The Affordable Care Act: Improving Incentives for Entrepreneurship and Self-Employment

Timely Analysis of Immediate Health Policy Issues

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Introduction

Individuals contemplating leaving the security and stability of a company job to become self-employed must consider the implications for their health insurance, as well as the financial risks associated with launching a new business. In most states, leaving a job means leaving the guarantee of subsidized health insurance coverage sponsored by the employer for the uncertainty of the non-group health insurance marketplace.

Many economists and health policy experts believe that tying health insurance coverage to job status results in people staying in jobs that they might otherwise leave, a phenomenon called "job lock."[1] Afraid that they may be denied health insurance coverage because of preexisting conditions, unable to afford the premiums, or lose access to a trusted provider, many workers may decide to stay in their job, even if their skills and talents are not optimally deployed. However, under the Affordable Care Act (ACA), access to high-quality, subsidized health insurance coverage will no longer be exclusively tied to employment.

Relying upon the most recent economic literature on the implications of health care reforms for the rate of self-employment and on information about pre-ACA insurance market rules, we estimate the state-by-state effect of full ACA implementation on self-employment.

- The empirical economics literature strongly supports the notion that reforms which guarantee issue coverage and those which provide financial support to purchasers outside the employment context significantly increase the likelihood of self-employment.
- As a result of the ACA, including guaranteed issue of non-group coverage and the financial assistance available for its purchase, we estimate that the number of self-employed people in the United States will be 1.5 million higher than it would otherwise have been. Relative increases in self-employment will vary across states as a function of pre-ACA market reforms already in place. We estimate a range from an increase of 248,000 in California to no measurable change in Massachusetts, where extensive health care reforms were enacted in 2006.

Background

The shortcomings of the non-group health insurance market are well-documented, and they create significant barriers to coverage for the self-employed.[2] For many consumers, compared to employer-sponsored plans, non-group health insurance policies are more expensive for comparable benefits due to higher administrative costs and have higher cost-sharing.[3] And in most states, individuals attempting to purchase insurance may be denied a policy because of their health status, age, or some other risk factor. If they are sold a policy they may be charged more because of these same factors, and particular types of care can be excluded from coverage based upon current or past health issues. There is no employer to help defray the cost of the premium (on average, offering employers contribute close to 80 percent of the single premium), and to obtain an affordable policy, non-group purchasers have to forgo critical benefits, such as maternity, pharmaceuticals, and mental health services.[4]

There has been a patchwork of federal and state laws attempting to improve people's ability to move from job to job or from a job to self-employment without losing access to good health coverage. However, the protections offered under this patchwork have significant limitations.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 permits employees—and eligible dependents—to remain on their employer's group health plan even after their employment ends.[5] To qualify for this benefit under federal law, employees must work for an employer with 20 or more employees; 40 states have enacted "mini-COBRA" laws that extend the benefit to people working for employers with fewer than 20 employees.[6] Unfortunately, many people find COBRA coverage unaffordable, because they must pay the full cost of the premium, plus an administrative fee, without any employer subsidy.[7] For those who have lost their income from their job, or who are just starting a business without a steady flow of revenue, COBRA's monthly premiums may seem out of reach.

Yet, until the ACA is fully implemented next year, individuals must maintain their COBRA coverage for the full duration as a necessary prerequisite to accessing the consumer protections under another federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA provides that individuals transitioning out of group coverage are guaranteed access to a health insurance policy that covers preexisting conditions, so long as they have had 18 months of continuous coverage, exhaust their COBRA coverage and do not go for more than 63 days without coverage. HIPAA doesn't prevent insurers from charging eligible individuals a higher premium rate based on their health status, and many individual market insurance products do not cover a comprehensive set of benefits. More than half of the states meet this HIPAA requirement by guaranteeing access to coverage under the state high-risk pool.[8]

Self-employed individuals are able to benefit from a federal tax deduction to

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Table 1: State "Group of One" Laws

