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Saving Small-Employer Health Insurance

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ABSTRACT: Health care reform devotes substantial attention to resuscitating the small-group health insurance markets that serve employers with fewer than fifty full-time employees. Nevertheless, a number of interweaving provisions embedded within the Affordable Care Act create strong incentives that, starting in 2014, will tend to undermine these markets and, in the process, increase the fiscal cost of reform. First, small employers with predominantly low-income employees will tend to opt out of small-group markets. Second, small employers with mixed-income employees will have strong incentives to offer coverage that is either technically not "affordable" or that fails to provide "minimum value" in order to preserve the availability of premium and cost-sharing subsidies on individual markets for their low-income employees. Third, small employers with unusually low-risk employees will have strong incentives to self-insure any group plan they do offer in order to avoid cross-subsidizing higher-risk groups. Analyzing these risks collectively, this Article offers a number of recommendations for saving small-group markets. For instance, it argues that the Small Employer ("SHOP") exchanges that are intended to organize small-group markets in 2014 must strategically target the weaknesses of self-insurance by offering simple and risk-free coverage options that facilitate employee choice. They must also market this coverage aggressively in response to insurance brokers' likely financial incentives to push self-insurance on small employers. Additionally, state and federal regulators should explore various possibilities for making small employers more likely to offer group coverage through SHOP exchanges. To accomplish this, they should consider regulating stop-loss insurance and preventing churning between the self-insured and small-group markets.

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INTRODUCTION

Private health insurance is sold in three distinct types of markets: large-group, small-group, and individual.[1] Traditionally, large-group markets have operated well, allowing virtually all large employers to offer reasonable coverage to their employees.[2] By contrast, individual markets have proven disastrous in most states, resulting in innumerable difficulties for people seeking to purchase health insurance directly from insurers.[3] Small-group markets, which serve employers with fewer than fifty full-time employees, have long been situated between these two polar extremes: they both suffer some of the difficulties of individual markets and enjoy some of the advantages of large-group markets.[4]

The Affordable Care Act ("ACA") was designed to build on this existing system of private health insurance coverage.[5] Rather than starting from scratch, it sought to preserve the large-group market while dramatically remaking the individual market.[6] In response to the mixed track record of small-group markets, the ACA adopted a correspondingly intermediate approach to regulating these markets. On one hand, the ACA subjects small-group markets to many of the new insurance rules that it applies to individual markets, including requiring the provision of "essential health benefits," limiting permissible medical underwriting to age and smoking status, and instituting minimum medical-loss ratios.[7] It also requires the establishment of Small Employer ("SHOP") exchanges to help organize small-group markets, just as it does for individual markets.[8] On the other hand, though, the ACA preserves small employers' freedom not to offer coverage, provides subsidies to support SHOP exchanges that are more limited than those directed towards individual exchanges, and leaves small-employers free to "self-insure" in order to avoid many of the regulatory requirements that they would otherwise face.[9]

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1. *See* KENNETH S. ABRAHAM & DANIEL SCHWARCZ, HEALTHCARE SUPPLEMENT TO ABRAHAM'S INSURANCE LAW AND REGULATION 3–4 (5th ed. 2010).

2. *See* David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 30–31 (2001).

3. *See* Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 135–36 (2011).

4. *See* Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685, 691–92 (1999).

5. *See infra* Part I.

6. *See* Monahan & Schwarcz, *supra* note 3, at 136–53.

7. *See* Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1001, 124 Stat. 119, 130–38 (2010) (codified as amended in scattered sections of 42 U.S.C.); ACA § 1201, 42 U.S.C. §§ 300gg-1 to 300gg-7 (2006 & Supp. V 2011); ACA § 1302, 42 U.S.C. § 18022 (Supp. V 2011).

8. ACA § 1311(b)(1)(B), 42 U.S.C. § 18031(b)(1)(B).

9. *See infra* Part I.

This Article argues that this mixed approach to regulating small-group markets will subject them to substantial instability beginning in 2014, when many of the ACA's most important reforms come into effect. First, the ACA's reforms are likely to encourage many small employers with predominantly low-income employees to opt out of small-group markets, despite small-business tax credits that were explicitly designed to incentivize these firms to both offer and subsidize group coverage.[10] This is a result of the ACA's intertwined regulation of individual and small-group markets, which will actually make low-income employees of small employers *worse off* if they are offered "affordable" employer coverage that provides "minimum value." By virtue of being offered such coverage, low-income employees will become ineligible for very substantial premium and cost-sharing subsidies on the individual market that dwarf the tax benefits they would receive from employer-sponsored coverage.[11] This incentive for certain small employers to avoid offering coverage to low-income employees is unprecedented and is a largely unappreciated consequence of the ACA. Yet it will increase the fiscal cost of the ACA while decreasing the stability of small-group markets.

Second, the ACA is likely to cause many small employers with mixed-income employees to pursue strategies that simultaneously preserve premium and cost-sharing subsidies on the individual market for their low-income employees, while allowing their high-income employees to continue to enjoy the significant tax subsidy provided by purchasing group coverage with pre-tax dollars.[12] To accomplish this, a small employer can offer group coverage, but structure that coverage so that it either is not "affordable" for low-income employees or does not provide "minimum value." Under either approach, low-income employees would remain eligible for large public subsidies for coverage in the individual market, but high-income employees would nonetheless be able to acquire group coverage and thereby take advantage of the associated tax benefits. Crucially, group coverage that is "unaffordable" for low-income employees or does not provide "minimum value" would not necessarily be unattractive to high-income employees. An employer has many options for structuring its group plan in ways that technically meet one of these conditions, but that would, as a practical matter, provide affordable, desirable health insurance coverage for high-income employees.[13] This strategic behavior would once again increase the ACA's fiscal consequences and undermine the stability of small-group markets.

10. *See infra* Part II.A.
11. *See infra* Part II.A.
12. *See infra* Part II.C.
13. *See infra* Part II.B.

Third, the ACA is certain to make "self-insuring" the cost of their employees' health care costs more attractive for small employers.[14] By doing so, small employers will escape numerous requirements embedded within the ACA.[15] This will be particularly valuable for small employers who view their employees to be less risky than similarly aged small-employer groups. Self-insuring effectively allows these employers to escape the ACA's prohibition against premium discounts for healthier groups.[16] In addition, while self-insuring typically involves the retention of a large amount of risk on the part of employers, stop-loss insurance, which provides employers with coverage if certain medical expenses in a self-insured plan exceed a specified threshold, is becoming more readily available to small employers.[17] The heightened availability of stop-loss coverage has increased the likelihood that many small employers that offer group coverage post-2014 will elect to offer self-insured plans. If self-insurance becomes widespread among small employers, small-group markets could face substantial adverse selection: as comparatively healthy small groups exit the market, premiums must increase to reflect the decreasing health of the remaining small groups, which may further cause low-risk small groups to exit the market.[18] Crucially, the likelihood of adverse selection and the potential for it to result in a "death spiral" is directly related to the overall size of the small-group market, and thus to the first two sources of small-employer opt-out described above.[19]

These sources of instability pose substantial and under-appreciated obstacles to the future of small-group markets. This Article, however, argues that these obstacles are not insurmountable. State and federal lawmakers have numerous opportunities to mitigate these risks and preserve a vital segment of the private health insurance market. One of these opportunities has been described extensively elsewhere: states can, and should, regulate the provision of stop-loss insurance, which makes self-insurance a realistic option for most small employers by insulating them from genuine risk

14. Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another,"* 5 YALE J. HEALTH POL'Y L. & ETHICS 89, 105–06 (2005).

15. *See infra* Part III.

16. *See* Timothy Stoltzfus Jost & Mark A. Hall, *Self Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options* 9–10 (Wash. & Lee Pub. Legal Studies Research Paper Series, Accepted Paper No. 2012-24, 2012), *available at* http://ssrn.com/abstract=2070883.

17. *See id.* at 5–6.

18. *See infra* Part III.

19. *See* Ronen Avraham, Kyle D. Logue & Daniel Schwarcz, *Understanding Insurance Anti-Discrimination Laws* (Univ. of Mich. Law Sch. Law & Econ. Research Paper Series, Paper No. 12-017, 2013) (forthcoming, Southern California Law Review, 2013), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2135800.

associated with their employees' medical expenses.[20] Standing alone, however, this reform is unlikely to save most states' small-group markets.

Rather than focusing solely on stop-loss regulation, this Article explores a number of complementary approaches to defusing the risks to small-group markets described above.[21] It emphasizes that states must focus not just on increasing the risks to small employers of self-insuring, but also on designing coverage on SHOP exchanges to affirmatively attract small employers who may be considering either self-insuring or dropping coverage completely. In particular, states should design small-group coverage as a simple and risk-free option that facilitates employee choice, thus contrasting it with self-insurance, which is complicated, potentially risky, and eliminates employee choice.[22] SHOP exchanges must then market this message aggressively and limit the capacity of self-insurance to outcompete SHOP coverage by paying brokers higher commissions. Finally, states must take measures to limit churning between SHOP exchanges and self-insurance that would allow small employers to exploit changes in their risk status. They could accomplish this by either limiting enrollment periods for previously self-insured employers or charging such employers larger fees to join the exchange.

Ultimately, then, this Article argues that the risk that small-group markets will collapse after 2014 is significant, but can be substantially mitigated by a range of complementary regulatory interventions. Of course, a skeptic may reasonably wonder whether small-group insurance markets ought to be saved. If the insurance exchanges established by the ACA reform individual markets as intended, then they may provide a reasonable, and perhaps superior, alternative to small-group markets. Given that the ACA is in fact structured around functioning small-group markets,[23] however, this Article proceeds on the assumption that the ACA will not be able to accomplish its broader goals as effectively if that market segment collapses. Politically, the ACA will face dramatic new challenges if its numerous efforts to preserve small-group markets fail. And more practically, small-group markets provide tax benefits and preexisting infrastructure that can support the preservation and expansion of coverage, while much uncertainty remains regarding the stability and robustness of individual insurance exchanges.

This Article proceeds as follows. Part I begins by providing background on the ACA's reform of small-group markets. Part II then describes the risks

20. *See* Mark A. Hall, *Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers From Undermining Market Reforms*, 31 HEALTH AFF. 316, 316 (2012); Jost & Hall, *supra* note 16, at 13–15.

21. *See infra* Part IV.

22. *See infra* Part IV.

23. *See infra* Part I.

to small-group marketplaces stemming from small employers' incentives to offer coverage. Part II shows why small employers with low-income employees will tend to opt out of small-group markets and how small employers with mixed-income employees can exploit the ACA's rules to maximize public subsidies for their employees. Part III then explores the threats to small-group markets related to self-insurance and shows how they interact with the risks described in Part II to further decrease the stability of small-group markets and SHOP exchanges. Finally, Part IV explores various potential responses to these threats, including the regulation of stop-loss coverage and numerous complementary strategies.

I. THE ACA'S REFORM OF SMALL-GROUP MARKETS

A. SMALL-GROUP MARKETS PRE-ACA

Employer-provided health insurance has been a key component of health insurance access in the United States for many decades.[24] In 2010, just over 60% of the non-elderly population obtained health insurance coverage through an employer plan.[25] However, employees' access to such coverage differs dramatically according to the size of their employer. Historically, large employers have been much more likely than their smaller counterparts to offer health care coverage. In 2011, one large survey found that only 48% of firms with three to nine workers offered employee health coverage, while 99% of firms with more than 200 workers did so.[26]

The relative reluctance of small employers to offer coverage is attributable to at least three factors. First, the administrative costs associated with small-employer coverage are much greater on a per capita basis than they are for larger firms. Indeed, administrative expenses account for 25–27% of premiums in small-group markets, but only 5–10% in large-group markets.[27] Second, smaller firms do not often have the in-house expertise

24. *See* Hyman & Hall, *supra* note 2, at 25–26.

25. JOHN HOLAHAN & VICKI CHEN, THE HENRY J. KAISER FAMILY FOUND., CHANGES IN HEALTH INSURANCE COVERAGE IN THE GREAT RECESSION, 2007–2010, at 6 fig.6 (2011), *available at* http://www.kff.org/uninsured/upload/8264.pdf (reporting that 60.4% of non-elderly Americans were covered under an employer plan in 2010, down from 70.6% in 2000).

26. GARY CLAXTON ET AL., THE HENRY J. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 36 exhibit 2.2 (2011), *available at* http://ehbs.kff.org/pdf/2011/8225.pdf.

27. Cathy Schoen et al., *Building Blocks for Reform: Achieving Universal Coverage with Private and Public Group Health Insurance*, 27 HEALTH AFF. 646, 647 (2008). The Affordable Care Act's medical-loss ratio requirements, which became effective in 2011, may have already begun to lower administrative expenses in small-group markets. For an overview of 2011 data, see *The 80/20 Rule: Providing Value and Rebates to Millions of Consumers*, HEALTHCARE.GOV (June 21, 2012), http://www.healthcare.gov/news/reports/mlr-rebates06212012a.html.

necessary to navigate the complex decision-making process associated with choosing a quality health plan.[28]

Third, and most importantly, the poor health status of just one or two employees can disproportionately affect the cost and availability of small-employer coverage. Large employers can be insured at community-average rates because the law of large numbers tends to ensure that their employees' overall health care expenses are similar to those of the broader community.[29] Small groups do not have this same feature. Their employees' aggregate health care costs can be dramatically impacted by a single employee's high-cost medical condition. Furthermore, federal law prevents an employer from discriminating on the basis of health status with respect to a group plan's eligibility, premiums, or services.[30] A small employer is unable, therefore, to exclude high-risk employees from coverage, or charge the employee a higher premium for coverage. Because small-group policies are typically purchased on a yearly basis, small employers often face significant premium increases following years in which an employee becomes considered high-risk.[31] The extreme premium volatility that medical underwriting in small groups causes is thought to lead many small employers to decline to offer coverage in the first place or to drop coverage as premiums rise.[32]

These barriers to broad coverage in small-group markets have proven resistant to a variety of reform efforts. Throughout the 1990s, various states required insurers to issue coverage to any small group that applied and restricted the reasons that an insurer could decline to renew coverage.[33] Many states also implemented rating restrictions that limited the extent to which small-group premiums could vary based on the health risks of the employee group.[34] Despite these efforts, small-group offer rates remain quite low and have been falling in recent years.[35] At the same time, small

28. *See* David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 87 (2006).

29. *See* Hyman & Hall, *supra* note 2, at 32.

30. 29 U.S.C. § 1182 (2006 & Supp. V 2011).

31. *See* PAUL FRONSTIN ET AL., EMP. BENEFIT RESEARCH INST., SMALL EMPLOYERS AND HEALTH BENEFITS: FINDINGS FROM THE 2002 SMALL EMPLOYER HEALTH BENEFITS SURVEY 4 (2003), *available at* http://www.ebri.org/pdf/briefspdf/0103ib.pdf (noting that 28% of small employers surveyed experienced an annual increase in premiums of at least 20%).

32. *See, e.g.*, Roger Feldman et al., *The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance*, 32 J. HUM. RESOURCES 635, 654–56 (1997).

33. Hall, *supra* note 4, at 691–92.

34. *Id.* at 693–94.

