs to make employees “whole” for premium costs if they shifted to purchasing coverage on the exchange, we subtracted any subsidies and cost-sharing each household would attract from its expected healthcare costs.

It was also necessary to consider that such income supplements may alter the tax position of SLG employees. One change is virtually certain; two others are possible. First, by increasing an employee’s gross income, the supplements would increase the employee’s total tax liability. Second, the additional income may bump an employee into a higher marginal tax bracket. Finally, the supplements may affect the tax deductibility of premium payments. Non-self-employed workers may deduct premium payments in excess of 10% of their adjusted gross income (AGI). Hence, increases to AGI caused by the income supplements may reduce or eliminate the tax-deductible premiums.

Our estimates of the appropriate level of income supplementation for each SLG employee were adjusted for these three potential tax effects to ensure the supplements left employees “whole” (**Appendix Sections 6-7**). We did not adjust income supplements to SLG retirees for tax effects because retirees already pay tax on those benefits.

The chief sources of uncertainty are the estimated sizes of the study population and the precision of the predictions of the expected individual healthcare costs. The consistency of the estimated size of our study population with counts from the APES provides confidence about the precision of this estimate, at least in relation to current SLG employees. The large-scale, national representativeness of MEPS permits robust healthcare cost predictions.

#### **Ledger Gains to SLGs from Divestment**

*Medicaid Coverage.* To calculate household income as a percentage of the FPL, we used CPS data on total household income for SLG employees and under-65-retirees. For households with income below 138% FPL, we assumed household members younger than 65 years would be eligible for Medicaid, thereby shifting all of their costs from SLGs and to those programs. In our base calculation this assumption applied only to the 26 states (including the District of Columbia) that are implementing Medicaid expansions as of January 28, 2014 (**Appendix Table 4**).<sup>16</sup> In a secondary calculation, we assumed this for all states.

Both assumptions are imperfect. Income eligibility thresholds for Medicaid programs vary across states and population subgroups (children, pregnant women, etc.).<sup>17</sup> In certain states and for certain subgroups, income eligibility thresholds are above 138% FPL. The main consequence of not accounting for these nuances is that we counted fewer individuals in the study population as Medicaid eligible than was truly the case. This would tend to bias downward our estimates of any SLG savings from divestment.

*Subsidies and Cost-Sharing for Individual Purchasers.* For households with incomes between 138-400% FPL, we followed ACA rules for determining the amounts of subsidies and cost-sharing (**Appendix Section 5**).<sup>18</sup> For households with income above 400% FPL, we assumed no subsidies or cost-sharing.

Household income determines the levels of both subsidies and cost-sharing. Therefore, if SLGs provide income supplements to offset any additional costs employees and retirees face in purchasing insurance on the exchange, this may in turn affect eligibility for subsidies and cost-sharing. The relationship between these variables is dynamic. As income supplements boost total household income, subsidies and cost-sharing drop, necessitating larger supplements to achieve status quo. Tax effects are an additional variable in this dynamic equation. We solve for the stable levels of subsidies, cost-sharing, and income supplements using a two-step, fixed point method (**Appendix Section 7**).

## **RESULTS**

### **Status Quo**

SLGs in the US employ approximately 12 million workers and have 1.5 million retirees under the age of 65 (**Exhibit 1**). The average household size is 3.5 persons for workers and 2.5 for retirees. Thus, SLGs provide health insurance benefits to up to 45 million individuals.

We estimate that the study population – SLG employees, SLG retirees under 65 years of age, and the families of both groups – will incur approximately \$1.8 trillion in healthcare costs over the next 10 years (**Appendix Table 5**). This total consists of \$1.59 trillion for employees and their families and \$250 billion for retirees and their families. For context, this equates to 6% of the total cost of the US healthcare system over the decade.<sup>19</sup>

### **Household Income and Eligibility for Financial Assistance**

Thirty nine percent of the study population had household incomes low enough to qualify for subsidies and/or cost-sharing on the health insurance exchanges (**Exhibit 2** and **Appendix Table 6**). Nationally, 40% of SLG employees had household incomes in the 138-400% FPL range and 33% of retirees did. An additional 3% of households met the ACA's Medicaid income eligibility threshold. There was substantial variation across states in the proportion of SLG employees and retirees whose household incomes fell within these bands (**Appendix Table 6**).

