How Will the Affordable Care Act Affect Jobs?

Timely Analysis of Immediate Health Policy Issues

March 2011

John Holahan and Bowen Garrett

Introduction

Opponents of health reform have made strong claims about the effect of the Affordable Care Act (ACA) on jobs. Supporters of legislation to repeal the ACA, the so-called "Repealing the Job Destroying Health Care Law Act," argue that the law will increase unemployment in an already fragile economy.[1] The argument is that the requirement to provide health insurance or improve benefits will increase the costs of labor to employers. In cases where wages or other benefits can be reduced as an offset, firms can absorb the increased cost of providing health insurance and there should be no employment effects. But if wages cannot be cut because of collective bargaining agreements or the fact that wages are already close to minimum wage levels, the demand for labor, and thus employment, would likely fall. Those making the job destroying claims often cite a study released before the details of the reform legislation were known, which found a loss of as many as 1.6 million jobs.[2] This view implies that repealing the ACA will increase employment.

This argument falls short for several reasons. First, the overall economic effects of the law are simply too small relative to the overall size of the economy to have much of an effect on employment. Second, there are many offsetting effects. The tax provisions in the law will reduce the demand for labor in many sectors and the Medicare cuts by themselves would reduce employment in the health sector, but the expansion of coverage through Medicaid and income-related subsidies in the exchanges would have the opposite effect on spending and employment. Third, the new law will not affect most firms, either because they already provide health insurance meeting the new federal standards, or they are exempt from the new requirements (firms with fewer than 50 workers). This paper draws heavily on an earlier paper that looked at the impact of health reform on the economy and employment but updates that effort.[3] The basic conclusion is that the ACA will not have a noticeable effect on net levels of employment.

Spending and Financing Provisions Are Very Small Relative to the Size of the U.S. Economy

It is almost impossible for the ACA to have a significant effect on the overall economy or on unemployment simply because the effect of net new federal spending on health care (over and above reductions on spending on Medicare and other government programs) is very small relative to the size of the economy. Over the six-year period, 2014–2019, net federal spending due to the ACA is estimated by the Congressional Budget Office (CBO) to be $439 billion.[4] The projected gross domestic product (GDP) over the same period is about $116 trillion; thus new spending would amount to about 0.38 percent of GDP. Over the entire 2010–2019 period, new federal spending on health care (net of reductions in current payments) would be roughly the same as above while GDP would be $178 trillion. Over this longer period, new federal spending would be 0.25 percent of GDP. Using a different modeling approach and considering spending from all sources, the Center on Medicare and Medicaid Services (CMS) actuaries estimated the increase in national expenditures attributable to reform to be $311 billion over 10 years—0.17 percent of GDP over the same period.[5]

Offsetting Effects

This does not mean that there will not be important effects on individual sectors of the economy. The expansion of health insurance coverage through new Medicaid coverage and income-related subsidies will increase federal spending on health care ($938 billion over 10 years, mostly from 2014 through 2019). This will result in increased demand for labor in the health sector, including increasing use of medical equipment, new technologies and pharmaceuticals and could lead to wage and salary increases in the health sector. At the same time, spending reductions in Medicare and other government programs will partially finance health reform ($511 billion).[6] These reductions will have the opposite effect, reducing the demand for labor and the purchase of services and equipment in the health sector. The net effect, however, will be positive—higher net spending on health care services and more employment in the health sector.

On the other hand, the net new spending will be financed through various taxes on insurers, medical device and pharmaceutical manufacturers and the earned and unearned income of individuals with incomes over $200,000 ($250,000 for couples). The increased taxes on health care providers and insurers could mean

Urban Institute

higher prices for drugs, medical devices and insurance premiums, which could lower the demand and employment in those sectors. But increased revenues will more than offset these effects due to more people having health insurance and thus using more pharmaceuticals and medical devices.[7]

The increased payroll taxes on those with incomes above $200,000 will have a small effect on demand for goods and services because only a very small share of the population will be affected, and higher income people are the least likely to change their consumption behavior as a consequence of a new tax. The same is true for the effect the tax on unearned income would have on investment decisions. The estimated revenue from the taxes on payroll and unearned income was only $210 billion. Again, this is over an eight-year period in which cumulative GDP is $148 trillion (in other words, the tax revenue would amount to 0.2 percent of GDP).