35. CLAXTON ET AL., *supra* note 26, at 36 exhibit 2.2 (finding the offer rates for the smallest employers fell from 59% in 2010 to 48% in 2011).

employers continue to face much greater health insurance costs than their larger counterparts.[36]

Health reformers have nonetheless remained interested in increasing small-group offer rates, for at least two reasons. First, the individual market for health insurance in most states has historically been even less attractive than the small-group market, particularly for individuals with negative health history or risks. Although individual health insurance markets vary significantly by state, most suffer from significant adverse selection, meaning that the population that buys coverage has a higher risk level than the population as a whole.[37] Such adverse selection not only increases premiums, it also leads insurers to engage in various risk-management techniques that limit coverage or increase costs for individuals with poor health histories.[38] These techniques, which include excluding coverage for pre-existing conditions and rescinding coverage for innocent misrepresentations when an individual becomes high risk, also ultimately harm healthy individuals who find coverage unavailable once it is needed.[39] Group insurance coverage is thought to suffer from less adverse selection than the individual market.[40]

Another reason that reform efforts have focused on increasing small-employer offer rates is that there are tax benefits that are available exclusively to employer-provided coverage, which increase small-group coverage affordability compared to individual coverage. Employer-sponsored health insurance can be paid entirely with pre-tax income, whereas coverage an employee purchases on the individual market must be paid for with after-tax dollars.[41] This tax benefit not only makes employer-provided coverage more affordable for all employees,[42] but it also encourages employers to contribute to coverage and low-risk employees to opt for coverage they might otherwise find too expensive given their risk level.[43]

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36. *See* Jon Gabel et al., *Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii Is Up, Wyoming Is Down*, 25 HEALTH AFF. 832, 835 (2006).

37. *See, e.g.*, Melinda Beeuwkes Buntin et al., *The Role of the Individual Health Insurance Market and Prospects for Change*, 23 HEALTH AFF. 79, 81–82 (2004).

38. *See id.*

39. *See* ABRAHAM & SCHWARCZ, *supra* note 1, at 3.

40. *See, e.g.*, Hall, *supra* note 4, at 689, 692–93.

41. *See* I.R.C. §§ 106, 125 (2006 & Supp. V 2011) (providing that both employer and employee contributions towards employer-provided health insurance coverage can be excluded from an employee's income). No similar provision exists for individual coverage purchased directly by an employee. Self-employed individuals may, however, deduct health insurance premiums paid from their taxable income. *See id.* § 162(l).

42. *See* Mark A. Hall & Amy B. Monahan, *Paying for Individual Health Insurance Through Tax-Sheltered Cafeteria Plans*, 47 INQUIRY 252, 252 (2010).

43. For a more detailed discussion of the impact of the tax benefit for employer-provided coverage on risk pooling, see generally Amy B. Monahan, *The Complex Relationship Between Taxes*

B. THE REGULATION OF INDIVIDUAL AND SMALL-GROUP MARKETS POST-ACA

The potential strengths of small-group markets coupled with their historical shortcomings made them a core target of the ACA.[44] Because of the interconnections between small-group and individual markets, understanding the ACA's potential effects on the former requires considering its regulation of the latter.

1. The ACA's Regulation of Individual and Small-Group Markets

Many of the ACA's small-group market reforms also apply to individual-insurance markets. Starting in 2014, the pricing, offering, and renewal of policies in both markets will be strictly regulated. Health insurers will be required to offer coverage to every applicant,[45] forbidden from excluding any pre-existing conditions,[46] and allowed to cancel or decline to renew coverage in very limited circumstances.[47] In both markets, insurers will be permitted to vary price based only on four factors: age, geographic location, tobacco use, and family size.[48] The extent to which premiums can vary based on tobacco use will be constrained to a 1.5 to 1 ratio, and age-based premium variation will be similarly limited to a 3 to 1 ratio.[49] Importantly, these rules limit insurer pricing of small-group policies, but they do not apply to the individuals who comprise the small group.[50] Preexisting federal law requires that employees be charged premiums for group coverage that do not vary based on health status.[51]

The ACA also substantially regulates the content of health insurance policies in individual and small-group markets beginning in 2014. It requires plans in these markets to cover benefits that the Secretary of Health

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and Health Insurance (Univ. of Minn. Law Sch. Legal Studies Research Paper Series, Paper No. 10-01, 2010), *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1531322.

44. *See, e.g.*, THE WHITE HOUSE, HEALTH REFORM FOR SMALL BUSINESS: THE AFFORDABLE CARE ACT INCREASES CHOICE AND SAVING MONEY FOR SMALL BUSINESSES (2010), *available at* http://whitehouse.gov/files/documents/health_reform_for_small_businesses.pdf; COUNCIL OF ECON. ADVISERS, EXEC. OFFICE OF THE PRESIDENT, THE ECONOMIC EFFECTS OF HEALTH CARE REFORM ON SMALL BUSINESSES AND THEIR EMPLOYEES (2009), *available at* http://www.whitehouse.gov/assets/documents/CEA-smallbusiness-july24.pdf.

45. ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154 (2010) (codified as amended at 42 U.S.C. § 300gg-1 (2006 & Supp. V 2011)) (adding § 2702 to the Public Health Service Act ("PHSA")).

46. ACA § 1201, 42 U.S.C. § 300gg (adding § 2704(a) to the PHSA).

47. ACA § 1201, 42 U.S.C. §§ 300gg-2, -12 (adding §§ 2703, 2712 to the PHSA).

48. ACA § 1201, 42 U.S.C. § 300gg (adding § 2701 to the PHSA).

49. *Id.*

50. *See id.*

51. 29 U.S.C. § 1182(b) (2006 & Supp. V 2011).

& Human Services ("HHS") defines as "essential health benefits."[52] It also limits cost-sharing in various ways. Plans are prohibited from utilizing lifetime or annual benefit limits with respect to any essential health benefits.[53] In addition, individual and small-group plans are required to limit the overall cost-sharing a plan imposes[54] to the cap applicable to high-deductible health plans offered in conjunction with a health savings account.[55] In 2012, the out-of-pocket limit on such plans was $6050 for individual coverage and $12,100 for family coverage.[56] Notably, the ACA imposes an additional cost-sharing restriction that applies to small employer plans, but not plans purchased in individual markets: small-group plans may not have deductibles that exceed $2000 for individual coverage or $4000 for family coverage.[57]

Plans in individual and small-group markets are also subject to several rules designed to ensure both that a sufficient amount of premiums are spent on medical care and that firms do not compete by trying to cherry pick healthier-than-average enrollees. In both individual and small-group markets, plans must spend 80% of premium dollars on medical losses, leaving a maximum of 20% for administrative expenses and profits.[58] Any amounts spent in excess of that 20% must be refunded to policyholders.[59] The ACA also establishes a risk-adjustment mechanism that applies to both individual and insured group plans.[60] This program extends indefinitely and charges low actuarial-risk plans a penalty while providing payments to high actuarial-risk plans in order to discourage insurers from competing for low-risk enrollees.[61]

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52. ACA § 1201, 42 U.S.C. § 300gg-6 (2006 & Supp. V 2011) (adding § 2707 to the PHSA); ACA § 1301, 42 U.S.C. § 18021 (2006 & Supp. V 2011); ACA § 1302, 42 U.S.C. § 18022.

53. ACA § 1201, 42 U.S.C. § 300gg-11 (2006 & Supp. V 2011) (adding § 2711 to the PHSA).

54. Such cost-sharing is often referred to as an out-of-pocket maximum.

55. ACA § 1302(c)(1), 42 U.S.C. § 18022(c)(1) (2006 & Supp. V 2011).

56. Rev. Proc. 2011-32, 2011-22 I.R.B. 835.

57. ACA § 1302(c)(2)(A), 42 U.S.C. § 18022(c)(2)(A).

58. ACA § 1001, 42 U.S.C. § 300gg-18(b)(1)(A) (2006 & Supp. V 2011). These requirements are labeled "medical-loss ratio" requirements, or MLR rules. Large-group plans are subject to a higher medical-loss ratio of 85%. ACA § 1331, 42 U.S.C. § 18051 (Supp. V 2011).

59. ACA § 1001, 42 U.S.C. § 300gg-18(b)(1)(A) (2006 & Supp. V 2011).

60. ACA § 1343, 42 U.S.C. § 18063 (Supp. V 2011). The ACA also establishes two temporary reinsurance programs designed to protect insurers against high-risk enrollees. *See* ACA § 1341, 42 U.S.C. § 18601; ACA § 1342, 42 U.S.C. § 18602.

61. ACA § 1343, 42 U.S.C. § 18063. There is also a temporary three-year program that establishes "risk corridors" to protect insurers against the risk of uncertain rate-setting in the first few years of exchange operation. *See* Mark A. Hall, *The Three Types of Reinsurance Created by Federal Health Reform*, 29 HEALTH AFF. 1168, 1170–71 (2010).

For both the individual and small-group markets, the ACA will create insurance exchanges in each state with the goal of simplifying and streamlining insurance-purchasing decisions. States will have the option of keeping the individual and small-group markets separate or merging them into a single market.[62] Regardless, plans offered on an exchange must be "qualified health plans" that meet the requirements described above and provide actuarial value within a range of 60% to 90%.[63] In order to help consumers compare insurance options, plans will be classified by actuarial values that are labeled bronze (the lowest actuarial value plans, at 60%), silver (70% actuarial value), gold (80% actuarial value), or platinum (90% actuarial value).[64] While insurers are permitted to offer plans outside of the exchange, both individual and small-group plans offered outside of the exchange must still comply with all of the regulations described in this Subpart.[65] As explored more fully in Part III, small employers may circumvent many of the ACA's provisions by electing to self-insure their health plans.

2. The ACA's Subsidies and Taxes in Individual and Small-Group Markets

The ACA contains a complex mix of incentives and penalties with respect to both an employer's decision to offer coverage and an individual's decision to elect coverage. The ACA's most well-known provision, the "individual mandate," imposes a financial penalty on individuals who have affordable coverage available to them and decline to acquire it.[66] Coverage is considered affordable if premiums are less than or equal to 8% of the individual's household income.[67] The penalty for failing to purchase such coverage is equal to the greater of (1) $695 per person in a household, up to a maximum of $2085, or (2) 2.5% of household income.[68] Public coverage, individually purchased coverage, and employer coverage can all exempt individuals from this penalty.[69]

In order to increase the number of individuals who have access to affordable coverage, the ACA provides substantial subsidies in the form of tax credits for the purchase of individual health insurance coverage through

62. ACA § 1311(b)(2), 42 U.S.C. § 18031(b)(2); ACA § 1312(c)(3), 42 U.S.C. § 18032(c)(3).

63. ACA § 1302, 42 U.S.C. § 18022.

64. ACA § 1302(d), 42 U.S.C. § 18022(d).

65. ACA § 1201, 42 U.S.C. § 300gg-6 (2006 & Supp. V 2011) (adding § 2707 to the PHSA).

66. ACA § 1501(b), I.R.C. § 5000A (Supp. V 2011).

67. ACA § 1501(b), I.R.C. § 5000A(e)(1).

68. Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, § 1002, 12 Stat. 1029, 1032 (codified as amended at I.R.C. § 5000A(c)) (amending the ACA).

69. ACA § 1501(b), I.R.C. § 5000A(f).

an exchange.[70] The credits are available to individuals with household income between 100% and 400% of the federal poverty limit ("FPL") and are calculated on a sliding scale that specifies the percentage of income an individual will be required to pay for coverage.[71] The credit is equal to the difference between the amount the individual is required to pay and the actual cost of the second-lowest-cost silver-level plan available to her based on age and geographic area.[72] The ACA also provides reductions in cost-sharing for individuals with household income between 100% and 400% FPL who elect silver-level coverage on an exchange.[73]

Individuals who are offered employer coverage that is affordable and provides "minimum value" are *not* eligible for these tax credits or cost-sharing subsidies.[74] Employer coverage is considered affordable if the employee's share of premiums does not exceed 9.5% of the employee's household income.[75] For example, if an employee earns $22,340 per year (currently 200% of the federal poverty level), but is eligible for employer-provided coverage, she could receive a premium tax credit only if the required contribution for her employer coverage exceeds $2122 per year (9.5% of her income). A plan fails to provide minimum value if "the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs."[76]

Although the ACA imposes potential financial penalties on employers that fail to provide health care coverage to employees,[77] small employers with fewer than fifty full-time employees are not subject to these penalties.[78] Instead, the ACA provides some small employers with a limited incentive to

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70. ACA § 1401(a), I.R.C. § 36B.

71. ACA § 1401(a), I.R.C. § 36B(b).

72. To illustrate, assume that a single individual has household income exactly equal to 200% FPL. That individual would be entitled to a tax credit equal to the difference between the premium for silver-level coverage available to her and 6.3% of her household income, thereby ensuring that the individual only has to pay 6.3% of household income in order to purchase silver-level coverage. The credit is not, however, limited to silver-level coverage. The individual can take the credit and use it to purchase coverage of any level with the exchange. If the individual chooses to purchase coverage that is either more or less generous than the silver-level coverage on which the credit is calculated, her share of premiums would be either lower or higher than the 6.3% assumed.

73. ACA § 1402, 42 U.S.C. § 18071 (Supp. V 2011).

74. ACA § 1401(a), I.R.C. § 36B(c)(2)(C) (Supp. V 2011).

75. ACA § 1401(a), I.R.C. § 36B(c)(2)(C)(i)(II).

76. ACA § 1401(a), I.R.C. § 36B(c)(2)(C)(ii).

77. Effective in 2014, the ACA imposes a monetary penalty on employers with more than fifty full-time employees who either do not offer health insurance coverage or do offer coverage but have at least one employee who receives a tax credit or cost-sharing reduction. ACA § 1513, I.R.C. § 4980H. Employers that do not offer coverage and have at least one full-time employee who receives a premium tax credit face an annual fee of $2000 per full-time employee, excluding the first thirty employees from the assessment. ACA § 1513, I.R.C. § 4980H(c)(1).

78. ACA § 1513, I.R.C. § 4980H(c)(2).

voluntarily offer coverage. Beginning in 2010, employers with fewer than twenty-five full-time equivalent employees and average wages of less than $50,000 were potentially eligible for a tax credit.[79] In order to qualify, the employer must provide health insurance to employees and pay at least 50% of the cost of such coverage.[80] Initially, the maximum credit available was 35% of the employer-paid portion of the premiums.[81] Beginning in 2014, the maximum credit amount will increase to 50% of the employer-paid premiums but will only be available for two consecutive years.[82] The net result is that the maximum duration of this credit is six years (four years from 2010 through 2013, and two years beginning in 2014 or thereafter).

In addition to this temporary subsidy, the ACA allows small employers to provide exchange-based coverage as a cafeteria plan benefit.[83] Cafeteria plans allow employees to pay for certain qualified benefits with pre-tax dollars.[84] Even if an employer does not make any contribution to an employee's health insurance, such plans can save employees substantial sums by allowing them to pay for insurance using pre-tax dollars. Prior to the ACA, there was uncertainty regarding whether such cafeteria plans could be used to pay for individual, rather than group, health insurance.[85] The ACA resolves this uncertainty by providing that cafeteria plans can only be used to pay for exchange-based health insurance coverage if a small employer offers its employees "the opportunity to enroll through such an Exchange in a qualified health plan in a *group* market."[86] While regulations have yet to be issued providing the precise contours of this provision, the implication is that a small employer eligible to participate in an exchange could designate one or more group plans offered on the exchange to employees, and those employees could pay their share of the premiums for such coverage on a pre-tax basis through the employer's cafeteria plan. In no event, however, could a cafeteria plan be used to pay for individual coverage purchased through an exchange.[87]

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79. ACA § 1421, I.R.C. § 45R(d).

80. In order to receive the maximum credit, the employer must have ten or fewer full-time equivalent employees that are paid average annual compensation of $25,000 or less per full-time employee. ACA § 1421, I.R.C. § 45R(c)–(d) (Supp. V 2011).

81. ACA § 1421, I.R.C. § 45R(g).

82. *Id.*

83. ACA § 1515(a), I.R.C. § 125(f)(3).

84. In recent years, there has been interest at the state level in requiring employers to offer their employees the ability to purchase individual health insurance through a cafeteria plan. *See generally* Mark A. Hall et al., *Using Payroll Deduction to Shelter Individual Health Insurance from Income Tax*, 46 HEALTH SERVICES RES. 348 (2011).