### **Full Divestment**

Exiting employment-based health insurance altogether would be a more expensive proposition for SLGS than the status quo for all 50 states and the District of Columbia (**Appendix Tables 7-9**). This result is primarily driven by the size of the employer penalties. But penalties aside, in 29 states, the size the income supplements required to leave employees and retirees no worse off outstrip the combined savings reaped from subsidies and Medicaid displacement. A recalculation that assumed all states proceeded with Medicaid expansions (as opposed to the 26 jurisdictions that currently are) did not eliminate the net losses associated with full divestment (**Appendix Tables 10-12**).

### **Selective Divestment**

An alternative strategy for SLGs is to encourage particular subgroups of beneficiaries to seek coverage elsewhere. The subgroups could be constructed in myriad ways. We focused on the cost implications of shifting two clearly defined subgroups: (1) under-65-retirees, and (2) employees whose household income levels make them eligible for either Medicaid coverage or subsidies on the exchanges.

*Retirees.* It should not be surprising that several cities and municipalities have already signaled interest in shifting under-65 retirees to alternative sources of coverage: several elements of the cost equation suggest it may be particularly advantageous to do so. Employer penalties do not apply and the tax effects of income supplementation are minimal or nil.

We estimated that shifting retirees and their households to health insurance purchased on the exchanges could save SLGs more than \$18 billion over 10 years (**Exhibit 3** and **Appendix Table 8**). Every state would save. Approximately 80% of these savings stem from subsidies and cost-sharing; the rest come from Medicaid displacement of SLG coverage. Total savings rise to more than \$21 billion over 10 years under the assumption that all states undertake Medicaid expansions (**Exhibit 3** and **Appendix Table 11**).

*Medicaid- or Subsidy-Eligible Employees.* Because current employees account for most of SLGs' healthcare costs, the savings attained by any selective shifts of this group are potentially much larger than those attained from shifting retirees. The cost equation employed in our model lays bare which groups of employees will provide the most lucrative returns to selective divestment: employees who are Medicaid eligible, or who attract substantial subsidies and cost-sharing on the exchanges.

We estimate that shifting this subgroup of workers from employment-based coverage would save SLGs more than \$100 billion over 10 years (**Exhibit 3** and **Appendix Tables 13**). Despite paying \$88 billion in penalties and almost \$30 billion in income supplements over the decade, the \$197 billion gained in subsidies and cost-sharing and the \$21 billion absorbed by federal support of Medicaid expansions, overwhelm these losses. Total savings would increase to more than \$130 billion over 10 years if all states undertook Medicaid expansions (**Exhibit 3** and **Appendix Table 14**).

## **DISCUSSION**

This study estimated that completely exiting the direct provision of employment-based health insurance would not save SLGs money. However, selective divestment to take advantage of coverage options introduced by the ACA could save SLGs nearly \$119 billion over the next 10 years (or \$150 billion if all states implemented Medicaid expansions). Savings of this magnitude could substantially improve the weak financial position of many SLGs.

The vast majority of the savings we have identified would come from costs shifted to the federal government. Hence, if SLGs were to follow *en masse* the selective divestment strategies we have outlined, it could add more than 10% to the projected costs of ACA reforms.<sup>20</sup> For the kinds of political and practical reasons mentioned earlier, divestment *en masse* seems unlikely, at least in relation to current employees. Therefore the SLG savings and additional costs to the federal government we have estimated are best interpreted as upper bounds.