Overall, the economic impacts of coverage expansions, reductions in current Medicare and other government spending and new taxes are largely offsetting. There are more offsets and new revenues than new spending and, thus, a small reduction in the deficit ($143 billion) in the first 10 years according to the CBO. Beyond the first 10 years, CBO projects the effects of reform to be deficit reducing. The overall effect on GDP will be extremely small. Given that the health sector is one of the more intensive labor sectors in the U.S. economy, health care reform could result in a small aggregate increase in demand for labor. There are many other forces, such as monetary and fiscal policy, that will have a much greater effect on economic activity than health reform.

Impacts on Business Will Be Minimal

Some have argued that penalties in the law for not offering coverage to workers who end up receiving government subsidies will hurt small business. This argument ignores the fact that small business (with fewer than 50 workers) will be exempt from these penalties. A frequently cited report from the National Federation of Independent Business (NFIB) produced prior to the drafting of reform legislation assumed that businesses with fewer than 50 workers would be subject to the penalty.[8] Though it does not reflect the legislation actually enacted, many continue to cite the report's estimate of 1.6 million fewer workers under reform.[9] The report's own estimates suggest exempting firms with fewer than 20 workers would reduce the figure by 467,000. Exempting firms with fewer than 50 workers would probably reduce the figure by another 150,000 or so more. Furthermore, the figure referred to gross job losses—elsewhere the report estimated that more than 800,000 jobs would be gained in the health care sector as a result of the coverage expansions. A proper interpretation of the NFIB estimates in light of the legislation actually passed would indicate relatively little net job loss.

A recent paper by Garrett and Buettgens estimates that premium contributions by small firms (fewer than 100 employees) would fall by 8.2 percent under the ACA with virtually no change in the number of covered workers.[10] This occurs because such firms have the option of purchasing coverage in the new Small Business Health Options Program (SHOP) exchanges, where administrative costs will be lower than in current markets, and premiums will fall as a result. In addition, firms with fewer than 50 workers receive $4.5 billion in employer subsidies in the form of tax credits (2010 dollars).[11] A small share of firms with more than 80 workers would pay $2.0 billion in assessments if their full-time employees receive subsidized coverage through the exchange. On balance, taking premiums and assessments into account, small businesses would save 8.7 percent compared with their current premium contributions.

Garrett and Buettgens also found that medium-size firms, those with between 100 and 1,000 employees, would experience little change in coverage and a small drop in premium contributions (0.5 percent).[12] Medium-size firms that offer employer-sponsored insurance (ESI) would be unaffected (94 percent of employers with 100 to 999 employees offered health insurance to their workers in 2009).[13] But there are some medium-size firms that do not offer coverage and, in aggregate, they would pay $11.8 billion in assessments due to full-time employees obtaining subsidized coverage through the exchange. Large firms would see an increase in coverage of about 2.2 percent, but premiums would fall slightly because they would, on average, have healthier covered lives. Large firms would pay $3.8 billion in assessments. As a result of higher take-up and assessments on some firms, the health insurance related costs for larger firms would increase by about 1.0 percent.

The savings of 8.7 percent for small firms means that if anything, they would have lower costs of labor and should be more willing to expand employment. Moreover, it would become more attractive to start a small firm, given access to health insurance and ability to purchase health insurance through an exchange, as well as the opportunity for some to obtain employer subsidies. The incentives for entrepreneurship should increase, not decrease.[14] This is particularly true for those wishing to move from employment in firms to self-employment; the exchanges and insurance market reforms will make that option feasible for many who otherwise would have been tied to employers as their sole source of health insurance.