State	Guaranteed Issue?	Limited to Open Enrollment Periods?	Limited to Some Plans?	Maximum Preexisting Exclusion Period?	Premium Surcharges for Health Status?
Colorado	Yes*	Yes	Yes	Yes, 6 months	No
Connecticut	Yes	No	Yes	Yes, 12 months	No
Delaware	Yes	No	Yes	Yes, 12 months	Yes
Florida	Yes*	Yes	Yes	Yes, 24 months	Yes
Hawaii	Yes	Yes	No	No	Yes
Maine	Yes	No	Yes**	Yes, 12 months	No
Massachusetts	Yes	No	No	Yes, 6 months	No
Michigan	Yes*	No	Yes***	Yes, 6 months	No
Mississippi	Yes	No	No	Yes, 12 months	Yes
New Hampshire	Yes	Yes	No	Yes, 9 months	No
North Carolina	Yes	No	Yes	Yes, 12 months	Yes
Rhode Island	Yes	No	No	Yes, 6 months	No
Vermont	Yes	No	No	Yes, 12 months	No
Washington	Yes*	No	No	Yes, 9 months	No

Source: Data compiled through review of federal and state laws by researchers at the Center on Health Insurance Reforms, Georgetown University Health Policy Institute. Current as of January 2012. Available at www.statehealthfacts.org. States may have additional rules or requirements.

*****Business "group of one" must have earned a significant percentage of their income from their business for a year before applying for coverage.

****In Maine, if insurer also sells individual insurance, then it may offer the self-employed person an individual market policy instead of a small group policy.

*****In Michigan, only Blue Cross Blue Shield is required to guarantee issue to the self-employed.

help them purchase their own health insurance. This deduction is not available to other individuals buying insurance on their own, such as workers in jobs that don't offer health benefits. Even with this deduction, however, many self-employed people may still be turned down for coverage because of their health status or instead be offered an unaffordable premium or a limited benefit package that does not fully cover their health needs.

In addition, 14 states have enacted laws to allow "groups of one," or self-employed individuals who have no other employees to access the protections of the small group market.[9,10] In these states, individuals who are self-employed may be able to buy the same health insurance policies sold to small employers and benefit from some or all of the same legal protections that small employers get. However, these additional state protections for self-employed individuals often come with limits and exceptions. For example, some require a significant percentage of income from self-employment for a year prior to coverage, and all but one allow preexisting condition exclusions.[11] (See Table 1).

While 34 states have created high-risk pools to help people with preexisting conditions, many of these programs have fallen short due to their own preexisting condition exclusions and prohibitively high premium costs.[12]

Only Massachusetts and Vermont have enacted comprehensive reforms that not only help ensure access to adequate coverage for people who do not have job-based health insurance, but also provide premium subsidies to help defray the cost for low- and moderate-income people. In many ways, the reforms included in the Affordable Care Act were modeled on these states' comprehensive approaches to expanding health insurance coverage.

The ACA includes a number of critical provisions designed to increase the accessibility and affordability of coverage, particularly for individuals with preexisting conditions. Under the ACA, beginning in 2014, no applicant for non-group coverage can be turned down because of their potential risk of incurring health claims. Individuals cannot be charged more because of their health status, and insurers must cover a comprehensive set of essential benefits and provide a minimum level of financial protection to people with health needs.

Perhaps most significantly for someone contemplating losing the security of a steady income in order to start their own business, the law provides tax credits to reduce premium costs for low- and moderate-income individuals and families (up to 400 percent of the federal poverty level, or FPL) without access to affordable employer-based coverage.[13] Assistance is also provided to lower deductibles and co-payments for individuals and families earning less than 250 percent FPL. Many states are also poised to expand Medicaid to low-income individuals and families earning less than 138 percent FPL, meaning that individuals starting a business who may not yet have much income could be eligible for public coverage.[14]