Our analysis makes a number of simplifying assumptions. One is that removing any differences in the costs of health insurance will make SLG employees indifferent to the prospect of obtaining insurance elsewhere. This does not necessarily follow. Plans purchased on the exchange may have smaller networks and require

SLG employees and retirees to switch doctors. Employees who shift to Medicaid coverage may have trouble finding willing providers.<sup>21,22</sup>

It is possible that an accumulation of such non-monetary factors may prompt some beneficiaries to respond strategically – for example, by seeking employment elsewhere, shifting to coverage available through a spouse’s policy, even dropping coverage and pocketing the income supplement. The theoretical effects of such behavioral responses on our estimates are unclear; they run in both directions and disentangling and quantifying them requires further research.

Employers, too, may engage in strategic behavior. Salary adjustments or hiring practices may be used to alter the mix of employees eligible for the federally-subsidized coverage. SLGs may also seek to minimize their exposure to penalties by reducing the size of their full-time or full-time equivalent workforce, turning to part-time workers, outsourcing, and other measures. However, employers’ latitude to take such action is constrained. Unions would vigorously resist any such large-scale changes. Moreover, since SLGs tend to be relatively large employers, workforce changes could reduce the size of penalties based on employee multipliers, but it would be infeasible for most to shrink below the thresholds established for the applicability of the mandate and penalties.

Another simplifying assumption is that all SLGs currently offer coverage to their employees and retirees, all of whom take it up. This is not the case. The Kaiser Family Foundation’s 2013 health insurance survey suggested that although virtually every SLG had some offering, 80% of workers were eligible, of whom 91% took up insurance, resulting in a coverage proportion of 73%.<sup>5, 23</sup> Uptake rates for eligible employees are high chiefly because SLG plans tend to be generous. The number of under-65-retirees who receive health insurance benefits from SLGs is more difficult to estimate. As a proxy, we used the proportion who, according to the CPS, received SLG retirement benefits. Overestimating the number of employees and retirees to whom insurance is currently provided would result in overestimates of the size of current obligations and total savings attainable, but it should have little effect on the size of per-person savings.

We assumed that SLGs, like private sector employers, are liable to pay the ACA penalties for failing to provide insurance or offering “unaffordable” insurance. Among the legal challenges to the ACA, some have specifically argued that forcing SLGs to pay

penalties violates the 10<sup>th</sup> Amendment of the U.S. Constitution.<sup>24</sup> A related but broader series of challenges argue that the precise wording of the ACA make both the subsidies and the penalties linked to them unlawful in states that have declined to establish their own exchanges.<sup>25</sup> If tax penalties against SLGs were found to be unconstitutional, and subsidies survived, this would increase the potential savings from divestment.

## **CONCLUSIONS**

Employment-based health insurance is a central pillar of the U.S. healthcare system. Its existence has long framed options for reform. Although the ACA sought to expand coverage by building around and strengthening employment-based insurance, the changes it introduces to the sources and financing of coverage have the potential to reset the playing field entirely. How employers will respond remains to be seen.

This study considered possible reactions by one large employer group with strong motives to reduce the burden of health insurance costs. We found that SLGs may save nearly \$119 billion over the next 10 years by shifting under-65-retirees and segments of their workforce to comparable plans on the exchanges and Medicaid programs. Such savings would be gained at the expense of the federal government.

SLGs garner no special treatment under the ACA. The cost advantages projected for them may apply to greater or lesser extents to other employers, depending on the demographic, income and healthcare utilization profiles of workers in those firms. The federal government could probably stem any rush toward divestment by changing key rules, such as penalty levels and eligibility for subsidies and cost-sharing. But until that happens, divestment is a strategic option that diligent business leaders may find difficult to ignore.