For firms of 100 or more, coverage expands slightly—about 0.7 percent for medium-size firms and 2.2 percent for large firms. Moreover, as noted above, medium-size and large firms pay $15.6 billion in assessments. Firms that do not offer coverage to their workers and choose instead to pay the assessment if some obtain subsidized exchange coverage would face somewhat increased labor costs and therefore have lower labor demand, a negative effect

on employment. However the total amount in assessments is very small in comparison to wages and salaries in the United States (0.2 percent of the $6.4 trillion wage base)[15] so any negative impact on jobs must also be small.

Firms induced to start offering coverage to avoid an assessment could lower wages or other benefits to offset the new costs if their workers value the new benefits and are not minimum wage workers.[16] To the extent that firms do offset new health costs in this way, the firms will not be affected. Individuals would have lower wages and demand for various goods and services would fall. On the other hand, more money would be spent on health care, which should offset any effects on employment.

Firms that start offering coverage but cannot pass new health-related costs back to the workers through lower wages or other benefits or forward them onto consumers in form of higher prices, may respond by employing fewer workers. This may also result in less output by the firm. If there is less output, individuals who would have purchased these services will most likely spend their money elsewhere, thus affecting employment elsewhere.

Most larger firms offer coverage already and are likely to continue offering after reform. The ACA should have little or no effect on employment in these firms. Though some in the business community are projecting large declines in employer-sponsored coverage after reform, Urban Institute analyses, like those of the CBO, suggest that large declines are unlikely. Although individual coverage through exchanges will provide a new alternative to ESI and would be subsidized for those below 400 percent of the federal poverty level, employers are unlikely to save money by dropping ESI and paying the penalty. This is because firms would need to compensate the workers from whom they remove a current benefit, particularly higher income workers, who would lose the valuable tax advantage of ESI. As Garrett and Buettgens argue, there is little scope for firms being able to save money from dropping ESI coverage except perhaps in firms where most workers have low wages as well as low family incomes, and these types of firms are the least likely to offer ESI today.[17]

In sum, while employment in firms subject to employer assessments could decrease, very few firms will be affected, and the total dollar amounts of assessments will be small relative to the costs of labor. Furthermore, the amount of new employer spending in the aggregate will actually be reduced as a consequence of the ACA; thus, any impact of the law on employment should be minimal.

The Employment Effects of the ACA Are Mainly Due to Worker Choices, Not Jobs Being Destroyed

The Congressional Budget Office has estimated that the ACA could reduce the amount of labor used in the economy on the order of half of a percent, "primarily by reducing the amount of labor that workers choose to supply."[18] Some have taken this half-percent figure and multiplied it by the number of workers to estimate the number of jobs taken out of the economy by ACA, but this is an incorrect application of the CBO's findings. The expansion of Medicaid and the provision of subsidies in the exchanges will give workers options for retaining insurance coverage even if they were to work part-time or stop working. By providing new opportunities to obtain health care outside of employment, the ACA could lead some workers to reduce their work hours or leave their job to pursue other interests. The relatively small reduction in labor supply does not represent jobs lost as a result of ACA, but decisions made by those no longer locked into employment situations as a consequence of their need for health insurance. Plus, any reduction in labor supply the ACA causes would occur over an extended period of time as the exchanges come online and new options and incentives become clear to workers. If the ACA were to induce certain workers to leave their jobs during a period of high unemployment, such as we have today, others looking for work would quickly fill the vacancies.

Cost-Containment Provisions in the ACA Will Boost the Economy and Employment Over Time

There are many cost-containment measures in the ACA, and other proposals could build on those measures if adopted. Cost containment would have somewhat opposite effects than the effects of coverage expansion. To the extent the cost-containment efforts are successful, they will reduce the growth in health care costs. This will reduce the demand for labor as well as incomes in the health care sector, but it will increase the discretionary income that individuals and families have to spend elsewhere. Thus, if these efforts are successful, there will be additional spending outside the health sector that will increase demand for labor in other sectors.