85. Hall & Monahan, *supra* note 42, at 257–59.

86. ACA § 1515(a), I.R.C. § 125(f)(3) (emphasis added). Beginning in 2014, if a state elects to allow large groups to participate in the exchange, those large employers would also have the ability to use a cafeteria plan to pay for exchange-based coverage. *Id.*

87. *See id.*

Finally, all employers, regardless of size, are potentially subject to an excise tax on high-cost plans starting in 2018. This so-called "Cadillac Tax" is equal to 40% of the amount by which an employer's group health plan premium exceeds certain dollar thresholds.[88] In analyzing whether the dollar-amount threshold is met, the costs of all applicable group health plans of an employer are aggregated.[89] The excise tax generally applies to the extent that the annual cost of such plans exceeds $10,200 for self-only coverage or $27,500 for any other form of coverage.[90]

The ACA's various individual and employer penalties and incentives are difficult to parse because they are both varied and intertwined. Part II below will explore how the ACA's regulations and incentives are likely to affect a small employer's decision to offer its employees health insurance coverage.

II. SMALL EMPLOYERS AND THE DECISION TO OFFER GROUP COVERAGE POST-ACA

The rate at which employers offer their employees some form of health insurance is often broken down by employer size. In 2011, for instance, health insurance was offered by 48% of employers with between 3 and 9 employees, 71% of employers with between 10 and 24 employees, 85% of employers with between 25 and 49 employees, and 93% of employers with between 50 and 199 workers.[91] Among employers with over 200 employees, 99% offered their employees health insurance.[92] The correlation between employer size and the propensity to offer group health coverage is both strong and persistent over time.[93]

This Part argues that beginning in 2014, the propensity of small employers to offer group health coverage will correlate less with size than with the income profile of their employees. It argues that due to tax credit eligibility provisions, small employers with predominantly low-income employees will face strong incentives to drop coverage completely starting in 2014. By contrast, it shows that small employers with predominantly high-

88. I.R.C. § 4980I(a). The term "group health plan" includes not only standard medical plans, but also health reimbursement arrangements, health flexible spending accounts offered through a cafeteria plan, and health savings accounts. *See id.* § 4980I(f)(4) (citing I.R.C. § 5000(b)(1)). Notably, it excludes stand-alone dental and vision plans from its reach. Stand-alone dental and vision plans are also included in the definition of group health plan under § 5000(b)(1) but are specifically exempted from the excise-tax provisions. *See id.*

89. *Id.* § 4980I(b)(2)(A).

90. *Id.* § 4980I(b)(3)(C)(i). Multiemployer plans get a special break that provides that all multiemployer plan coverage shall be considered to be "coverage other than self-only coverage." *Id.* § 4980I(b)(3)(B)(ii). A multiemployer plan is a plan that more than one employer contributes to pursuant to a collective bargaining agreement. *See id.* § 414(f)(1) (2006 & Supp. V 2011).

91. CLAXTON ET AL., *supra* note 26, at 36 exhibit 2.2.

92. *Id.*

93. *See id.*

income workers will have strong incentives to offer some form of group coverage. Finally, it shows that small employers whose employees vary significantly in their income levels will face more complicated incentives, but are likely to favor offering coverage. However, they are likely to design that coverage so that it is either not "affordable" with respect to low-income employees or does not provide "minimum value."

A. *SMALL EMPLOYERS WITH PREDOMINANTLY LOW-INCOME EMPLOYEES*

Starting in 2014, small employers whose employees are predominantly low income will generally opt not to offer any form of employer-sponsored coverage. There are four contributing elements to this prediction. The first, and most important, is that employers of predominantly low-income employees will generally make their employees worse off by offering coverage. This is because individuals who are offered employer coverage that is "affordable" and provides "minimum value" are not eligible for either premium tax credits or cost-sharing subsidies on the individual insurance exchanges.[94] This effect is unprecedented: never before could an employer's decision to offer health insurance coverage potentially make its employees worse off. Yet, this effect has received remarkably little attention in the academic literature.[95]

Although the amount that low-income employees of small employers would forfeit in public subsidies as a result of being offered coverage depends on numerous factors, it is certain to be quite large. For instance, assuming an annual premium of $4780 for silver-level coverage in 2014, an employee making 200% of the federal poverty limit ("FPL"), or about $22,000, would lose an estimated $3394 in health insurance premium subsidies.[96] Because this credit is based on the maximum percentage of income that an eligible individual will be required to pay for silver-level coverage, if premiums are higher than currently anticipated, the forfeited

94. I.R.C. § 36B(c)(2)(C) (Supp. V 2011).

95. There are, of course, notable exceptions. *See generally* David Gamage, *Pervasive Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms Are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669, 701–08 (2012) (noting that the ACA will discourage low- and moderate-income employees from accepting jobs that provide affordable health insurance). The Congressional Budget Office has in its projections acknowledged that small firms, particularly with low-income workers, would drop coverage as a result of the ACA, but it does not make clear the basis for its projections (for example, whether their prediction is driven by the incentives described here, or whether it is based on low demand from low-wage workers). *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Harry Reid, Majority Leader, U.S. Senate 9 (Dec. 19, 2009), *available at* http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/108xx/doc10868/12-19-reid_letter_managers_correction_noted.pdf.

96. The individual would then be entitled to a tax credit equal to the difference between $4780 (the silver-plan premium) and $1386 (6.3% of household income), which equals $3394. *See* ACA, Pub. L. No. 111-148, § 1401(a), 124 Stat. 119, 213 (2010) (codified as amended at I.R.C § 36B).

subsidy from being offered employer-sponsored coverage will be even larger.[97] Importantly, while the credit is calculated on the basis of the second-lowest-cost silver plan, the employee would be free to choose any plan offered within the exchange.[98] Thus, if the individual chose a bronze-level plan with an annual premium of only $4100, she would still receive the $3394 tax credit and would only be required to pay $706 out of pocket for such coverage.

In addition to losing valuable premium tax credits, the same low-income employees would lose valuable cost-sharing subsidies as a result of being offered employer-sponsored coverage. Under the ACA, individuals eligible for premium tax credits who elect silver-level coverage will receive cost-sharing reductions. An individual who earns 200% FPL, for example, would be eligible to have her out-of-pocket maximum reduced by two-thirds and the percentage of expenses that a plan pays increased to 87%.[99] Assuming that the out-of-pocket maximum in 2014 will be $6350,[100] the individual in this example would have her out-of-pocket maximum reduced to approximately $2115, significantly limiting that individual's risk exposure. Similarly, the individual's co-insurance amounts would be reduced if she were to incur medical expenses above the deductible.[101] By offering this employee coverage, an employer would eliminate the employee's eligibility for these benefits as well.

Although an employer that declined to offer group coverage would forfeit certain tax benefits, these tax benefits would pale in comparison to the subsidies on an insurance exchange for low-income employees. Employees only have the ability to pay for health insurance coverage with pre-tax dollars if an employer offers them coverage.[102] As a result, individuals who must purchase their own coverage on the exchange, even if subsidized with premium tax credits, must pay their share of the premium with after-tax dollars. For low-income employees, however, it is extremely unlikely that the ability to pay premiums on a pre-tax basis would outweigh the benefit of the premium tax credit and cost-sharing subsidies described above. Most low-income employees have no federal income tax liability,[103] meaning that the

97. *See id.*

98. *See id.*

99. ACA § 1402, 42 U.S.C. § 18071 (Supp. V 2011).

100. This estimate of the out-of-pocket maximum in 2014 was obtained from THE HENRY J. KAISER FAMILY FOUND., PATIENT COST-SHARING UNDER THE AFFORDABLE CARE ACT 2 (2012), *available at* http://www.kff.org/healthreform/upload/8303.pdf.

101. *See* ACA § 1402, 42 U.S.C § 18071.

102. *See* I.R.C. §§ 106, 125 (2006 & Supp. V 2011).

103. In 2008, over 30% of all income tax filers faced no federal income tax liability. *See* Kyle Mudry, *Individual Income Tax Rates and Shares, 2008*, STAT. INCOME BULL., Winter 2011, at 22, 24, *available at* http://www.irs.gov/pub/irs-soi/11intro8winbul.pdf (finding that only 63.6% of federal income tax returns filed in 2008 were taxable returns).

tax exclusion for employer-provided coverage would be valuable only for the payroll tax exemption. As a result, the exemption would be worth 7.65% of the premium amount.[104] If the employer were to provide coverage with a $5000 premium, the tax benefit associated with group coverage would only be worth $383,[105] much less than the estimated premium tax subsidy of $3394 that an employee could receive in the absence of an employer's offer of coverage.

Low-income employees would be better off without an offer of affordable coverage from their employer, even if such coverage were high-value and fully-subsidized. Assume that a small employer with only low-income employees offered high-value coverage and paid its full $5000 per-employee cost. The employees of the firm would pay no tax on the employer's contribution to health care coverage, satisfy the individual mandate, and have quality health insurance coverage. Nevertheless, these employees would be worse off than employees of a competitor firm that did not offer any health insurance. The competitor firm could pay its workers wages that were $5000 higher than the original firm because it would not have any health care costs. Furthermore, while the workers would pay tax on the $5000 of additional wages, they would also be eligible for a tax credit of $3394 based on the previous assumptions. Provided the exchanges offered coverage options that satisfy employee preferences at prices that are similar to employer premiums, employees would in almost all circumstances prefer $5000 in additional, taxable wages and a $3394 tax credit to lower wages and employer-provided health insurance.

A second factor that may contribute to employers with low-income employees choosing to drop coverage is that doing so could potentially allow their employees to escape the individual mandate. Some low-income employees would not be subject to the individual mandate at all if they lacked affordable employer coverage because, even with the tax subsidies, coverage might be deemed unaffordable.[106] These employees would,

104. Payroll taxes are imposed on all wages. *See* I.R.C. §§ 3101(a)–(b), 3111(a)–(b).

105. Note that the benefit would be twice as large if one took into account the fact that the employer also saves its share of payroll taxes.

106. Premium tax credits under the ACA are based on the maximum percentage of income an eligible individual is required to pay for the second-lowest-cost silver plan available to her. *See supra* notes 96–97 and accompanying text. For individuals with income above 250% FPL, the maximum percentage is 8.05%, rising to 9.5% at 300% FPL and thereafter. HCERA, Pub. L. No. 111-152, § 1001, 124 Stat. 129, 1031 (2010) (codified as amended at I.R.C. § 36B(b)(3)(A)(i) (Supp. V 2011)) (amending the ACA). The threshold for affordability for purposes of the individual mandate is 8% of income. I.R.C. § 5000A(e)(1)(A) (Supp. V 2011). As a result, even if a tax-credit-eligible individual selects bronze-level coverage, she may still avoid the individual mandate if her share of the premium after-tax credits exceeds 8% of her income. If her employer were to offer her coverage that required a payment of only 7% of income, she would be subject to the mandate and would either have to elect coverage or pay a

however, be subject to the mandate if they were offered affordable employer-sponsored coverage. Thus, by offering coverage, it is possible that a small employer would cause its employees to be subject to the individual mandate. An employer offer of affordable coverage could therefore financially harm an employee who would not have purchased insurance in the absence of a mandate.

The third basis for our prediction that small employees with low-income employees will drop coverage is that, starting in 2014, they will feel much less of a moral obligation to offer group coverage. Small employers often cite moral obligations to employees as one of the reasons they offer group coverage.[107] This is understandable: in the current system, an individual who does not have coverage and becomes sick can suffer dire financial consequences, not only in the short term through unpaid medical bills, but also in the long-term because insurers in most states can deny coverage based on health history and risk.[108] However, both of these factors should begin to shift in 2014, when the consequences of being uninsured change significantly. Recall that core provisions in the ACA require insurers to offer coverage to individuals without any preexisting-condition exclusions or premium adjustments based on medical condition.[109] This means that anyone who becomes sick and does not have health insurance coverage can easily acquire it at community-average prices, although that person might have to wait until the next open-enrollment period.[110] Though this does not entirely eliminate the harm that can result from a lack of coverage, it significantly limits it, potentially making small employers less likely to offer coverage than they are under the status quo.

The final explanation for our prediction that small employers with predominantly low-income employees will choose not to offer coverage in future years is that the ACA neither requires nor meaningfully rewards such a decision. As previously noted, small employers are not subject to the employer mandate and face no penalty associated with failing to offer group coverage.[111] Instead, the ACA offers limited-time tax credits to qualifying

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monetary penalty. For more detail on the mechanics of the individual mandate, see Amy B. Monahan, *On Subsidies and Mandates: A Regulatory Critique of ACA*, 36 J. CORP. L. 781 (2011).

107. *See, e.g.*, FRONSTIN ET AL., *supra* note 31, at 7 fig.6 (finding that in 2002, 77% of small businesses stated that a major factor in their decision to offer health insurance was that "it was the right thing to do").

108. *See Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals)*, THE HENRY J. KAISER FAMILY FOUND., http://kff.org/other/state-indicator/individual-market-rate-restrictions/ (last visited May 13, 2013).

109. *See supra* Part I.

110. *See* ACA, Pub. L. No. 111-148, § 1311(c)(6), 124 Stat. 119, 175 (2010) (codified as amended at 42 U.S.C. 18031(c)(6) (Supp. V 2011)) (requiring the Secretary of HHS to establish an annual open enrollment period for the individual market exchanges).

111. *See supra* Part I.

small businesses that not only offer, but also subsidize, such coverage.[112] To be eligible for this incentive, an employer must have fewer than twenty-five full time employees and average wages of less than $50,000.[113] This credit has been available since 2010, but its utilization has fallen far short of expectations.[114] Despite estimates that somewhere between 1.4 million and 4 million employers were eligible for the credit, fewer than 200,000 claimed it in 2010.[115]

While small-business tax credits will increase to up to 50% of the employer's contributions to premiums starting in 2014,[116] their use by small employers is not likely to increase and may actually decrease. Recall that the credit is available for a maximum of two years beginning in 2014.[117] The limited duration of the credit makes it unlikely that it alone would substantially impact employers' decisions about whether to offer group coverage. This is because establishing a health insurance program for one's employees inevitably involves a number of fixed costs that are much more economical if they are spread over a longer period of time.[118] Additionally, it may be harder for the employer to drop coverage once it is offered than to simply not offer coverage in the first place.[119]

Before concluding, it is important to briefly mention why this analysis does not necessarily suggest that large employers will also choose to drop coverage. Without a doubt, some of the analysis described above—such as

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112. ACA § 1421, I.R.C § 45R (Supp. V 2011).

113. *Id.*

114. In 2012, the Government Accountability Office ("GAO") released a report finding that only 170,300 small employers claimed this credit. U.S. GOV'T ACCOUNTABILITY OFFICE, SMALL EMPLOYER HEALTH TAX CREDIT: FACTORS CONTRIBUTING TO LOW USE AND COMPLEXITY 9 (2012), *available at* http://www.gao.gov/assets/600/590832.pdf.

115. *Id.*

116. *See id.* at 6.

117. *See supra* text accompanying note 82.

118. In order for an employer to establish a health plan, the employer must devote internal resources to determine the basic structure of the plan, such as eligibility provisions. In addition, the employer as a practical matter almost always needs to engage either an insurance broker or an employee benefits consultant in order to structure a self-insured plan or purchase a group insurance contract. The employer must also obtain legal services if it wants employees to be able to pay premiums on a pre-tax basis, as the employer must adopt a cafeteria plan in order to permit such pre-tax payments. The employer must also make adjustments to payroll processing to account for these pre-tax payments. Finally, the employer needs, with the advice of counsel, to put compliance systems in place to ensure that all federal and state laws governing group health plans are complied with. It is the authors' opinion that the significance of these upfront costs will mean that few employers will establish a group health plan that they intend to have in place for only two years.