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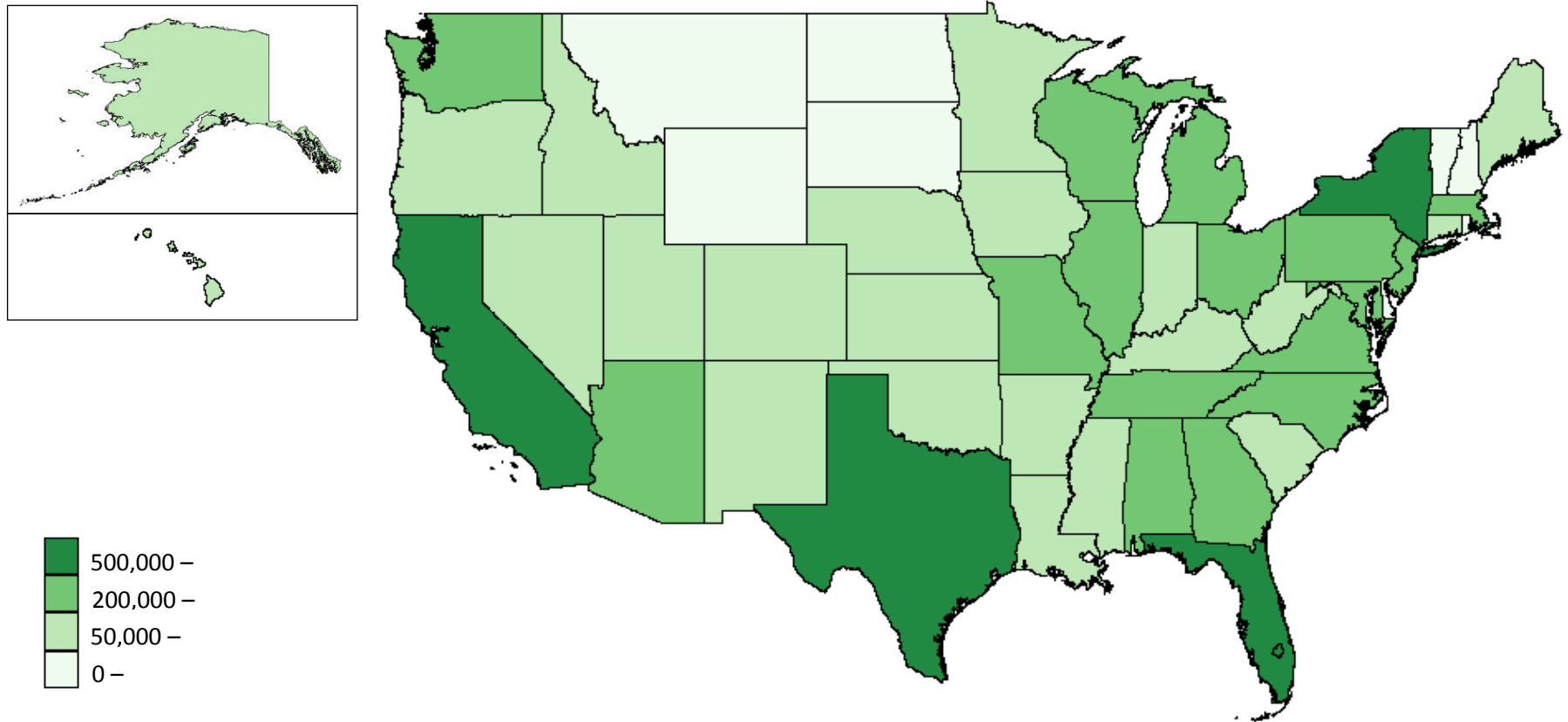
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EXHIBIT 1: Number of State and Local Governments Workers and Retirees below 65 Years of Age (Panel A)