Successful cost containment will have other economic effects as well. It will reduce the growth in spending on Medicare and, after the initial expansion, Medicaid. This will reduce the taxes and borrowing the federal government has to undertake to finance these programs. The Council of Economic Advisers (CEA) has argued that containing costs of the two large programs would reduce the federal budget deficit, increase national savings, keep interest rates lower, and increase economic growth.[19] The CBO and the Joint Tax Committee both project the excise tax on high-cost insurance plans to reduce the rate of growth of annual health care costs by 0.5 percentage points per year once implemented.[20] Other provisions in the ACA may also reduce costs, including bundling payments, accountable care organizations, medical homes and care coordination for dual eligibles. Curtailing the growth in health care costs will mean lower costs for businesses and individuals. The CEA has estimated that reducing the growth in

health care costs by 1 percentage point per year would result in a 4.0 percent higher GDP by 2030,[21] due to a higher national savings rate, more capital formation and higher output. Faster growth in GDP would mean more jobs, lower unemployment, and higher family incomes.

Other Effects

Health reform will affect the overall economy in other ways. First, health reform would reduce job lock, that is, the tendency for individuals to stay in a given job to retain their health insurance. Because health reform will allow for considerably more flexibility, the movement from job to job will make the labor market more efficient and will increase economic productivity. Repeal of health reform will have the opposite effect.

Second, to the extent that health reform improves health in the long run, as is expected, it should increase labor supply by reducing disability and workers' absenteeism, improve learning and increase workers' productivity. These effects will take considerable time to materialize and will probably have a small positive impact on the economy. Once again, repeal would have the opposite effect.

Conclusion

The ACA is unlikely to have major aggregate effects on the U.S. economy and on employment primarily because the changes in spending and taxes are very small relative to the size of the economy. Moreover, most of the effects offset each other. This of course implies that repeal would also have little effect on the macroeconomy. The increased spending because of the ACA will increase demand for health services and demand for labor in the health sector. Cuts in Medicare and various cost-containment provisions, if successful, will have opposite effects. The new taxes on insurers, medical devices and pharmaceutical manufacturers could have adverse effects on those industries, except for the fact that coverage expansion should provide new revenues well in excess of new tax obligations. Cost-containment efforts, if successful, will have somewhat opposite effects, reducing the growth in spending on Medicare and Medicaid, which will reduce the taxes or borrowing the federal government has to undertake. Cost-containment that reduces the federal budget deficit would result in faster economic growth, more employment and higher family incomes. Cost-containment would also free up private dollars to be spent in non-health areas of the economy.

Concern over the impact of the ACA on small businesses is misplaced. All small businesses with fewer than 50 workers will be exempt from any assessments. Most larger firms already provide health insurance to their workers and so are unlikely to face assessments under the new law. Small businesses should benefit from the availability of lower cost plans and the efforts to increase competition and contain costs within exchanges. The Garrett and Buettgens analysis showed little change in coverage among small firms and lower costs because of reduced premiums in exchanges and employer subsidies. A small minority of medium-size and large firms do not provide ESI today and will either start providing coverage or pay assessments, leading to higher costs, although many will be able to offset these costs through lowering other benefits or slowing wage growth. Some firms will also see higher take-up among employees who now do not accept employer offers. These effects, however, will be small, and there will generally be offsetting effects. Whether slightly positive or slightly negative, the ACA should not have a significant impact on overall employment.

Notes

[1] Michael J. Chow and Bruce D. Phillips, "Small Business Effects of a National Employer Healthcare Mandate," Washington, DC: National Federation of Independent Business, 2009; John Boehner, Eric Cantor, Dave Camp, John Kline, Paul Ryan, and Fred Upton, "Obamacare: A Budget-Busting, Job-Killing Health Care Law," January 6, 2011; Beacon Hill Institute, "Killing Jobs through National Health Care Reform," March 2010, http://www.atr.org/userfiles/BHI%20Health%20Care%20Reform%20as%20Job%20Killer(7).pdf.

[2] Michael J. Chow and Bruce D. Phillips,"Small Business Effects of a National Employer Healthcare Mandate" (Washington, DC: National Federation of Independent Business, 2009).