119. For an overview of the endowment effect, see Russell Korobkin, *The Endowment Effect and Legal Analysis*, 97 NW. U. L. REV. 1227, 1230–42 (2003). For a critical view of experiments purporting to establish the endowment effect, see Charles R. Plott & Kathryn Zeiler, *The Willingness to Pay—Willingness to Accept Gap, the "Endowment Effect," Subject Misconceptions, and Experimental Procedures for Eliciting Valuations: Reply*, 101 AM. ECON. REV. 1012 (2011).

the changing moral dimensions of employers' health insurance plans—applies regardless of employer size. It is also true that low-income employees of large employers will lose federal tax and cost-sharing subsidies if they are offered affordable coverage that provides minimum value.[120] The key difference, however, is that small employers are not subject to the employer mandate.[121] By contrast, large employers are subject to the mandate, and the amount of the associated penalty for such employers is specifically tied to the subsidies that their employees receive on an individual insurance exchange.[122] As a result, a larger employer could not simply drop group coverage and allow its employees to reap the benefits of the premium tax credits. Doing so would result in an annual penalty of approximately $2000 per employee.[123] A large employer is likely to be better off using that amount of money to subsidize its own health plan or increase employee wages. At the very least, the cost-benefit calculation is much more difficult for large employers contemplating completely dropping coverage. For small employers, however, it seems clear that those with predominantly low-income employees will find the decision to not offer coverage beginning in 2014 an easy one.

B. SMALL EMPLOYERS WITH PREDOMINANTLY HIGH-INCOME EMPLOYEES

In contrast to the situation described above, small employers with predominantly high-income employees[124] are likely to have substantial incentives to offer coverage after 2014. This prediction is premised on four core factors. First, employers will not jeopardize the availability of public subsidies for their high-income employees by offering coverage because those employees would not be eligible for any subsidies on individual insurance exchanges in the first place. For employees with household incomes above 400% FPL, neither premium nor cost-sharing subsidies will be available.[125] Even for those at the top end of the subsidy range, roughly between 350% and 400% FPL, the subsidies may not easily outweigh an offer of employer-provided coverage, given that the subsidy amount declines

120. *See* ACA, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213 (2010) (codified as amended at I.R.C. § 36B (Supp. V 2011)).

121. *See* ACA § 1513, I.R.C. § 4980H.

122. *Id.*

123. *See id.*

124. It is difficult to determine how many small firms would fall into this category, or any of the other categories we have identified, because comprehensive data on wages by firm size are not readily accessible. While the median earnings of full-time workers is near 400% FPL, we do not know the average wages of small firms or the distribution of wages within such firms. *See* BUREAU OF LABOR STATISTICS, U.S. DEPT. OF LABOR, REPORT 1038, HIGHLIGHTS OF WOMEN'S EARNINGS IN 2011, at 8 tbl.1 (2012), *available at* http://www.bls.gov/cps/cpswom2011.pdf (reporting average weekly earnings of $756 in 2011, which on an annualized basis is $39,312 or just under 400% FPL).

125. *See* ACA § 1401, I.R.C. § 36B; ACA § 1402, 42 U.S.C. § 18071 (Supp. V 2011).

as an individual's income level approaches 400% FPL.[126] For example, an individual earning 399% FPL would be entitled to a premium tax credit of $546 if we again assume that premiums for silver-level coverage will be $4780 in 2014.[127] And that individual's out-of-pocket maximum would be reduced by only one-third, with the plan's cost-sharing average moved up to only 70%.[128] As a result, for small employers whose employees' incomes are either greater than or near 400% FPL, their decision to offer group coverage should not be significantly affected by the ACA's premium or cost-sharing subsidies.

Second, for small employers with relatively high-income employees, the value of the tax exclusion for employer-provided coverage is significant. Assume again that the employer provides coverage with a $5000 premium.[129] The full value of that coverage is excluded from an employee's income for purposes of federal and state income taxes as well as payroll taxes, resulting in an implicit subsidy of at least $2132 for an employee in the top income bracket.[130] An employer that did not offer coverage of some sort—even coverage without any employer contribution—would cause high-income employees to forfeit this subsidy. Indeed, the tax subsidy is one of the primary reasons employer-sponsored coverage is as dominant as it is, and nothing about this subsidy will change after health care reform is fully implemented.

Third, in 2014, core provisions of the ACA should make a small employer's size matter much less in its decision to offer coverage. Currently, even small employers with predominantly high-income employees may not offer group coverage because of the high costs that can result from just a single employee with a serious health condition.[131] This should change when the ACA's guaranteed issue and rating restrictions become effective in 2014.[132] These rules will shield small employers from group medical underwriting, guaranteeing them the option of purchasing group coverage at nearly community-average prices.[133] At the same time, SHOP exchanges,

126. *See* ACA § 1401, I.R.C. § 36B.

127. *See id.* Calculated using the assumption that 399% FPL is $44,568, based on 2012 poverty guidelines.

128. For an overview of HHS's proposed approach to cost-sharing reductions, see THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP'T OF HEALTH & HUMAN SERVS., ACTUARIAL VALUE AND COST-SHARING REDUCTIONS BULLETIN 11 tbl.1 (2012), *available at* http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf.

129. This assumption is loosely based on the average cost of employer-provided coverage in 2011. *See* CLAXTON ET AL., *supra* note 26, at 1 (finding that the average cost of employee-only single coverage in 2011 was $5429).

130. Calculated by using a combined federal income and payroll tax rate of 42.65%.

131. *Cf.* CLAXTON ET AL., *supra* note 26, at 41 exhibit 2.9 (reporting that 55% of small businesses cited high cost as the most important reason why they did not offer group coverage).

132. *See supra* Part I.B.

133. *See supra* Part I.

and perhaps MLR requirements, should help to reduce the administrative expenses traditionally associated with small-employer coverage. All of this means that the costs of small-group coverage that may have historically overwhelmed the tax benefits of such coverage will be substantially reduced.

Finally, high-income employees are much more likely to value the option of employer-sponsored health insurance than low-income employees. In part, this is because these employees are more likely than their low-income counterparts to have assets that they would like to protect from medical creditors and from potential bankruptcy if their assets are insufficient to fully pay their medical bills.[134] Additionally, high-income individuals tend to use their health insurance more than low-income individuals.[135] One caveat to this analysis, though, is that some high-income employees may be exempt from the individual mandate if and only if their employer did not offer group coverage. For this to be true, the individual would have to face an individual premium on the exchange that exceeded 8% of household income, thereby making coverage unaffordable for purposes of the mandate, while her employer offered coverage whose required employee contribution was less than 8% of her income.[136] While this modestly cuts against the argument made here, it is ultimately of little consequence given the benefits that group health insurance provides to high-income employees.

C. *MIXED-INCOME SMALL EMPLOYERS*

For many of the reasons discussed in the preceding two sections, small employers with a substantial number of both high- and low-income employees will face a complicated decision about whether to offer coverage. Offering coverage will tend to be in the interests of their high-income employees, but doing so may very well be against the interests of their low-income employees.

An attractive option for small employers who fit this mold is to offer coverage to all of their employees, but to structure that coverage so that it either does not provide "minimum value" (the "minimum-value strategy") or is not "affordable" for their low-income employees (the "affordability strategy"). Either strategy would preserve the ability of their low-income employees to receive subsidies on an individual exchange while allowing their high-income employees to receive the tax benefits of employer-

134. It is also the case, however, that very high-wealth individuals may have sufficient assets to self-insure against any medical expenses.

135. *See, e.g.*, Barak D. Richman, *Insurance Expansions: Do They Hurt Those They Are Designed to Help?*, 26 HEALTH AFF. 1345, 1345 (2007).

136. *See* ACA, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213 (2010) (codified as amended at I.R.C. § 36B (Supp. V 2011)).

provided coverage.[137] This is because individuals are only eligible for subsidies on an individual insurance exchange if they do not have the option of employer-sponsored coverage that is both affordable and provides minimum value.[138]

Under the minimum-value strategy, a small employer would structure its plan to have an actuarial value below 60%.[139] This would mean that for an average population the plan would pay less than 60% of the cost of covered services. Such a plan would require significant cost-sharing through deductibles and co-insurance requirements.[140] At first glance, it appears that only employers whose high-income employees would find a high cost sharing plan desirable would likely pursue the minimum-value strategy. It should be noted, though, that such plans are becoming increasingly common, reflecting the growth of consumer-driven health care.[141] Moreover, high-deductible plans for high-income employees actually make good economic sense, because they preserve the benefits of consumer-driven health care (limiting the risk of ex post moral hazard) without the costs of that approach (shifting excessive risk onto employees).[142]

Employers that desire to pursue the minimum-value strategy are, in fact, likely to find the consumer-driven design to be a convenient way to create a low actuarial value plan that remains attractive to employees. A consumer-driven health plan typically involves a tax-favored savings account, known as a health savings account ("HSA"), combined with a high-deductible health plan.[143] In employer-sponsored consumer-driven plans, the employer typically contributes some amount to the employee's HSA, while the employee can also make additional pre-tax contributions to such accounts.[144] While there is not yet final guidance on this issue, preliminary guidance from the IRS suggests that while employer HSA contributions will be taken into account for purposes of actuarial value, employee contributions will not.[145] As a result, an employer pursuing the minimum-

137. *See* ACA § 1401(c)(2)(C), I.R.C. § 36B(c)(2)(C).

138. *See id.*

139. As explained later, an employer would need to self-insure to accomplish this. *See infra* Part III.B.2.

140. *See* THE HENRY J. KAISER FAMILY FOUND., WHAT THE ACTUARIAL VALUES IN THE AFFORDABLE CARE ACT MEAN 4 tbl.2 (2011), *available at* http://www.kff.org/healthreform/upload/8177.pdf (showing various estimates of 60% actuarial value plans under the ACA, with deductibles that range from $2750 to $6350 for single coverage).

141. *See* CLAXTON ET AL., *supra* note 26, at 57 exhibit 4.3 (reporting that 23% of firms that offer group health plans offer a consumer-driven plan).

142. *See* Regina E. Herzlinger, *Let's Put Consumers in Charge of Health Care*, HARV. BUS. REV., July 2002, at 44, 45–50.

143. *See* Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 780 (2006).

144. *See* CLAXTON ET AL., *supra* note 26, at 131 exhibit 8.7.

145. *See* I.R.S. Notice 2011-73, 2011-40 I.R.B. 474, 474–75.

value strategy could set up a consumer-driven plan with no employer contribution to the HSA, thereby lowering actuarial value. Nothing, however, would prevent the employer from raising employee wages or even suggesting to employees that they might want to contribute any associated wage increase to their HSA. This subtle change in the funding of the HSA may be all that is necessary to turn a plan that provides minimum value into one that does not.

The minimum-value strategy is likely to be particularly attractive for small employers with relatively healthy employees because the expected cost-sharing amounts for these employees would be low. The ability, however, to manipulate HSA contributions to provide less than minimum value will likely broaden the appeal of the minimum-value strategy to other small employers beyond merely those with low expected costs. In the end, no matter how it is structured, the minimum-value strategy would allow low-income employees to claim premium tax credits and cost-sharing subsidies, while still permitting higher-income employees to receive group coverage on a pre-tax basis. Not insignificantly, the minimum-value strategy would also enable high-income employees to satisfy the requirements of the individual mandate at low cost.[146]

The affordability strategy is somewhat simpler to implement than the minimum-value strategy, and it has the advantage of allowing the employer to offer a group plan featuring high levels of coverage. Under the affordability strategy, the employer would first determine the employee-income level at which it desired to preserve subsidies. It might choose to preserve the option of subsidies for all employees making less than 400% FPL, or it might choose a lower threshold given that the subsidies as employees approach 400% FPL are relatively small. Once that threshold is chosen, the employer needs only to ensure that employees with incomes falling below the chosen threshold are required to pay annual premiums that exceed 9.5% of their income.[147] For example, if an employer desired to

146. An individual satisfies the requirements of the individual mandate if she is covered by "minimum essential coverage." ACA, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 242–44 (2010) (codified as amended § at 42 U.S.C. § 18091 (Supp. V 2011)). Any employer-provided coverage is considered "minimum essential coverage." *See* ACA § 1501(b), I.R.C. § 5000A(f)(1)(b) (Supp. V 2011). As a result, a less-expensive, low-actuarial value plan would give employees the ability to satisfy the mandate at comparatively low cost.

147. Note that while an employer would set contribution rates based on employee income, eligibility for tax credits is actually determined based on *household* income, which would include not only the employee's income, but also the income of any spouse or dependent children. *See* ACA § 1401(a), I.R.C. § 36B. As a result, the employer might set the employee-contribution rate so that it exceeds 9.5% of the chosen income threshold, but not all employees with incomes under the threshold will necessarily be eligible for premium tax credits, because a spouse's income may result in household income that is too high. This is not a serious impediment to the affordability strategy, but rather shows its flexibility. By structuring the plan so that it will not result in any employees *who would otherwise be eligible for premium tax credits*

ensure that all employees with income equal to or less than 300% FPL would remain eligible for premium tax credits and cost-sharing subsidies, it would set employee contributions for the group plan at or above $3,184.[148] If the employer wanted to preserve tax credits for all employees at or below 400% FPL, each employee's contribution would need to be at or above $4,245.

To see how these two strategies might work, it is helpful to work through a simple example of each. Assume that a small employer, Widget Company, has twenty employees who are all the same age and non-smokers. Ten of these employees make 200% FPL, and ten have household incomes of 500% FPL. Assume first that Widget decides to sponsor a group health plan, but not to pursue either the affordability or minimum-value strategies. In fact, Widget pays the entire premium. As described earlier, if the cost of coverage is $5000 per individual, then group coverage will provide the low-income employees with approximately $383 in tax benefits and the high-income employees with approximately $2132 in tax benefits.[149] The federal subsidy that would result simply from the payment of group coverage with pre-tax dollars is $25,150.

Now assume that the small employer adopts the affordability strategy. To do so, it could offer to pay only 50% of the costs of coverage (or some lesser amount), requiring its employees to pay the remaining $2500.[150] Because $2500 is more than 9.5% of the low-income employees' wages ($22,000), these employees would be eligible for subsidies on the exchange because they would not have the option of "affordable" employer coverage. They would thus each be able to receive $3394 in health insurance premium subsidies. The high-income employees would still opt for group coverage and would still receive a tax benefit of $2132 each. The total federal subsidy under the affordability strategy would be $55,260: $33,940 in premium tax credits and $21,320 in federal tax subsidies resulting from pre-tax purchasing. In addition, the employer's costs would decrease by $25,000, which would be shifted onto employees.[151]

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losing their credits, no employee is harmed. Furthermore, the availability of the group plan ensures that high-income employees continue to enjoy pre-tax purchasing.

148. This figure is just above 9.5% of 300% FPL, which in 2012 was $33,510.

149. *See supra* Part II.

150. Economists have explained that an employer's contribution to health insurance premiums constitute part of an employee's wages. *See* Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177, 180 (1989). Therefore, if Widget decreases its contribution to health insurance premiums by $2500, it should raise employee wages by an equal amount. Employees can, in turn, pay their required $2500 contribution to coverage with pre-tax dollars through a cafeteria plan. *See* I.R.C. § 125(a), (i) (2006 & Supp. V 2011). As a result, while the employer has technically reduced its contribution towards coverage, an employee is no worse off.