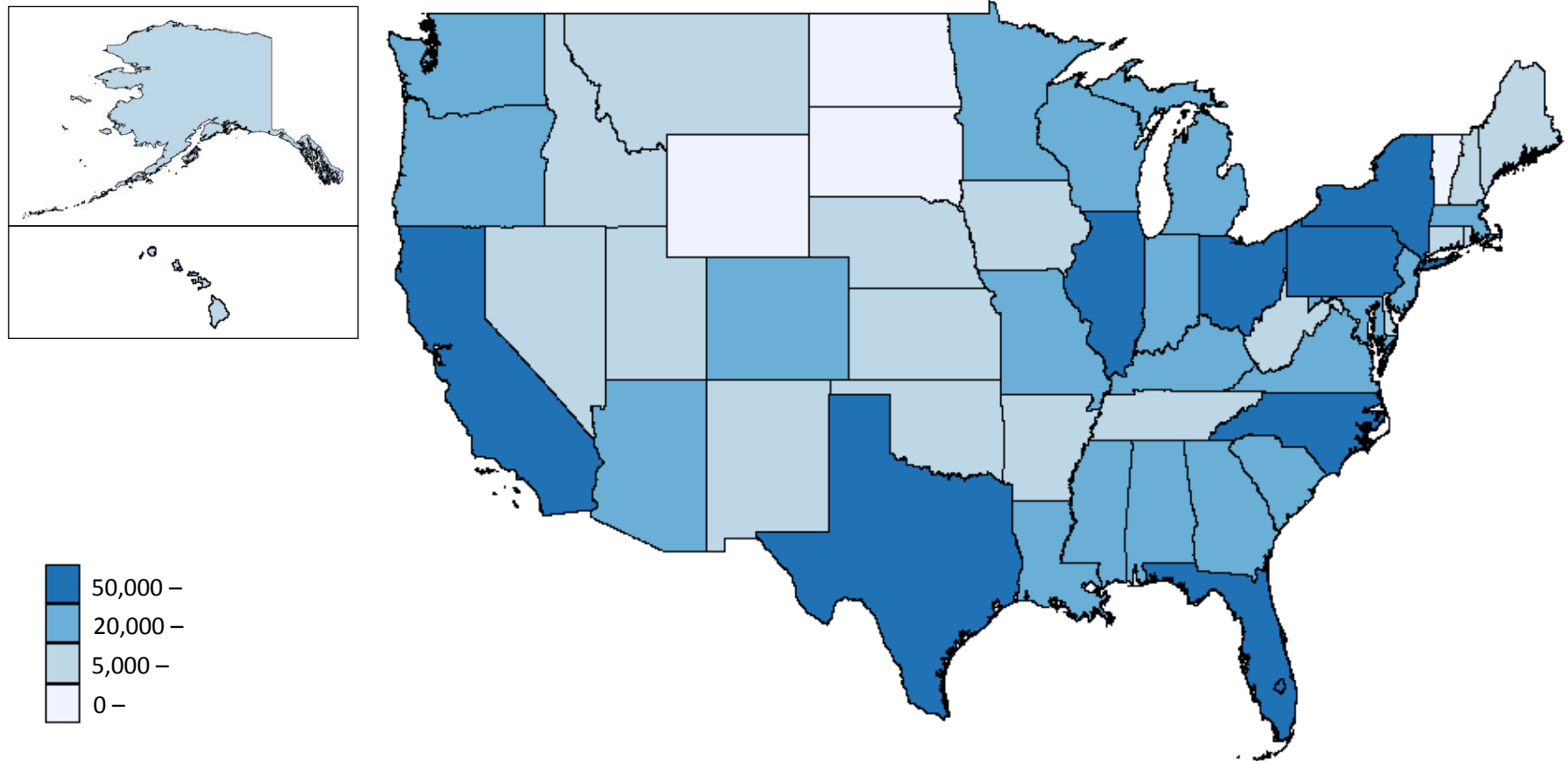
**A) State and Local Government**



SOURCE: Authors' calculations using U.S. Current Population Survey

EXHIBIT 1: Number of State and Local Governments Workers and Retirees below 65 Years of Age (Panel B)