[3] John Holahan, "Will Health Care Reform Hurt the Economy and Increase Unemployment?" (Washington, DC: The Urban Institute, 2010).

[4] Congressional Budget Office, "Letter to the Honorable Nancy Pelosi Providing Estimates of the Spending and Revenue Effects of the Reconciliation Proposal" (Washington, DC: Congressional Budget Office, March 20, 2010).

[5] Centers for Medicare and Medicaid Services, Office of the Actuary, "Estimated Financial Effects of the Patient Protection and Affordable Care Act" (Baltimore, MD: Centers for Medicare and Medicaid Services, 2010).

[6] Congressional Budget Office, "Letter to the Honorable Nancy Pelosi," 2010.

[7] We derived an estimate of the growth in prescription drug spending due to increases in coverage as follows: Assuming drug spending remains constant as a share of expenditures by insured persons, we estimate about $300 in additional prescription drug spending by each of those who would gain insurance coverage under reform in 2014. Assuming the same growth rate for personal health care spending as currently projected in the National Health Accounts, and using CBO estimates of the reduction in the number of uninsured, we would predict that the prescription drug spending would increase by about $65 billion between 2014 and 2019. The Joint Committee on Taxation estimates that revenues from assessments on drug manufacturers and importers would be $27 billion between 2011 and 2019. We made similar calculations for insurers and medical device manufacturers and reached similar conclusions, though the differences for the latter were much smaller.

[8] Chow and Phillips, "Small Business Effects."

[9] Also on this point, see FactCheck.org, "A Job-Killing Health Care Law?" January 7, 2011. http://www.factcheck.org/2011/01/a-job-killing-law/.

[10] Bowen Garrett and Matthew Buettgens, "Employer-Sponsored Insurance under Health Reform: Reports of its Demise are Premature" (Washington, DC: The Urban Institute, 2011).

[11] The Garrett-Buettgens analysis is based on a microsimulation model that estimated the effect of the ACA as if it were fully implemented in 2010.

[12] Garrett and Buettgens, "Employer-Sponsored Insurance."

[13] Agency for Healthcare Research and Quality, Center for Financing, Access, and Cost Trends, "Percent of Private-Sector Establishments that Offer Health Insurance by Firm Size and Selected Characteristics: United States, 2008" (Rockville, MD: Agency for Healthcare Research and Quality, 2009), http://www.meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/national/series_1/2009/tia2.pdf.

[14] Council of Economic Advisors, "The Economic Effects of Health Care Reform on Small Businesses and Their Employees" (Washington, DC: Council of Economic Advisors, 2009).

[15] Congressional Budget Office, "The Budget and Economic Outlook: An Update" (Washington, DC: Congressional Budget Office, 2010).

[16] Lawrence Summers, "Some Simple Economics of Mandated Benefits," *American Economic Review* 79, no. 2 (1989): 177–83.

[17] See discussion section of Garrett and Buettgens, "Employer-Sponsored Insurance."

[18] Congressional Budget Office, the Executive Office of the President, "The Budget and Economic Outlook: An Update," Box 2-1 (Washington, DC: Congressional Budget Office, 2010).

[19] Council of Economic Advisers, the Executive Office of the President, "The Economic Case for Health Care Reform" (Washington, DC: Council of Economic Advisers, 2009).

[20] Council of Economic Advisers, the Executive Office of the President, "The Economic Case for Health Care Reform: Update" (Washington, DC: Council of Economic Advisers, 2009).

[21] Council of Economic Advisers, "The Economic Case for Health Care Reform: Update."

About the Authors and Acknowledgements

John Holahan, Ph.D., is director in the Health Policy Center of the Urban Institute. Bowen Garrett, Ph.D., is an affiliated scholar at the Urban Institute and chief economist at McKinsey and Company's Center for U.S. Health System Reform. The authors are very appreciative of the comments and advice provided by Linda Blumberg, Stephen Zuckerman and Robert Kocher.

About the Urban Institute

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit www.urban.org.