Impact of Health Insurance Coverage on Entrepreneurship: Recent Literature

Two recent papers have empirically analyzed the effect of insurance market reforms on entrepreneurship. We use findings from these studies as benchmarks to predict state-specific increases in self-employment under the ACA. The most recent study, by Fairlie, Kapur, and Gates (FKG), constitutes two separate analyses using Current Population Survey (CPS) data from 1996 to 2006.[15] The first estimates the probability that an individual wage or salary worker in year one will create a business and become self-employed in the filing year, as a function of having their own employer-provided health insurance or coverage through a spouse's employer, presence of a family member with bad health, and an array of socio-economic characteristics (race/ethnicity, immigrant status, age, education, wage, income, and home ownership). They find large, statistically significant results indicating that men and women are less likely to start businesses if they do not have a spouse with employer-based insurance and if there is a family member in bad health. The presence of a family member in poor health would

greatly increase the risk of uninsurance or under-insurance outside of the employer-based market.

The second approach to examining these issues taken by FKG focuses on the increase in probability of self-employment when an individual moves from age 64 to 65 and becomes eligible for Medicare. Once an individual reaches age 65, he/she is eligible for enrollment in the Medicare program and is no longer dependent upon employment associated with insurance coverage for access to guaranteed comprehensive insurance coverage. Thus, an increase in business ownership at age 65 would be expected if access to adequate, affordable coverage is a constraint in pursuing self-employment.

They find that the increase in probability of owning a business once an individual reaches age 65 represents an increase of 13 percent of the mean probability.

The second recent study in this area was done by DeCicca for the Upjohn Institute.[16] This analysis takes advantage of a natural experiment—New Jersey's Individual Health Coverage Plan—which introduced substantial non-group health insurance market reforms in the state beginning in August 1993. These reforms provided guaranteed issue, renewability, and pure community rating for individually purchased coverage in New Jersey. While no financial support was provided for individually purchased coverage under these reforms, the changes to the rules of issue and rating bear a resemblance to those included in the ACA's 2014 reforms.

DeCicca found that, depending upon which comparison group of states is used, self-employment in New Jersey was 14 to 20 percent higher in the early years following implementation of the reforms than it would have been in the absence of those reforms. He also found increased effects of the reforms on the clinically obese, those smoking at least half of a pack of cigarettes per day, and those age 50 to 65. These latter findings are consistent with the notion that self-employment is limited to an even greater extent for those who can expect to have the most difficult time obtaining adequate, affordable coverage in unreformed non-group markets.

Applying Recent Findings

These analyses take very different approaches to quantifying the effects of limited non-group insurance options on the decision to start a business or become self-employed. None of the approaches taken are perfect corollaries to the extensive changes to the non-group market that will be implemented under the ACA in 2014, which include guaranteed issue, modified community rating, and financial assistance for most non-group insurance purchasers, among other market reforms. However, the FKG analysis focusing on Medicare assesses the self-employment implications of guaranteed issue coverage with community rating and federal financial subsidies for the purchase of coverage. And while it takes a very different analytic approach, the low-end of DeCicca's self-employment effect estimates of the New Jersey non-group market reforms are consistent with those in the FKG Medicare analysis.

As a result we use the FKG Medicare analysis finding of a 13 percent increase in self-employment as our expected self-employment effect of the ACA in the 35 states without prior reforms of this type in the non-group market. We attribute no change in self-employment due to the ACA in Massachusetts, as the reforms enacted there in 2006 should have already increased self-employment to a level comparable to that under the ACA. Likewise, we attribute no change in the level of self-employment to Vermont due to the state statute that allows the self-employed to obtain small group coverage, as well as their subsidized health insurance program—Catamount Health—which provides comprehensive coverage with sliding scale premiums to those up to 300 percent FPL.