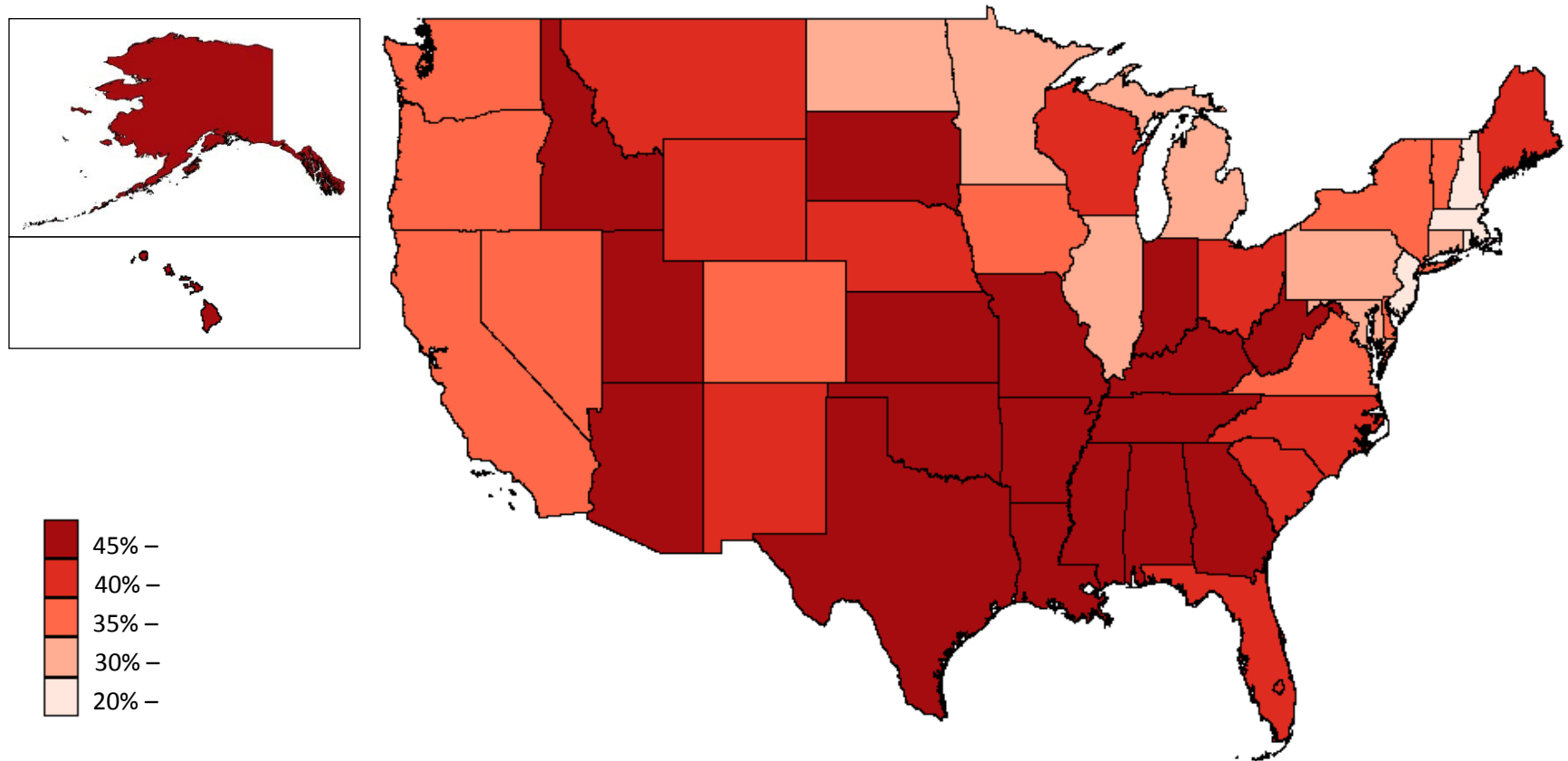
**B) State and Local Government Retirees under Age 65**