151. In the previous example, Widget had been paying the full premium cost of $5000 for all twenty employees, for a total cost of $100,000. By decreasing its contribution to coverage to

Under these assumed numbers, a very similar result could be reached if the employer opted to pay 100% of the costs of its employees' coverage, but offered a consumer-driven plan with high deductibles and co-pays that did not provide "minimum value." Assume, for example, that the employer offered a plan with a $3000 annual deductible that required employees to pay 30% of all costs once the deductible had been satisfied.[152] Assume further that the annual premium for this plan was $3000 per employee. As under the affordability strategy, low-income employees would likely opt for coverage on the exchange, because the premium tax credits combined with richer coverage would likely be more attractive than the employer plan.[153] High-income employees, in contrast, would still likely stay in the group plan in order to keep the tax advantage unless, of course, they anticipated consistently high medical expenses.[154] Overall, under this minimum-value strategy, the federal subsidy would be $46,740: the same $33,940 in premium tax credits as above and a reduced $12,800 in tax subsidies resulting from pre-tax purchasing of group coverage. Overall health insurance costs would, however, be reduced. While the cost of exchange-based coverage would remain unchanged from the affordability example, the drop in group premiums would reduce overall health insurance costs by $20,000.[155]

To be sure, the tradeoffs of the minimum-value and affordability strategies would depend substantially on the age and smoking status of the various employees, an issue that the above example assumes away. First, these factors could influence the amount of the public subsidies that the low-income employees would receive on the exchange.[156] If low-income employees also tended to be older, this would increase the benefits of these approaches because the exchange subsidies are determined based on the maximum percentage of income an individual is required to pay for silver-

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$2500 per employee, half of its employees decline group coverage in order to elect cheaper, exchange-based coverage. But recall from note 150, that Widget has also raised employee wages by $2500 per individual. The end result is that Widget is paying $50,000 more in wages, but $75,000 less in health insurance premiums, saving a total of $25,000.

152. These numbers are loosely based on estimates of a 60% actuarial value plan. *See* THE HENRY J. KAISER FAMILY FOUND., *supra* note 140, at 4.

153. For some low-income employees who are young and healthy and do not anticipate incurring any significant medical expenses, the fully subsidized employer plan may in fact be more attractive than partially subsidized exchange-based coverage. For those individuals who do not anticipate significant medical expenses, lower premiums are more attractive than richer benefit coverage.

154. The issue of consistently high medical expenses is discussed in more detail below. *See infra* Part III.B.3.

155. The drop in overall health insurance costs is attributable to the reduction in overall group premiums from $5000 in the affordability example to $3000 in the minimum value strategy, under the assumption that ten employees will elect group coverage in either scenario.

156. ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 155 (2010) (codified at 42 U.S.C. § 300gg (2006 & Supp. V 2011)) (adding § 2701 to the PHSA).

level coverage.[157] If an employee is older, she is still required to pay the same percentage of income as a younger individual; the premium tax credit simply increases. By contrast, the subsidies might not be as large if the low-income employees were younger. Second, these factors could have distributional consequences among the employer's employees. For instance, if the low-income employees were young and non-smoking, then high-income employees would be forced to pay more for group coverage because they would not have young, non-smoking employees in the group pool to subsidize their costs.

An employer that offered low-income employees "affordable" coverage with "minimum value," thus ignoring the savings illustrated above, would disadvantage itself in the labor market. Such an employer would presumably have to subsidize coverage in order to make it affordable for low-income employees, whereas an employer pursuing either the affordability or minimum-value strategy would exploit federal subsidies for the health insurance coverage of its low-income employees. As a result, an employer offering affordable group coverage with minimum value would have higher labor costs than its competitors that shifted low-income employees to exchanges. This effect could be exacerbated if the employer's subsidy that assures "affordable" coverage is not actually as generous as the available tax credit.[158] In that case, the employer would presumably have to raise the wages of low-income employees to make up for any premium tax credit and cost-sharing subsidies that such employees would lose by virtue of being offered affordable coverage. If the employer allows the gap between its plan and the exchange-based plans to persist, it may lose such workers to other firms that do not offer affordable coverage.[159] On the flip side, if the employer declines to offer a group plan in order to preserve the tax subsidies for low-income employees, it would need to raise the salaries of high-income employees in order to account for the lost tax exclusion.

D. THE IMPACT OF SMALL EMPLOYERS' COVERAGE DECISIONS

Primarily because of the eligibility provisions for the premium tax credits and cost-sharing subsidies, along with the fact that small employers face no penalty for failing to offer coverage, small employers with

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157. *See* ACA § 1401, I.R.C. § 36B(b)(3)(C) (Supp. V 2011).

158. Recall that employer coverage is "unaffordable" when the employee's contribution exceeds 9.5% of income, whereas an individual earning 200% FPL would be eligible for a premium tax credit that limits the individual's cost for silver-level coverage to 6.3% of income. *See supra* Part I.B.2.

159. For an overview of the literature regarding worker sorting based on health insurance preferences, see Alan C. Monheit & Jessica Primoff Vistnes, *Health Insurance Enrollment Decisions: Preferences for Coverage, Worker Sorting, and Insurance Take Up* 6–10 (Nat'l Bureau of Econ. Research, Working Paper No. 12429, 2006), *available at* http://www.nber.org/papers/w12429.pdf.

predominantly low-income employees will likely drop group coverage. It is essentially the only rational choice for such employers; doing otherwise would forfeit thousands of dollars that would otherwise be available from the federal government. Similarly, small employers with mixed-income employees are likely to continue to offer group coverage, but to structure such coverage so that it is either "unaffordable" or does not provide "minimum value." The end result of these two phenomena is that low-income individuals will receive coverage on the individual market, rather than through their employer, and consequently, the small-group market will be smaller than many have anticipated.

The decreased number of individuals within the small-group market will complicate the viability of SHOP exchanges and small-group markets more broadly. Perhaps most importantly, small insurance pools tend to be much more susceptible to adverse selection than large insurance pools. This is because the risk composition of the pool can be dramatically impacted by the exit of some low-cost policyholders.[160] Additionally, reduced take-up by small employers of group coverage will likely interfere with a SHOP exchange's ability to take advantage of economies of scale.[161] The effect may be significant, as there are various fixed costs to operating an exchange, such as maintaining a website and producing and disseminating information about available plans.[162]

In addition to these effects on SHOP exchanges, the strategies described in this section could also quite negatively impact the fiscal implications of the ACA. Small employers' efforts to preserve their employees' eligibility for individual subsidies on insurance exchanges—either by dropping coverage completely or by pursuing the affordability or minimum-value strategy—will, of course, increase the federal government's obligations to provide subsidies. This will increase the costs of providing such subsidies above current estimates.[163] The Part below explores yet another serious threat to the viability of small-group markets: that small employers that offer group coverage post-2014 will leave the insured market in favor of self-insured arrangements.

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160. *See* Avraham, Logue & Schwarcz, *supra* note 19, at 5–6.

161. *See* TIMOTHY STOLTZFUS JOST, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 9 (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jul/1426_Jost_hlt_insurance_exchanges_ACA.pdf.

162. *Id.* at 17.

163. *See* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 2 (2012), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

III. SELF-INSURANCE AND SMALL-GROUP MARKETS POST-ACA

As made clear in the previous Part, the discrepancies between regulation of individual and small-group markets, along with tax credit and cost-sharing eligibility rules, create distinct incentives for small employers to either drop group coverage or modify it so that it is "unaffordable" or does not provide "minimum value." Unfortunately, this is hardly the only threat associated with SHOP exchanges and the small-group market. For reasons discussed in detail below, the ACA also increases the risk that small employers that offer any form of group coverage will choose to self-insure their plans. To the extent that this risk comes to fruition, it could substantially destabilize the SHOP exchanges by subjecting them to adverse selection. Given the limited pool of policyholders that we predict will be in small-group markets in the first place, any further erosion of these markets caused by self-insurance may create a real risk of market collapse. This Part explores the likely expansion of self-insurance in small-group markets post-ACA and examines its potential effect on market viability.

A. *BACKGROUND ON SELF-INSURANCE*

A self-insured health plan is one in which the employer retains liability for claims, rather than transferring that liability to an insurer.[164] Historically, the principal attraction of self-insurance has been that it allows employers to escape state insurance regulation—particularly mandated benefit laws—under ERISA's preemption rules.[165]

Although self-insuring provides regulatory relief, doing so can be costly. Employers who self-insure generally hire third-party administrators ("TPAs"), who are usually insurers, to operate all non-risk-bearing elements of the health benefit plan, such as processing claims and paperwork.[166] They also often purchase stop-loss insurance, which limits an employer's risk from unpredictably high claims by transferring it to an insurer.[167] Such stop-loss insurance can be structured to protect employers either if any individual employee incurs claims above a specified threshold or if the aggregate claims of all employees exceed a specified threshold.[168] Either way, these

164. *See* Korobkin, *supra* note 14, at 114.

165. *See* Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1370 (2007).

166. CHRISTINE EIBNER ET AL., RAND CORP., EMPLOYER SELF-INSURANCE DECISIONS AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA) 7, 10 (2011), *available at* http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR971.pdf.

167. *Id.* at 10.

168. *Id.* Assume, for example, that an employer self-insures its health plan but has purchased a stop-loss policy with an aggregate attachment point of $100,000. The employer would be at risk for the first $100,000 of claims under the medical plan, after which the stop-loss carrier would reimburse the employer for claims paid under the medical plan.

thresholds are termed "attachment points" and function much like deductibles in ordinary insurance policies.[169] In some cases, stop-loss insurers can apply a different attachment point to a particular employee or refuse to include that employee's costs in coverage at all, a phenomenon known as "lasering."[170]

Even where a self-insuring employer purchases stop-loss coverage, the employer still retains some risk of loss. First, the employer retains any risk below the attachment point of stop-loss coverage.[171] Second, and much less appreciated, the employer is liable for medical-plan claims even if the stop-loss carrier does not reimburse the employer.[172] This might occur if the stop-loss insurer becomes insolvent or refuses to pay a claim on the basis that there was a material misrepresentation in the employer's application or a policy exclusion applies.

Large employers have been historically much more likely and able to self-insure than small employers because of their superior ability to bear risk. Large employers have a big enough employee population to be able to predict risk relatively accurately, meaning that they are much less dependent on stop-loss insurance than small employers. In addition, large employers have greater financial resources to absorb the costs of slightly higher-than-expected medical losses. Stop-loss coverage is in fact much less common among the largest self-insuring employees for these reasons.[173]

By contrast, small employers have rarely chosen to self-insure in the past precisely because of the increased risk and fixed costs of doing so. In fact, it is estimated that only 7.9% of firms with three to forty-nine employees that offered a group health plan were self-insured in 2010.[174] In the rare instances when small employers have self-insured, they almost always rely on stop-loss coverage.[175] In the absence of such coverage, a single employee or employee family member becoming very sick could jeopardize a small employer's business.

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169. *Id.*

170. *See id.* at 21.

171. *See id.* at 4.

172. *See* Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 364 (4th Cir. 1997) (explaining that for a self-insured plan "with or without stop-loss insurance . . . the provision of benefits depends on the *plan's* solvency" (emphasis added)).

173. *See* EIBNER ET AL., *supra* note 167, at 14 (estimating that 7.9% of the smallest firms offered a self-insured health plan, whereas 80.4% of the largest firms did so).

174. *Id.*

175. *See id.* at 21.

B. BENEFITS TO SMALL EMPLOYERS OF SELF-INSURING IN 2014

1. General Advantages

Even while designing the ACA, policymakers understood that the law might increase the tendency of small employers to self-insure. Indeed, the ACA itself contains a provision requiring the Secretary of HHS to study the extent to which the ACA's insurance-market reforms may encourage small and midsize employers to self-insure.[176] The reason is that, starting in 2014, the benefits of self-insuring will increase substantially, particularly for small employers. In particular, self-insurance will allow small employers to escape the requirement that (1) offered coverage include essential health benefits, (2) they participate in risk-adjustment programs, (3) their insurance comply with medical-loss ratios, (4) all premium increases be reviewed, and (5) deductibles not exceed $2000 for an individual and $4000 for a family.[177]

There are a variety of reasons why small employers may desire to escape these provisions of the ACA. Two of these reasons have been well-developed elsewhere, and are therefore only briefly discussed here.[178] First, and most generically, regulation imposes compliance costs and limits flexibility. Being able to avoid these requirements by self-insuring could allow an employer to save money and maintain flexibility in designing its plans. Indeed, very similar considerations have historically prompted many large employers to self-insure.

Second, self-insuring would allow small employers with a relatively low-risk population to avoid cross-subsidizing higher-risk small employers. Such employers, in essence, need only pay "premiums" that are based on their own employees' health rather than the health of the entire pool of individuals in the small-group market.[179] The size of this benefit depends on the risk level of the employer's workforce: for small employers with very healthy employees who incur few claims, this benefit could be substantial.[180] And because self-insured employers are exempt from the ACA's prospective risk assessment mechanism, such employers will not have to subsidize plans with higher-risk employees.[181]

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176. ACA, Pub. L. No. 111-148, § 10103(f), 124 Stat. 119, 895–96 (2010) (amending the ACA by adding § 1254 "Study of Large Group Market"). Although the section is entitled "Study of Large Group Market," it contains provisions requiring that the risk of self-insurance in the small-group market be studied. *Id.* For the report that was issued in compliance with this statutory requirement, see EIBNER ET AL., *supra* note 167, at 4–5.

177. *See* Jost & Hall, *supra* note 16, at 8–10.

178. *See, e.g.*, EIBNER ET AL., *supra* note 167, at 61–63; Hall, *supra* note 20, at 316–17 (2012); Jost & Hall, *supra* note 16, at 8–10.

179. *See supra* note 179.

180. For an overview of potential state responses to the issue of small employers self-insuring, see Hall, *supra* note 20, at 317–19.

181. *See* ACA § 1343, 42 U.S.C. § 18063 (Supp. V 2011).

2. Self-Insurance as Part of the Affordability or Minimum-Value Strategies

While the above reasons for self-insuring apply to any small employer that desires to sponsor a group health plan in 2014 and thereafter, self-insurance is also highly relevant to those small employers with mixed-income employees that desire to pursue either the affordability or minimum-value strategy in order to preserve the tax-credit eligibility of their low-income employees.[182] Employers that want to pursue the minimum-value strategy *must* self-insure because the ACA requires all small-group plans to provide a minimum of 60% actuarial value, whether they are offered within or outside of an exchange, thereby automatically satisfying the "minimum value" standard.[183] There are, however, no such limitations on self-insured plans.[184]

An employer that self-insured would have numerous options for designing its plan to avoid providing "minimum value." Although the ACA mandates that small-group plans cannot use deductibles any larger than $2000 for an individual or $4000 for a family, a self-insured plan can employ much larger deductibles—any amount up to the out-of-pocket limits of $5950 for individual coverage and $11,900 for family coverage in 2010 dollars.[185] Using large deductibles is a very simple way for a small employer to keep the minimum value of a plan below 60%, because in a typical self-insured population, the vast majority of people will not exceed this deductible. As previously mentioned, small employers that embrace consumer-driven health care ideas are particularly likely to pursue this minimum-value strategy, especially if they happen to have low-risk employees.

Self-insurance could also be attractive to employers pursuing the affordability strategy. Recall that this strategy entails an employer sponsoring a group plan and setting employees' share of premiums at an amount that is considered unaffordable for all employees with household incomes below a certain threshold.[186] The principal benefit of self-insurance to an employer pursuing the affordability strategy is that self-insurance would enhance its capacity to inflate premiums to ensure unaffordability for the desired segment of its workforce. This is for several reasons. First, self-insured plans are not subject to the MLR rules[187] that require a certain percentage of

182. For descriptions of the minimum-value and affordability strategies, see *supra* Part II.C.

183. ACA § 1201, 42 U.S.C. § 300gg-6 (2006 & Supp. V 2011) (adding § 2707 to the PHSA); ACA § 1302(a), 42 U.S.C. § 18022 (Supp. V 2011).

184. Under proposed IRS guidelines, self-insured employers would determine whether their plan provided minimum value by using a government devised "calculator" that would allow them "to enter information about the plan's benefits, coverage of services, and cost-sharing terms" and would then apply that information to claims data reflecting typical self-insured employer plans. I.R.S. Notice 2012-31, 2012-20 I.R.B. 906.

185. *See* ACA § 1302(c), 42 U.S.C. § 18022(c).

186. *See supra* Part II.C.