We also attribute only a partial effect from the ACA on self-employment in those states that already have enacted reforms providing guaranteed issue of small group insurance to those with a group size of one, which essentially ensures access to coverage for the self-employed. States in this group include: Colorado, Connecticut, Delaware, Florida, Hawaii, Maine, Michigan, Mississippi, New Hampshire, North Carolina, Rhode Island, and Washington. However, these states do not provide financial assistance for the purchase of coverage, most still employ some degree of health status rating in their small group markets, and none have an individual requirement to obtain coverage. All of these factors will tend to make coverage more accessible and affordable for a large swath of the would-be self-employed and will come as part of the full implementation of the ACA. Consequently, we decrease the expected self-employment effect for these states from 13 percent to 2/3 of that amount, or 8.7 percent. This choice suggests that the financial assistance, essential health benefits, increased stability of premiums due to prohibitions on medical underwriting, and other reforms will constitute a larger portion of the effect than guaranteed issue and pre-ACA small group market protections alone. New York and New Jersey are also included in the partial effect group due to having guaranteed issue in their non-group insurance markets prior to the ACA. New York has pure community rating in its insurance market and New Jersey has modified community rating, and neither have an individual mandate to obtain coverage. Over time, the absence of a coverage requirement led to large premium increases in these markets due to adverse selection, and New Jersey, as a result, repealed some of its non-group reforms in 2003, outside the window of the DeCicca analysis.[17]

Findings

Table 2 shows the estimated number of those who would have been self-employed in each state in the year 2014 in the absence of health care reform, our projected estimate taking into account the effect of the ACA, and the difference between the two (i.e., the effect of health reform). Overall, we estimate that the number of self-employed people in the United States will be about 1.5 million higher following the universal availability of non-group coverage, the financial assistance available for it, and other related market reforms. This national figure translates into about an additional 248,000 self-employed in California, and another 124,000 self-employed in Texas. As noted earlier, we attribute no

Table 2: Level of Self Employment by State, With and Without Reform, 2014

State	Self Employment Absent Reform	Post-Reform Self Employment	Increase Due to Reform
Alabama	118,000	134,000	16,000
Alaska	31,000	35,000	4,000
Arizona	301,000	340,000	39,000
Arkansas	99,000	112,000	13,000
California	1,901,000	2,149,000	248,000
Colorado	304,000	331,000	27,000
Connecticut	185,000	202,000	17,000
Delaware	31,000	33,000	2,000
District of Columbia	21,000	24,000	3,000
Florida	819,000	891,000	72,000
Georgia	432,000	488,000	56,000
Hawaii	58,000	63,000	5,000
Idaho	83,000	94,000	11,000
Illinois	475,000	537,000	62,000
Indiana	224,000	253,000	29,000
Iowa	148,000	167,000	19,000
Kansas	116,000	131,000	15,000
Kentucky	150,000	170,000	20,000
Louisiana	179,000	203,000	24,000
Maine	73,000	79,000	6,000
Maryland	231,000	261,000	30,000
Massachusetts	281,000	281,000	0
Michigan	317,000	344,000	27,000
Minnesota	258,000	292,000	34,000
Mississippi	102,000	110,000	8,000
Missouri	242,000	273,000	31,000
Montana	72,000	81,000	9,000
Nebraska	104,000	117,000	13,000
Nevada	104,000	117,000	13,000
New Hampshire	74,000	81,000	7,000
New Jersey	304,000	330,000	26,000
New Mexico	94,000	106,000	12,000
New York	743,000	808,000	65,000
North Carolina	378,000	411,000	33,000
North Dakota	52,000	58,000	6,000
Ohio	514,000	581,000	67,000
Oklahoma	173,000	196,000	23,000
Oregon	212,000	240,000	28,000
Pennsylvania	464,000	524,000	60,000
Rhode Island	43,000	46,000	3,000
South Carolina	155,000	176,000	21,000
South Dakota	57,000	65,000	8,000
Tennessee	258,000	292,000	34,000
Texas	955,000	1,079,000	124,000
Utah	99,000	112,000	13,000
Vermont	41,000	41,000	0
Virgina	333,000	376,000	43,000
Washington	346,000	376,000	30,000
West Virginia	46,000	52,000	6,000
Wisconsin	256,000	290,000	34,000
Wyoming	32,000	36,000	4,000
Total	**13,090,000**	**14,587,000**	**1,500,000**

Notes: Pre-reform estimates based upon a 2-year merged file of the 2011 and 2012 Current Population Survey data (data years 2010 and 2011), reweighted to reflect the size of the 2011 population, then increased for expected population growth to 2014 and rounded to the nearest 1,000 people.