SOURCE: Authors' calculations using U.S. Current Population Survey

EXHIBIT 2: Households of State and Local Government Workers and Retirees below 65 Years of Age Falling below 400% of the Federal Poverty Level (Panel A)

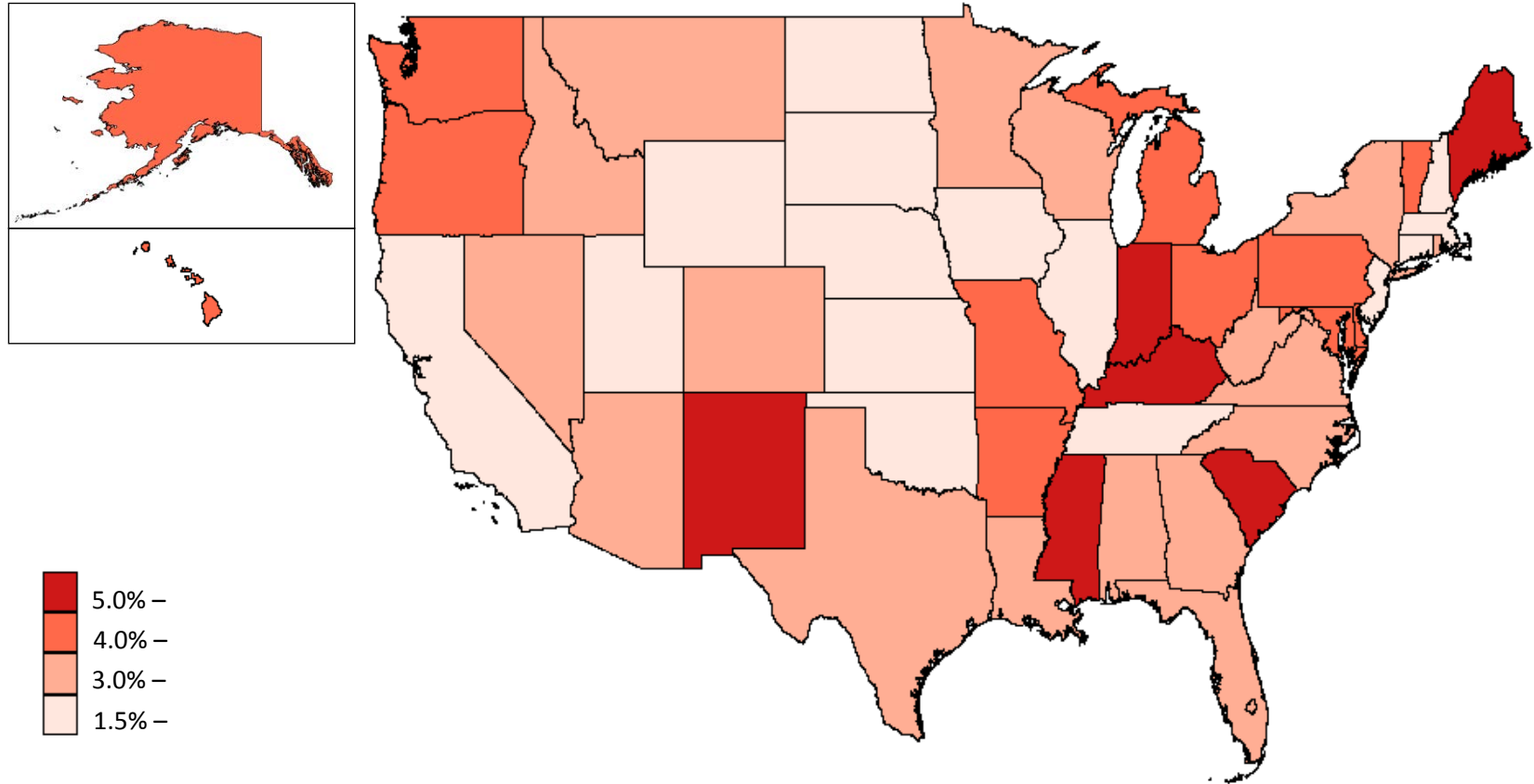
**A) Employees and Retirees with Household Incomes between 138-400% of the Federal**