187. *See* 42 U.S.C. § 300gg-18 (2006 & Supp. V 2011).

premiums to go towards actual medical expenses. Second, self-insured plans also escape any scrutiny under the ACA's rate review process. Third, any excessive premium in a self-insured plan redounds to the benefit of the employer, rather than a third-party insurer. Admittedly, these benefits may not be important for employers pursuing the affordability strategy if market-based group premiums are well above affordability levels for the desired segment of the workforce. In that case, the employer could simply adjust its contribution to coverage so that employees' share of premiums equaled or exceeded desired thresholds. This strategy, however, may be difficult if the employer wants to ensure unaffordability for employees at the high-end of the premium-subsidy threshold or feels labor-market pressure to contribute some amount towards premiums. [188]

3. A Hidden Benefit of Self-Insurance and the Minimum-Value Strategy: Dumping High-Risk Employees

While the premium tax credits are likely to drive mixed-income firms to pursue either the affordability or minimum-value strategy, there is likely an added benefit to employers of pursuing the minimum-value strategy and self-insuring. Employers that implemented a low actuarial value plan would create a perhaps unintended incentive for any employees with high health risks to decline employer coverage and instead seek coverage through an individual exchange. Because low actuarial value plans require high levels of cost-sharing, they will tend to be unattractive to those with significant medical needs. Employees with reason to know they will incur significant medical expenses would be better off paying more in premiums in return for lower cost-sharing of medical expenses. This employee self-sorting could further increase the benefits of self-insurance for employers: self-insuring would not only allow the employer to implement the minimum-value strategy, but it would also make its group plan even more affordable by decreasing its risk profile. Only a small employer that was self-insured would enjoy the benefit of this decreased risk profile of its employees. Although group health plans must satisfy various non-discrimination requirements related to health status and compensation level, it is unlikely that a plan design that simply appealed more to high-income or low-risk individuals would run afoul of current interpretations of these requirements. [189]

We have argued elsewhere that large employers are likely to actively pursue strategies that are specifically designed to dump high-risk employees

188. It is important to keep in mind that while insured plans can only vary premiums based on two specific health factors—age and tobacco use—actual health risk is much broader. So an employer that self-insures enjoys cost savings from all low-risk employees, not just those who are young non-smokers.

189. *See* Monahan & Schwarcz, *supra* note 3.

onto individual exchanges.[190] Small employers may be unlikely to engage in this type of sophisticated analysis. They are, however, likely to understand that a low-actuarial cost plan will be unattractive to anyone with significant medical needs. Additionally, even if this does not enter into employers' initial decision-making process for their health plans in 2014, those employers that pursue the minimum-value strategy beginning in 2014 are likely to see the lowered group health plan costs that result, not just from offering a low-actuarial value plan, but also from offering a plan in which predominantly healthy employees choose to enroll. If these results are then shared within the small-employer community, SHOP exchanges may see further erosion as more small employers elect to pursue a minimum-value and self-insurance strategy. At the same time, individual exchanges may experience increased adverse selection risk as the risk-profiles of their enrollees become worse.[191]

C. *Reduced Risks of Self-Insuring in 2014*

At the same time that the potential benefits to small employers of self-insuring will increase in 2014, the downsides of doing so will decrease significantly. The primary reason for this change is that small employers who opt to self-insure in 2014 will face dramatically reduced risk from the prospect of their employees becoming sick. Historically, the risk of self-insuring has largely been conceptualized as short term: in any given year, premiums charged might be insufficient to pay the cost of employees' covered medical expenses.[192] But self-insuring has always involved a long-term risk as well: over time, covered medical expenses of employees or their dependents could systematically increase if just a few people in that population became quite sick. Stop-loss coverage was no solution to this risk because such coverage is itself risk-rated.[193] The reason that commentators rarely focused on this risk was that it was not generally unique to self-insurance. Outside of a few states that regulated medical underwriting in the small-group market, small employers often bore this long-term risk even if they purchased traditional coverage because insurers would adjust their premiums upward in response to any increased risk of the insured group.[194]

Starting in 2014, however, the ACA's reforms of small-group markets will largely eliminate the long-term risk associated with self-insuring. The

190. *See id.*

191. *See id.*

192. *See* EIBNER ET AL., *supra* note 167, at 9–10.

193. *See* Letter from Eric Smithback, Chairperson, Stop Loss Work Grp., Am. Acad. of Actuaries, to Office of Health Plan Standards and Compliance Assistance, U.S. Dep't of Labor 12 (June 29, 2012), *available at* http://www.dol.gov/ebsa/pdf/StopLosso088.pdf ("For individual stop loss, carriers use both manual rating and experience rating to determine the coverage and premiums for a given employer.").

194. Hall, *supra* note 4, at 691–92.

ACA requires insurers in the small-group and individual markets to price their policies without taking into account any health-related information other than age and tobacco use.[195] Consequently, a self-insured small employer that perceived the cost of self-insuring to be increasing due to the deteriorating health of its workforce could simply abandon the decision to self-insure and purchase coverage at community-average rates on the small-group market. Historically, this option was not available because the coverage acquired on the small-group market would reflect the health-risk level of the small group.[196] However, by eliminating such medical underwriting in the small-group market, the ACA indirectly also eliminated the long-term risk that has historically accompanied self-insuring.

To be sure, not all of the risk of a self-insurance strategy would dissipate as a result of this change.[197] First, small employers who self-insured would still face the short-term risk that their employees would incur larger than expected medical costs before the employer could switch to conventional small-group coverage. This risk, however, can be reduced, but not eliminated, through the purchase of stop-loss insurance. Second, self-insuring small employers would face new strategic risks from uncertainties surrounding the anticipated costs and benefits of a self-insurance program because the magnitude of the benefits and the costs of self-insuring are hard to predict.[198] Third, if the stop-loss carrier either denies claims or becomes insolvent during the contract period, the employer will generally be liable to pay medical-plan claims.[199] Fourth, there is also some liquidity risk associated with self-insuring, as coverage may not be payable until the end of the year while costs are incurred throughout the year.[200] Finally, there would be some legal and regulatory risk from electing to self-insure: rules governing stop-

195. ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154 (2010) (codified at 42 U.S.C. § 300gg (2006 & Supp. V 2011)) (amending § 2701 of the PHSA).

196. *See* Hall, *supra* note 4, at 716–17.

197. For an overview of stakeholder perceptions of risk in this context, see KEVIN LUCIA, CHRISTINE MONAHAN & SABRINA CORLETTE, GEORGETOWN UNIV.'S HEALTH POLICY INST., CROSS-CUTTING ISSUES: FACTORS AFFECTING SELF-FUNDING BY SMALL EMPLOYERS: VIEWS FROM THE MARKET (2013), *available at* http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf405372.

198. On the cost side, the future expense of purchasing stop-loss insurance, paying a TPA, and complying with legal and regulatory rules would be subject to uncertainty. And the magnitude of the potential benefits described above obviously also depends on numerous unknowns including the success of individual insurance exchanges, the choices of employees, and the costs of regulatory burdens.

199. *See supra* note 173 and accompanying text.

200. For example, assume that a small employer self-insures but purchases stop-loss insurance with an aggregate attachment point of $100,000. On January 2, an employee is injured in a car accident, and incurs several hundred thousand dollars of covered medical expenses. The employer may need to have $100,000 available to pay those claims in January, rather than having the $100,000 paid over the course of the year. This could produce severe cash flow problems for the small business.

loss insurance could always change, as could the various regulatory exemptions associated with self-insuring.

Although a small business's decision to self-insure starting in 2014 would thus continue to entail some risk, this risk would be relatively manageable for most small employers that offered any form of group coverage post-2014. This is because the small employers that are likely to be interested in offering any form of group coverage in 2014 and thereafter are those that have a non-trivial percentage of high-income employees.[201] These small employers are the most likely to be willing to take on some risk from self-insuring if the expected benefits of doing so outweigh the expected costs. The reason, in a nutshell, is that firms with higher aggregate labor costs can absorb more easily the type of loss that might be associated with higher than anticipated employee health costs and the burden of shifting to an insured plan.

To see why, consider a stylized example. Suppose that self-insuring is expected to generate a cost savings of $20,000 relative to offering an insured plan. Also assume, however, that this is a risky proposition, such that there is a 20% chance that self-insuring will produce a loss of $50,000 and an 80% chance that it will produce a benefit of $37,500. An employer with twenty employees who each make $25,000 a year is likely to be concerned about this strategy because it includes a 20% chance of a 10% increase in labor costs. By contrast, a small employer with twenty employees who each make $100,000 a year would face only a 20% chance of a 2% increase in labor costs, which is a much more tolerable downside.

A final, and more speculative, reason that self-insurance may become less costly to small employers in 2014 is that firms, for the first time, will be actively competing to develop affordable self-insurance products in the small-group market.[202] Anticipating the potential benefits to some small employers of self-insuring in 2014, various firms have been working to develop more cost-effective ways to facilitate small firm self-insurance. Although it is hard to predict the degree to which this new-found competition will be able to reduce the costs of self-insurance, it seems likely that it will do so to some degree.

D. THE IMPACT OF SMALL EMPLOYERS' DECISIONS TO SELF-INSURE

The primary risk of substantial self-insurance in the small-group market is that it may trigger adverse selection in SHOP exchanges. Adverse selection occurs whenever an insurance pool disproportionately contains high-risk individuals. Recall that self-insurance is particularly likely to be attractive to low-risk small employers who can thereby take advantage of their better-

201. *See supra* Part II.

202. *See* Jost & Hall, *supra* note 16, at 6–8 (describing the recent growth in the market for small-employer self-insurance arrangements).

than-average risk profile. This means that those small employers who do opt for exchange coverage rather than self-insurance will tend to be comparatively high risk. This problem is made even worse by the fact that small employers who initially choose to self-insure, but then observe heightened expenses among their employees, can easily opt back into the SHOP exchange. And, of course, the migration of companies could also work in the opposite direction, so that firms obtaining group coverage through a SHOP exchange could opt to self-insure if they find their employees incurring much lower expenditures than the firm is paying in premiums.

Several economic models have attempted to predict the impact that increased self-insurance among small employers may have on premiums in the small-group market. The official study for the Department of Labor estimated that if low-risk stop-loss coverage becomes widely available, increased self-insurance among small employers would result in relatively modest adverse selection in the small-group market, causing a premium increase of 3.3% for platinum-level coverage.[203] A study by the Urban Institute estimated significantly larger impacts of self-insurance on the small-group market, calculating that premiums will be up to 24.8% higher in the small-group market if low-risk stop-loss coverage is widely available.[204] The primary difference between the models used in the two studies is the assumed level of attachment point in the stop-loss policies.[205] The official Department of Labor study modeled an attachment point of $20,000 at the lowest,[206] whereas the Urban Institute study modeled results if stop-loss coverage was available with an attachment point as low as $0.[207]

Concerns regarding the effects of increased rates of self-insurance on small group markets are therefore well-established. But there may be additional risks to self-insurance that are not reflected in these studies. First, the extant literature fails to take into account the desirability of self-insurance to small employers with mixed-income employees who want to pursue either the minimum-value or affordability strategies. As described above, employers interested in these strategies are either required or likely to self-insure. This means that the prospect of self-insurance among small employers may be more likely than existing analyses suggest.

Second, there may also be a heightened risk of adverse selection in SHOP exchanges because the employees who do purchase coverage in

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203. EIBNER ET AL., *supra* note 167, at 63.

204. MATTHEW BUETTGENS & LINDA J. BLUMBERG, THE URBAN INST., SMALL FIRM SELF-INSURANCE UNDER THE AFFORDABLE CARE ACT 12 exhibit 8 (2012), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Nov/1647_Buettgens_small_firm_self_insurance_under_ACA_ib.pdf.

205. *See id.* at 5.

206. EIBNER ET AL., *supra* note 167, at 57–58.

207. *See* BUETTGENS & BLUMBERG, *supra* note 205, at 10.

exchanges will tend to be disproportionately high-income. This may interfere with the ability of carriers to use increased cost-sharing to limit the expenditures of high-risk policyholders. High cost-sharing requirements are less likely to restrain the spending of high-risk, high-income individuals than the costs of high-risk, low-income individuals.[208] As a result, to the extent that a SHOP exchange experiences adverse selection, it will have limited tools at its disposal to reign in the spending of enrollees.

Third, and perhaps most importantly, the risk of adverse selection on SHOP exchanges is enhanced by the fact that enrollment in these exchanges will tend to be relatively small for reasons independent of self-insurance. As described in Part II, small employers with predominantly low-income employees will have strong incentives not to offer group coverage at all, notwithstanding modest tax credits designed to encourage such coverage. This increases the risk of adverse selection from self-insurance, as small pools of policyholders are at increased risk of adverse selection because an influx of high-risk individuals will more dramatically impact overall per-person expected costs.[209]

Even apart from adverse selection risk, small employers' move toward self-insured plans may increase the risk of employment discrimination against high-risk individuals.[210] Recall that a single high-risk individual can dramatically increase costs for small groups. Stop-loss carriers typically medically underwrite such coverage, meaning that they review the health profiles of the individuals whose medical risks are being reinsured.[211] Stop-loss carriers also often apply higher individual attachment points for employees expected to incur higher than average medical expenses.[212] Stop-loss carriers are also able to "laser" certain individuals and exclude them entirely from coverage under the policy.[213] To be clear, these practices do not directly impact the individual; they only impact the employer's ability to obtain stop-loss coverage for that individual's losses. But it is easy to imagine that an employer may be unenthusiastic about hiring an individual whose expenses a stop-loss carrier will not cover under its policy. A firm that fired an individual on such a basis would generally, but not always, be engaging in

208. *See* Clark C. Havighurst & Barak D. Richman, *Distributive Injustice(s) in American Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 7, 41–49.

209. Avraham, Logue & Schwarcz, *supra* note 19, at 5–6.

210. We thank Professor Tim Jost for bringing this risk to our attention. For a broader discussion of this phenomenon, see Jessica L. Roberts, *Healthism and the Law of Employment Discrimination*, 99 IOWA L. REV. (forthcoming Jan. 2014).

211. *See* Letter from Eric Smithback to Office of Health Plan Standards and Compliance Assistance, *supra* note 194, at 12–13.

212. *See* EIBNER ET AL., *supra* note 167, at 21.

213. *Id.*

unlawful discrimination.[214] In reality, though, policing against such discrimination is extremely difficult.[215]

IV. SAVING SMALL-GROUP MARKETS

Given the multiple reasons to be worried about the health of small-group markets outlined in Parts II and III, this Part presents various potential strategies for preserving the viability of SHOP exchanges. The existing literature on small-group markets post-ACA has focused on regulating stop-loss coverage.[216] While regulating stop-loss coverage can help limit the risk of self-insurance, a much broader range of tools are available to counteract damaging strategic behavior by small employers and ensure that the SHOP exchanges will be competitive against the option of self-insurance. Unlike the regulation of stop-loss insurance, these tools can also help limit the risk that small employers will drop coverage entirely.

A. *REGULATE STOP-LOSS COVERAGE*

To date, the primary proposed policy response to the self-insurance risk has been enhanced regulation of stop-loss coverage. Professors Mark Hall and Timothy Jost have been particularly active, and persuasive, in advancing this approach.[217] Although states cannot directly regulate self-insured employers under ERISA, stop-loss insurance is subject to state insurance regulation.[218] By making stop-loss insurance less available to small employers, states could decrease the attractiveness of self-insurance for these employers. This is because stop-loss insurance is a practical necessity for small businesses considering self-insuring, as described above.[219] Proposed state regulatory approaches range from banning stop-loss coverage for small employers, to regulating minimum attachment points, to prohibiting stop-loss insurers from risk-rating their premiums on the basis of group risk.[220]

Banning stop-loss insurance for small employers entirely or prohibiting risk-rating by stop-loss insurers are both unlikely to gain political traction in most states. Simply banning stop-loss insurance for small employers directly would discriminate against small employers. While three politically liberal states—New York, Delaware, and Oregon—do indeed do this, these rules were passed prior to the ACA and thus in a much less politically contentious

214. *See* Roberts, *supra* note 211 (noting that discrimination by employers on the basis of smoking and obesity may not violate federal law as it is currently interpreted).