ACA effect on self-employment to either Massachusetts or Vermont due to the reforms already in place in those states.

Conclusion

Research evidence of pre-reform job lock and empirical research demonstrating a significant increase in self-employment because of significant health care reforms or availability of Medicare benefits, strongly suggests that the level of self-employment in the United States will increase as a consequence of full implementation of the ACA. Taking into account the most recent findings in the economic literature on this topic, we make a rough estimate that the number of self-employed individuals will increase by about 1.5 million, a relative increase of more than 11 percent. The anticipated effects vary by state, since some states have already taken policy steps that facilitate independently purchased coverage by the self-employed. Most notably, we do not predict any change in self-employment in Massachusetts or Vermont, the states that have gone the farthest in this regard. With those exceptions, we do, however, expect noticeable increases in self-employment across the country as the ACA's provisions for guaranteed issue, modified community rating, essential health benefits, improved transparency, and financial assistance for those with incomes below 400 percent FPL are put in place.

Endnotes

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[5] Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99–272 (Apr. 7, 1986), as amended.

[6] *Expanded COBRA Continuation Coverage for Small Firm Employees*, 2010. Kaiser Family Foundation and Health Policy Institute, Georgetown University. See http://www.statehealthfacts.org/comparetable.jsp?ind=357&cat=7.

[7] Kaiser Family Foundation and Health Research and Education Trust, *Employer Health Benefits Annual Survey 2012*. See http://ehbs.kff.org/pdf/2012/8345.pdf.

[8] *Non-Group Coverage Rules for HIPAA-eligible Individuals*, 2012. Kaiser Family Foundation and Center on Health Insurance Reforms, Georgetown University. See http://www.statehealthfacts.org/comparetable.jsp?ind=356&cat=7.

[9] *Small Group Health Insurance Market Guaranteed Issue, 2012*. Kaiser Family Foundation and Center on Health Insurance Reforms, Georgetown University. See http://www.statehealthfacts.org/comparetable.jsp?ind=350&cat=7.

[10] Five states require insurers to guarantee issue coverage to all applicants in the non-group market, but these laws have done little to expand health insurance coverage, due to high premiums and preexisting condition exclusion periods.

[11] Co. Rev. Stat. §10-16-102(6)(a); Fla. Stat. §627.6699(3)(u); Mich. Comp. Laws §500.3701(r); Rev. Code Wash. §48.43.005(33).

[12] *State High Risk Pool Preexisting Condition Exclusion and Look Back Periods for Applicants Without Qualifying Prior Credible Coverage, 2011*. Kaiser Family Foundation. See http://www.statehealthfacts.org/comparetable.jsp?ind=604&cat=7.

[13] Federal poverty guidelines vary with family size. In 2013, the poverty level (i.e., 100 percent FPL) for a single individual is $11,490; for a family of four it is $23,550. See http://aspe.hhs.gov/poverty/13poverty.cfm.

[14] Avalere. *To Date, 20 States & DC Plan to Expand Medicaid Eligibility*, 15. *Will Not Expand, and the Remainder Are Undecided*. State Reform Insights, April 22, 2013. See http://www.avalerehealth.net/news/spotlight/20130422_Medicaid_Expansion.pdf.

[15] Fairlie RW, Kapur K, and Gates S. "Is Employer-Based Health Insurance a Barrier to Entrepreneurship?" *Journal of Health Economics*. 30, 146–162, 2011.

[16] DeCicca P. "Health Insurance Availability and Entrepreneurship." Upjohn Institute Working Paper 10–167, April 2010. http://research.upjohn.org/up_workingpapers/167/

[17] State law was modified in 2003 to reintroduce gender rating and geographic rating and to move away from comprehensive insurance plans, introducing what are referred to as basic and essential" health plans, which are very limited benefit plans plus hospital benefits.

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