SOURCE: Authors' calculations using U.S. Current Population Survey

EXHIBIT 2: Households of State and Local Government Workers and Retirees below 65 Years of Age Falling below 400% of the Federal Poverty Level (Panel B)

**B) Employees and Retirees with Household Incomes below 138% of the Federal**



SOURCE: Authors' calculations using U.S. Current Population Survey

**Exhibit 3. Estimated Savings to State and Local Governments from Selective Divestment Strategies (\$1,000,000s) Part I**

State	Shifting only under-65-retirees		Shifting only employees eligible for subsidies or Medicaid	
	26 states expand Medicaid (1a)	All states expand Medicaid ** (1b)	26 states expand Medicaid (2a)	All states expand Medicaid ** (2b)
Alabama	32	47	241	383
Alaska	8	12	13	32
Arizona	74		339	
Arkansas	39		199	
California	176		1,289	
Colorado	32		189	
Connecticut	11		98	
Delaware	7		23	
District Of Columbia	3		8	
Florida	122	142	478	726
Georgia	60	67	325	676
Hawaii	33		57	
Idaho	10		72	102
Illinois	18		287	
Indiana	33	43	206	278
Iowa	12		117	
Kansas	12	14	75	212
Kentucky	23		274	
Louisiana	48	111	199	329
Maine	8	10	27	35
Maryland	34		205	
Massachusetts	30		161	
Michigan	43		238	
Minnesota	19		84	
Mississippi	21	31	173	318

SOURCE: Authors' calculations using U.S. Medical Expenditure Panel Survey and U.S. Current Population Survey

Notes:

\* State and local government totals for these states are only positive because of savings from retirees under age 65 years. The costs of terminating all employment-based coverage options for current state and local government workers in these states due to employer penalties and increased liabilities for taxes more than offset the gains from federal subsidies and cost-sharing.

\*\* Estimates are only shown in the "All States Medicaid Expansion" columns for states that do not currently have a Medicaid expansion planned for 2014. Under a Medicaid expansion, the estimates are different than the previous column and hence are shown.

**Exhibit 3. Estimated Savings to State and Local Governments from Selective Divestment Strategies (\$1,000,000s) Part II**

	Shifting only under-65- retirees	Shifting only employees eligible for subsidies or Medicaid		
State	26 states expand Medicaid  (1a)	All states expand Medicaid ** (1b)	26 states expand Medicaid  (2a)	All states expand Medicaid ** (2b)
Missouri	16	36	168	208
Montana	11	15	39	59
Nebraska	6	11	48	67
Nevada	10		34	
New Hampshire	4	11	12	24
New Jersey	43		188	
New Mexico	34		159	
New York	194		935	
North Carolina	67	81	434	623
North Dakota	1		18	
Ohio	98		427	
Oklahoma	19	37	127	245
Oregon	14		161	
Pennsylvania	82	103	128	199
Rhode Island	7		22	
South Carolina	76	87	123	230
South Dakota	4		15	21
Tennessee	17	39	165	323
Texas	117	138	755	1,417
Utah	7		94	133
Vermont	7		15	
Virginia	55	78	125	216
Washington	25		195	
West Virginia	23		123	
Wisconsin	9	18	153	274
Wyoming	8	10	23	34
<b>NATIONAL</b>	<b>1,864</b>	<b>2,171</b>	<b>10,063</b>	<b>13,009</b>
<b>10 YEARS</b>	<b>18,640</b>	<b>21,711</b>	<b>100,631</b>	<b>130,092</b>

SOURCE: Authors' Calculations with U.S. Medical Expenditure Panel Survey and U.S. Current Population Survey