215. *See, e.g.*, Samuel R. Bagenstos, *Has the Americans with Disabilities Act Reduced Employment for People with Disabilities?*, 25 BERKELEY J. EMP. & LAB. L. 527, 537–38 (2004) (book review).

216. *See generally* Hall, *supra* note 20; Jost & Hall, *supra* note 16.

217. *See generally* Jost & Hall, *supra* note 16.

218. *See id.* at 13–15.

219. *See supra* Part III.A.

220. *See id.*

environment because most small employers did not care to self-insure or purchase stop-loss coverage.[221] Similar logic applies to attempts to prohibit stop-loss insurers from risk-rating, an approach that New Jersey implemented prior to passage of the ACA.[222] This strategy would likely have the same effect as an outright prohibition on stop-loss insurance for small businesses because it would subject stop-loss insurers to a substantial risk of adverse selection.

A more politically viable option is to increase legally mandated stop-loss attachment points. Many states already have laws that limit attachment points,[223] and the National Association of Insurance Commissioners ("NAIC") has a model law on this topic.[224] Almost all of these laws require minimum attachment points that have not been increased in well over a decade, thus failing to keep up with inflation.[225] There is also an intuitive appeal to the notion that a small employer is not *really* self-insuring if it is passing off almost all of the risk of its employees' health care expenses to a third-party stop-loss carrier. Despite all of these factors, proposals to increase attachment points have gained little traction at the NAIC.[226] Furthermore, a recent proposal in California to require attachment points to be set at 125% of expected losses has faced sharp resistance from a number of groups.[227]

Although raising minimum attachment points for stop-loss insurance is a potentially politically viable option, it is also an incomplete solution. Raising minimum attachment points for stop-loss insurance would make self-

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221. *See* Hall, *supra* note 20, at 318.

222. Jost & Hall, *supra* note 16, at 14.

223. *See id.*; Letter from Sandy Praeger, Comm'r, Kan. Dep't of Ins., to Kathleen Sebelius, Secretary, U.S. Dep't of Health & Hum. Servs. & Hilda Solis, Secretary, U.S. Dep't of Labor 2 (July 19, 2012), *available at* http://www.dol.gov/ebsa/pdf/StopLosso108.pdf.

224. *See generally* STOP LOSS INSURANCE MODEL ACT (Nat'l Ass'n of Ins. Comm'rs 2002).

225. *See* Hall, *supra* note 4, at 693–95.

226. On November 29, 2012, the ERISA Working Group of the NAIC's Health Insurance and Managed Care Committee considered a proposal to amend the Stop Loss Insurance Model Act to raise minimum attachment points. The amendment would have raised minimum individual attachment points from $20,000 to $60,000 and would have raised minimum aggregate attachment points from the greatest of (i) $4,000 times the number of group members; (ii) 120% of expected claims; or (iii) $20,000, to the greater of (i) $15,000 times the number of group members; (ii) 130% of expected claims; or (iii) $60,000. *See* NAT'L ASS'N OF INS. COMM'RS, AGENDA AND MATERIALS FOR ERISA (B) WORKING GROUP 5–6 (2012), *available at* http://www.naic.org/documents/committees_b_erisa_2012_fall_nm_materials.pdf?/. The motion to adopt the revision failed. *See* Allison Bell, *Self-Insurance Battle Continues at NAIC Fall Meeting*, LIFEHEALTHPRO (Nov. 29, 2012), http://lifehealthpro.com/2012/11/29/self-insurance-battle-continues-at-naic-fall-meeti.

227. *See* Jason Millman, *Focus on Self-Insurance for Small Businesses*, SIIA (Aug. 2, 2012, 4:45 PM), http://www.siia.org/i4a/pages/index.cfm?pageID=6200; *Bill Analysis: Hearing on SB 1431 Before the S. Assemb. Comm. on Health* 10–11 (Ca. 2012), http://www.leginfo.ca.gov/pub/11-12/bill/sen/sb_1401-1450/sb_1431_cfa_20120630_150017_asm_comm.html.

insuring a riskier, and thus less attractive, proposition for small employers. But it would still allow small employers to pass off much of their risk to stop-loss insurers. At the same time, it would do nothing to change the fact that small employers who are low risk relative to other small employers with similar employee age and smoking profiles would have a positive expected benefit from self-insuring. Raising minimum attachment points will not, therefore, tend to deter risk-neutral or only moderately risk-averse small businesses from self-insuring,.

Additionally, raising minimum attachment points for stop-loss insurance is not without risks. First, to the extent that doing so failed to deter small businesses from self-insuring, it would merely force small businesses to bear risks that they would prefer to offload. This could harm small businesses without producing any beneficial improvement in health insurance markets. Second, raising attachment points could cause some employers simply to drop coverage entirely rather than turn to SHOP exchanges. Third, and finally, raising minimum attachment points could have the perverse effect of increasing the tendency of small employers who originally chose to self-insure to migrate back onto the SHOP exchange at the first sign that their workforce is incurring larger than community-level health expenses. Whereas a self-insured employer with robust stop-loss insurance might be willing to continue self-insuring after a single year of larger than expected costs, less stop-loss insurance makes this a more dangerous proposition. Perversely, this could actually increase the risk of adverse selection on SHOP exchanges.

Despite these concerns, raising the minimum attachment points for stop-loss insurance to some level at or above expected costs is a sensible proposal. At the same time, however, such a change would have a limited impact in addressing the many challenges described above. Moreover, even this moderate reform of stop-loss insurance will prove politically infeasible in many state legislatures. For these reasons, the remainder of this Part explores alternatives that could either act as a complement to stop-loss reform, if enacted, or could help protect the small-group market if such reform is not viable.

B. DESIGNING SHOPS TO COMPETE AGAINST SELF-INSURANCE

The existing literature has tended to focus on counteracting the self-insurance risk by making the option of self-insurance less appealing to small employers. States, however, must also focus on the flip side of the coin: making SHOP exchanges more attractive, particularly relative to the option of self-insuring. Doing so would have the benefit of not just counteracting the self-insurance risk, but also counteracting the risk that small businesses will choose to drop coverage entirely because they face no penalty for failing to offer group coverage.

To be sure, SHOP exchanges face important limitations in their capacity to compete against the self-insurance option. Most importantly, SHOP exchanges cannot offer discounts to certain low-risk small employers, while self-insurance allows low-risk small employers to enjoy the benefits of their low-risk status.[228] This limitation, however, is less damaging than it may first appear because plans within SHOP exchanges can offer roughly actuarially appropriate discounts to groups on the basis of their age and smoking status.[229] Thus, the mere fact that a small business has relatively young employees who tend not to smoke should not put SHOP exchanges at a competitive disadvantage to self-insurance.

Moreover, even with this sizable handicap, we believe that SHOP exchanges can compete effectively against self-insurance if they are properly designed and marketed to small businesses. For this to occur, however, SHOP exchanges must exploit the weaknesses of the self-insurance option, just as brokers and stop-loss insurers will undoubtedly attempt to exploit the weaknesses of SHOP exchanges. Fortunately, self-insurance has plenty of downsides, many of which are capable of overwhelming the advantages of self-insurance even for small employers with risk profiles that are moderately below what would be expected for small businesses with employees of a similar age and smoking status. In particular, self-insurance is complex, risky, and limits employee choice. By contrast, SHOP coverage can be made simple, risk-free, and choice-enhancing. As explained below, offering and fully supporting a defined-contribution model for health insurance may enhance a SHOP exchange's capacity to offer these benefits as a contrast to self-insurance. Crucially, this response to the self-insurance risk does not require any legislative or even regulatory action. There is, however, an important element of timing to these measures. While the actions described below will help make SHOP-based coverage more attractive, and therefore provide a counter-pressure against self-insurance, they will ultimately be effective only if adverse selection does not overwhelm premiums. SHOP exchanges therefore need to carefully consider implementing these strategies as the exchanges become operational. Any significant delay may result in self-insurance gaining the upper hand.[230] Furthermore, if premiums in the SHOP exchanges become significantly higher than firms can obtain through self-insured arrangements with reasonable stop-loss protection, these actions are much less likely to save small-group markets.

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228. *See supra* Part III.

229. *See supra* Part I.

230. Unfortunately, HHS recently announced that it was delaying until 2015 roll out of employee choice for small businesses in the 33 federally run insurance exchanges. It is also delaying the requirement that state-run exchanges offer an employee-choice option until that time. *See* Robert Pear, *Small Firms' Offer of Plan Choices Under Health Law Delayed*, N.Y. TIMES (Apr. 1, 2013), http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html?_r=0.

1. Leverage Employee Choice

Small employers typically cannot offer their employees a choice of health plans. Rather, when a small employer offers group coverage, whether that coverage is insured or self-insured, there is typically only a single option available.[231] This is likely because there are certain fixed costs associated with supporting more than a single health insurance option, making it impractical for small employers to offer multiple plans. By contrast, large employers can, and often do, offer employees a small menu of options from either a single or multiple carriers.[232]

The ACA, however, gives SHOP exchanges the unique ability to provide small employers with an easy way to allow their employees to choose from multiple plans. Under the ACA, small employers can designate multiple options within the SHOP exchange from which their employees can elect coverage.[233] An employer could, for example, give its employees the option of electing coverage under any plan offered in the exchange within certain metal tiers or just from among individually-specified plans.[234] Under this approach, the employer would presumably make a defined contribution towards coverage, requiring the employee to bear the additional costs of more expensive policies.[235] The employer's contribution to such a plan would not constitute taxable income and, crucially, the ACA specifies that employees' contributions to these plans can also be paid with pre-tax dollars.[236] By contrast, the ACA is clear that employee contributions towards the purchase of coverage on the individual market must be with after-tax dollars.[237]

Employee choice is a unique competitive advantage that the SHOP exchanges can offer over both traditional group insurance and self-insurance, and the exchanges should leverage it to their advantage. Such choice allows employees to select a plan among numerous alternatives that

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231. CLAXTON ET AL., *supra* note 26, at 55.

232. *Id.*

233. *See* Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act, 45 C.F.R. pt. 155 (2012); Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges, 45 C.F.R. pt. 156 (2012); Employer Interactions with Exchanges and Shop Participation, 45 C.F.R. pt. 157 (2012).

234. ACA, Pub. L. No. 111-148, § 1312(a)(2), 124 Stat. 119, 182 (2010) (codified at 42 U.S.C. § 18032(a)(2) (Supp. V 2011)).

235. The term "defined contribution health plan" has been used to refer to many different types of health plans and arrangements. *See* PAUL FRONSTIN, EMP. BENEFIT RESEARCH INST., PRIVATE HEALTH INSURANCE EXCHANGES AND DEFINED CONTRIBUTION HEALTH PLANS: IS IT DÉJÀ VU ALL OVER AGAIN? 3 (2012), *available at* http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2012_No373_Exchgs2.pdf.

236. ACA, § 1515, I.R.C. § 125 (2006 & Supp. V 2011). Beginning in 2014, if a state elects to allow large groups to participate in the exchange, those large employers would also have the ability to use a cafeteria plan to pay for exchange-based coverage. *Id.*

237. *See id.*

covers their particular providers and contains their preferred mix of premiums, out-of-pocket cost-sharing requirements, and covered services. At the same time, it places downward pressure on premiums by ensuring that individuals are fully aware of the financial effects of their choices.[238] Providing employees with a wide variety of health-plan choices will likely give small employers a competitive advantage over those that offer only a single option. In addition, providing such choice relieves small employers of the weight of responsibility that is inherent in selecting only a single option for employee health care, particularly if employees have negative experiences with the single plan selected.

2. Leverage Limited Risk

Self-insurance will be a risky proposition for small employers, particularly in states that raise minimum attachment points for stop-loss insurance. Even with low attachment points, there are various risks associated with self-insuring, as described in Part III, including stop-loss carrier insolvency or claim denial, changing costs and benefits of self-insurance, and liquidity risk for the small employer.

Purchasing coverage in a SHOP exchange, by contrast, can be pitched to small employers as an entirely risk-free strategy. Any form of coverage purchased through a SHOP exchange will present no risk to employers that their employees will experience larger-than-average health care expenses either because of natural fluctuations in health care expenses or because the small employer's pool of employees is less healthy than expected. It also relieves small businesses from bearing the risk of insurer insolvency or non-payment, both of which are technically borne by employees, but also substantially borne by providers in the case of traditional small-group coverage.

SHOP exchanges could further cultivate this competitive advantage by supporting defined-contribution arrangements that promote employee choice, as described above. A defined-contribution model goes even further than traditional small-group coverage in eliminating risk for employers sponsoring insurance coverage because it allows them to easily choose the extent to which they will bear future premium-cost increases.[239] For example, if an employer chose to make a $3000 contribution to each employee's health insurance choice, it could elect to keep that contribution level year after year, thereby forcing employees to bear any increased premiums. Alternatively, it could choose to increase contributions based on wage inflation or inflation in health insurance costs. Although employers sponsoring traditional group plans also have control over the amount of future premium increases they will bear, a defined-contribution model is

238. *See* FRONSTIN, *supra* note 235, at 3.

239. *See supra* text accompanying notes 236–38; *infra* text accompanying note 240.

more consistent with placing this risk on employees because it allows them to select a lower-cost plan in response to premium increases.

3. Leverage Simplicity

Perhaps the biggest competitive advantage that SHOP exchanges enjoy over self-insurance is their potential to make small-group coverage simple. Self-insurance is extremely complicated. It requires small employers to design a benefits package, select a stop-loss carrier, and meet an attachment point.[240] Applying for stop-loss requires medical underwriting of employees and may result in the lasering of specific employees.[241] Finally, self-insuring requires small employers to constantly reevaluate the calculation of whether to remain self-insured or switch to SHOP coverage based on factors including SHOP premiums, stop-loss premiums, lasering, insolvency and claim-payment risk, employee preferences, and potential legal and regulatory risks. Many small employers are likely to find these distractions highly unappealing and desire an option that allows them to focus on their core business.

By contrast, properly-designed SHOP exchanges can make the process of shopping for and maintaining group coverage extremely simple for small employers. SHOP exchanges, of course, are specifically meant to make selecting an appropriate small-group plan simple by presenting information about different plans in an organized format and centralized location.[242] But SHOP exchanges can, and should, do much more than this.

Historically, the small-group market has been burdened not only with higher overhead costs imposed by insurers, but also with the regulatory burden that comes along with sponsoring a group health plan.[243] Employer-sponsored health plans are subject to extensive federal regulation from reporting and disclosure obligations to fiduciary-duty requirements.[244] Even the presumably simple task of allowing employees to pay their share of health insurance premiums on a pre-tax basis requires a fair amount of legal know-how. Employers must establish a written cafeteria-plan document and administer the plan in accordance with fairly complex rules regarding when and to what extent an employee can change her health plan election during a plan year.[245]

SHOP exchanges could greatly enhance their value to small employers—and further distinguish themselves from the self-insurance

240. *See supra* Part III.

241. *See supra* Part III.

242. *See* Terry Gardiner, *Health Insurance Exchanges of Past and Present Offer Examples of Features that Could Attract Small-Business Customers*, 31 HEALTH AFF. 284, 286 (2012).

243. *See id.*

244. *See generally* 29 U.S.C. §§ 1001–1191 (2006 & Supp. V 2011).

245. *See* I.R.C. § 125 (2006 & Supp. V 2011).

option—by making these legal-compliance tasks as simple as possible. Essentially, SHOP exchanges could function as would the in-house benefits department at a large firm. The SHOP exchange could provide the employer with the required disclosures under ERISA, such as the summary plan description and any summaries of material modification. It could also provide employers with "off the shelf" cafeteria-plan documents that allow for the pre-tax payment of health insurance premiums. Importantly, exchange staff could also be trained to process mid-year "change of status" requests in accordance with IRS regulations, relieving small employers of this burden. SHOP exchanges could even consider providing COBRA administration for employers.[246] All of these services could be provided, for free, to exchange-participating employers, and they would be yet another tool to help counteract the attractiveness of self-insurance.

SHOP exchanges could potentially further enhance their simplicity relative to self-insurance by fully supporting defined-contribution arrangements. Choosing an appropriate plan is a complicated endeavor for a small business, even if the available options are clearly explained. Unlike individuals, small businesses must expend a substantial amount of effort in discerning and updating their own preferences (i.e., the preferences of their employees as a group). A defined-contribution model eliminates this complexity by relieving the employer of the need to select a plan, instead allowing individual employees to make this decision on their own. Indeed, a defined-contribution model could limit small employers to making a single decision: how much they want to contribute to their employees' coverage.[247] Eventually, the simplicity of this decision could enable small businesses to jettison their insurance brokers, thus reducing the administrative costs to small employers of acquiring coverage.

4. A Cautionary Note on Defined-Contribution Arrangements

While defined-contribution arrangements provide a unique competitive advantage for SHOP exchanges over self-insurance, they may result in adverse selection within an exchange if low-risk employees self-segregate into lower-cost plans. The ACA attempts to limit this risk by suggesting that employers may make available to their employees only plans within a specific

246. COBRA administration refers to administering the continuation of group health plan coverage where an employee would otherwise lose such coverage following one or more qualifying events. COBRA coverage gets its name from the Consolidated Omnibus Budget Reconciliation Act that created such rights, and it is subject to complex legal rules regarding notification of rights, election of coverage, and termination of coverage. *See* 29 U.S.C. §§ 1161–1169.

247. There are, however, reasons why employers might want to be more involved in the decision. Employers may, for example, only want to give their employees choices within certain metal tiers.

precious-metal category.[248] Other options may also help mitigate the risk, such as risk-adjustment mechanisms within an exchange. Nonetheless, adverse selection is a substantial risk associated with a defined-contribution model. Given the numerous incentives that small employers have to not play ball in the first place, however, SHOP exchanges must take on this risk for themselves and manage it as best they can.

C. *Broker Incentives and Selling SHOPs over Self-Insurance*

Unfortunately, simply designing SHOPs to compete effectively against self-insurance is not sufficient. Coverage through SHOP exchanges must also be actively marketed and sold to small businesses as a superior alternative to self-insuring. Currently, at least half of all small employers secure their health insurance coverage through insurance brokers, who help them navigate the complexities of selecting appropriate coverage.[249]

Brokers, however, are likely to have strong incentives to steer their small-employer clients to self-insurance over coverage through a SHOP exchange. Under the MLR rules, broker commissions paid in the small-group market are treated as non-medical expenses.[250] As a result, they must be included in the maximum 20% of premiums that can be spent on non-medical expenses—a fact that already has limited the commissions that brokers earn by selling small-group contracts.[251] The same limitations do not apply to stop-loss coverage, which is not subject to MLR restrictions.[252] Rules governing "navigators," who help small employers use SHOP exchanges, may further depress the commissions that brokers can make by selling traditional coverage to small employers.[253] On the other hand, commissions for selling stop-loss insurance tend to be quite high, as medical-loss ratios for

248. ACA, Pub. L. No. 111-148, § 1312(a)(2), 124 Stat. 119, 182 (2010) (codified at 42 U.S.C. § 18032(a)(2) (Supp. V 2011)).

249. *See* LESLIE JACKSON CONWELL, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 57, THE ROLE OF HEALTH INSURANCE BROKERS: PROVIDING SMALL EMPLOYERS WITH A HELPING HAND 1 (2002), *available at* http://www.hschange.com/CONTENT/480/480.pdf.

250. Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 74,864, 74,877 (Dec. 1, 2010) (codified at 45 C.F.R. § 158.160 (2012)) [hereinafter MLR Rules].

251. *See* MICHAEL J. MCCUE & MARK A. HALL, INSURERS' RESPONSES TO REGULATION OF MEDICAL LOSS RATIOS (2012), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Dec/1634_McCue_insurers_responses_MLR_regulation_ib.pdf.

252. *See* MLR Rules, *supra* note 250.

253. In particular, navigators need not be insurance brokers and are not allowed to receive different amounts of compensation for directing individuals to different carriers. *See* HEALTH INS. & MANAGED CARE (B) COMM., NAIC, MARKETING AND CONSUMER INFORMATION WHITE PAPER: NAVIGATORS, AGENTS AND BROKERS, MARKETING AND SUMMARY OF BENEFITS AND COVERAGE 4 (2012). Together, these two factors may result in further decreased compensation for insurance brokers who facilitate the purchase of coverage on a SHOP exchange, as compared to the commissions that they can receive from selling self-insurance related products.

such coverage can be as low as 60% in some states.[254] Given all these factors, commissions for stop-loss coverage are likely to be higher than those available for selling exchange-based coverage.

While there are potentially good market reasons to be unenthusiastic about self-insurance relative to SHOP coverage, financially motivated brokers may steer small employees to self-insurance in order to maximize their commissions. They may downplay the complexities, risks, and limitations associated with self-insurance, while emphasizing the potential problems with SHOP coverage. For small employers who have limited knowledge and interest in health insurance markets and a trusting relationship with their broker, this steering could prove extremely effective.

At least two options are potentially available to SHOPs looking to combat the prospect that brokers will steer small employers to self-insured plans. One promising possibility is for SHOP exchanges to employ a force of SHOP-exclusive brokers that would market only SHOP-based products to small businesses. These in-house brokers could aggressively pitch the advantages of an insured product over a self-insured product. They could explain the complications that may come with self-insurance while emphasizing the advantages of SHOP coverage. Finally, these agents could emphasize that brokers who offer contrary advice may be motivated by commissions rather than by employers' best interests.

A more aggressive, but quite sensible, option for overcoming broker incentives to push self-insurance is to directly regulate the commissions that stop-loss insurers pay. States could legislatively require that insurance brokers receive the same commissions for selling stop-loss coverage that they receive for selling traditional group coverage. Alternatively, they could adopt MLR rules for stop-loss coverage that mimic the ACA requirements for the small-group market. Less aggressively, states could pass strong commission-disclosure rules that require brokers to clearly disclose the fact that they have financial incentives to sell stop-loss coverage as an alternative to traditional group coverage.[255] To be sure, many of these approaches are likely to encounter serious political opposition given that brokers are a well-organized lobby and that there is no obvious source of counter-pressure in the political process. At the same time, though, the market problems that differential compensation for insurance brokers create are well understood and were at the root of a massive scandal in the property/casualty insurance industry less than a decade ago.[256]

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254. *See* Letter from Sandy Praeger to Kathleen Sebelius & Hilda Solis, *supra* note 223.

255. *See* Daniel Schwarcz, Transparently Opaque: Understanding the Lack of Transparency in Insurance Consumer Protection (Feb. 18, 2013) (forthcoming in UCLA Law Review, 2013).

256. Daniel Schwarcz, *Beyond Disclosure: The Case for Banning Contingent Commissions*, 25 YALE L. & POL'Y REV. 289, 290–91 (2007).

D. ADDITIONAL REGULATORY/LEGISLATIVE OPTIONS FOR STATES

1. Limit Churning Between SHOP Exchanges and Self-Insurance

Recall that one substantial attraction of self-insurance post-ACA is that small employers can always switch to SHOP-exchange coverage at community-average rates.[257] This protects small employers against the prospect that any of their employees will become high-risk in the future, thus triggering increased stop-loss insurance coverage costs. Migration in the opposite direction is also possible: small employers can shift into the self-insurance market from the SHOP exchange if their employees experience comparatively low health care costs. Both types of churning increase the risk of adverse selection on SHOP exchanges by facilitating employers' capacity to self-insure when they are low risk and switch to traditional group coverage if, and when, they become high risk. Limiting the capacity of small employers to switch between SHOP coverage and self-insurance could simultaneously make self-insurance a less attractive option and limit the prospect of self-insured employers causing adverse selection by opting back into the insured market. There are various ways this might be accomplished.

First, SHOP exchanges could implement an open-enrollment period for small employers that have previously been self-insured. Currently, federal regulations require SHOP exchanges to maintain rolling enrollment, meaning that small businesses can purchase coverage at any time throughout the year.[258] These rules, however, did not specifically contemplate the problems associated with extending rolling enrollment to previously self-insured employers. As such, HHS could clarify that these rules do not preclude SHOP exchanges from limiting rolling enrollment for previously self-insured employers. If the open-enrollment period for previously self-insured small employers were sufficiently long—perhaps once every other year—then small employers who opted to self-insure would face substantial barriers to switching back into the insured market once their group became high-risk. There is some precedent for this approach: in the past, Colorado has proposed a three-year waiting period for small businesses that first elect coverage in an individual market and then desire to switch back into a more heavily regulated small-group market in order to take advantage of rating restrictions applicable to that market.[259]

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257. *See supra* Part III.

258. *See supra* note 233 and accompanying text.

259. MARK A. HALL & ELLIOT WICKS, AN EVALUATION OF COLORADO'S SMALL-GROUP HEALTH INSURANCE REFORM LAWS 41 (1999), *available at* http://www.phs.wfubmc.edu/public/pub_insurance/PDF/colorado.pdf ("[The] amendment allows a self-employed individual to choose whether to purchase individual or group coverage. But if someone opts for individual coverage, they cannot switch back to the group market for three years, to prevent adverse selection.").

To be sure, this approach would not be perfectly effective. First, stop-loss insurers might try to combat this limitation by designing their policies' renewals to correspond with open enrollment on the exchange. However, this would require stop-loss carriers to issue policies for two-year periods, placing on them, and thus indirectly on their policyholders, a much greater risk that low-risk small groups would become high-risk. Second, self-insured small employers who became high-risk could elect simply to drop group coverage altogether, as individuals can enroll at any time on an individual exchange if they have had a change of status in their employer coverage.[260] This option, however, would penalize any high-income employees by leaving them unable to pay for coverage on a pre-tax basis. In summary, while limiting enrollment into SHOPs would not solve the churning problem, it could mitigate the problem substantially by making the decision to self-insure more complicated and risky.

A second option to reduce churning is to impose a state-level fee or tax on previously self-insured employers that seek coverage on the SHOP exchange. Employers would then need to factor this potential cost into their initial decision to self-insure, which should decrease the attractiveness of self-insuring. The primary barrier to this approach is that it could be interpreted as incorporating previous insurance status into the effective-rating factors, which would violate the provisions in the ACA limiting rating factors to a small number of variables.[261] However, given that the fee would be a one-time expense and would be paid to the state rather than the carrier, it seems likely that it could be framed as a tax rather than as a premium-rating factor.

Finally, SHOP exchanges may also want to address migration out of the exchange in addition to countering migration into the exchange. One approach for accomplishing this might be for the exchange to require employers to make a multi-year commitment to offer some form of group coverage on the exchange, if the employer offers any group coverage at all. This would not commit an employer to offering group coverage, nor would it constrain the employer's choice of carrier or plan, but it would prevent an employer from easily moving to self-insured coverage when its employees experience low claims costs. Unfortunately, this requirement could conceivably cause low-risk employers to eschew SHOP coverage in the first place. As such, its advisability is unclear.[262]

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260. *Cf.* ACA, Pub. L. No. 111-148, § 1311(c)(6), 124 Stat. 119, 175 (2010) (codified at 42 U.S.C. § 18031(c)(6) (Supp. V 2011)).

261. *See* ACA § 1201, 42 U.S.C. § 300gg (2006 & Supp. V 2011) (adding § 2701 to the PHSA).

262. Other "softer" alternatives may be both more palatable and more successful. For example, the exchange could offer a fee waiver for those employers that are willing to make a multi-year commitment to purchase coverage through SHOP to the extent that they chose to offer any type of group plan.

2. Merge the Individual and Small-Group Markets

The ACA explicitly gives states the option of merging their individual and small-group markets.[263] Essentially, the effect of merging the markets is to ensure that premiums are priced based on the risk profile of the combined market.[264] As a result, merging the markets may, in some states, alleviate the risk of adverse selection from self-insurance by increasing the size of the risk pool in the insured market. The effects of such a merger would, however, be felt in both the individual and small-group markets and could affect premiums in both markets.[265] Consequently, states would need to carefully model such a merger in order to determine the premium and coverage effects in both the individual and small-group markets before proceeding. Merging the two markets will not automatically maximize coverage while lowering premiums. It is likely to be most successful in states where the individual market is expected to be substantially larger than the small-group market. Where that is true, introducing a small number of high-risk individuals from the small-group market is unlikely to have a significant effect on premiums in the combined market. Given the potential upside of a merger, every state should give this option serious consideration, particularly if the state permits low attachment point stop-loss coverage for small employers.

3. Expand the Small-Group Market to 100 Full-Time Employees in 2014

In 2016, the ACA provides that the small-group market will consist of all firms with 100 or fewer full-time employees.[266] For 2014 and 2015, states have the choice of defining the small-group market as firms with either fifty or fewer or 100 or fewer full-time employees.[267] Opting for the 100 or fewer full-time employee standard beginning in 2014 will expand the size of the small-group market in the state. As discussed above with respect to merging the individual and small-group markets, this could potentially reduce the effects of adverse selection. While each state would need to model the expected results of a definitional change in 2014, this too is worth serious consideration.

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263. *See* ACA § 1312(c)(3), 42 U.S.C. 18032(c)(3) (Supp. V 2011).

264. *See generally* Jon Kingsdale, *How Small-Business Health Exchanges Can Offer Value to Their Future Customers—And Why They Must*, 31 HEALTH AFF. 275 (2012).

265. In Massachusetts, for example, where the individual market was quite small, merging the individual and small-group markets brought down premiums in the individual market. *See* RICK CURTIS & ED NEUSCHLER, INST. FOR HEALTH POLICY SOLUTIONS, SMALL-EMPLOYER ("SHOP") EXCHANGE ISSUES 16 (2011), *available at* http://www.healthexchange.ca.gov/Documents/Small%20Employer%20(SHOP)%20Exchange%20Issues.pdf.

266. ACA § 1304(b)(2), 42 U.S.C. § 18024(b)(2).

267. ACA § 1304(b)(3), 42 U.S.C. § 18024(b)(3).

E. A NOTE ABOUT FEDERAL LEGISLATIVE OPTIONS

It is of course true that there are many possible ways that federal legislation could be used to protect small-group markets. Just to name a few, Congress could directly regulate stop-loss insurance, it could choose to regulate self-insured plans on the same basis as insured plans, or it could change either the small-business tax credit or the premium tax credit to encourage more small businesses to offer group coverage. Given current political realities, however, this Article has focused on actions that states or federal regulators could take independently to remedy the likely weaknesses of the small-group market. It is most likely that states or federal regulators operating federally facilitated exchanges will be in the best position to effectively address challenges to small-group markets.

CONCLUSION

There are very good reasons to be worried about the viability of small-group markets when the ACA's reforms are widely implemented in 2014. The lack of a penalty associated with dropping group coverage, along with substantial individual tax credits that are available only if an employer does not offer "affordable" coverage that provides "minimum value," are likely to lead to many small firms exiting the group market. In addition, the increasing availability of stop-loss insurance will make self-insuring easier for small employers that desire to offer group coverage but do not want to face the new regulatory burdens the ACA imposes. If small-group markets are not only to survive, but prosper, SHOP exchanges must take on these threats to group coverage directly. While there are many legislative solutions available at the federal level to protect these markets, this Article has illustrated that there are also state legislative options and administrative remedies that states and federal regulators can undertake in order to help save small-group insurance markets.