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Will Employers Undermine Health Care Reform by Dumping Sick Employees?

Daniel Benjamin Schwarcz
Amy Monahan

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Amy Monahan and Daniel Schwarcz†

Abstract: This Article argues that federal health care reform may induce employers to redesign their health plans to encourage high-risk employees to opt out of employer-provided coverage and instead acquire coverage on the individual market. Although largely overlooked in public policy debates, this prospect of employer dumping of high-risk employees raises serious concerns about the sustainability of health care reform. In particular, it threatens the viability of individual insurance markets and insurance exchanges by raising the prospect of adverse selection caused by the entrance of a disproportionately high-risk segment of the population. This risk, in turn, threatens to indirectly increase the cost to the federal government of subsidizing coverage for qualified individuals and to exempt more individuals from complying with the so-called individual mandate. The Article offers several potential solutions to the prospect of high-risk employee dumping that can substantially mitigate these risks.

† Amy Monahan (monahan@umn.edu) and Daniel Schwarcz (schwarcz@umn.edu) are both Associate Professors of Law at University of Minnesota Law School. For helpful comments and suggestions, we thank Kenneth Abraham, Tom Baker, Kristin Hickman, Allison Hoffman, Timothy Jost, Maureen Maly, Brett McDonnell, and Elizabeth Weeks Leonard.
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Employer Dumping

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Introduction

Over the next several years, our nation will implement a historic overhaul of its health care system. That system currently encompasses more than 17% of the American economy, a figure that is trending upwards.\(^1\) Fittingly, then, an unprecedented amount of time, effort, and debate contributed to assembling the blueprint for this reform, culminating in the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively “ACA”).\(^2\)

Nonetheless, the ultimate impact of ACA on the American health care system remains extremely unclear.\(^3\) One of the central such uncertainties is how reform will affect employer-provided health insurance, which currently covers over 60% of the non-elderly American population.\(^4\) To date, commentators have generally focused on the prospect that employers will choose to drop coverage entirely when ACA’s core reforms are implemented in 2014.\(^5\) This prediction is largely driven by the expectation that


\(^2\) Pub. L. No. 111-148 & Pub. L. No. 111-152. References to these bills initially used the acronym “PPACA.” However, recent federal publications have switched to the shorter “ACA,” and we follow that convention here.

\(^3\) In part, this is because much depends on how the states and federal government implement the statutory text. See Alan Weil & Raymond Chip, New Role for States in Health Reform Implementation, 29 HEALTH AFF. 1178 (2010). At the same time, a substantial amount of uncertainty stems from the very fact that so many different constituencies helped to produce ACA’s highly complicated and inter-connected statutory text, resulting in 2800 pages of new law.

\(^4\) See Elise Gould, The Erosion of Employer-Sponsored Health Insurance: Declines Continue for the Seventh Year Running, 39 INT’L J HEALTH SERVICES 669 (2009) (“Employer-sponsored health insurance (ESI) remains the most prominent form of health coverage in the United States, at 62.9 percent of the under-65 population; however, the rate of this coverage has fallen every year since 2000, when 68.3 percent had ESI.”).

\(^5\) See David Hyman, Employment-Based Health Insurance: Is Health Reform a Game Changer?, N.Y.U. REV. EMP. BENEFITS & EXECUTIVE COMPENSATION (forthcoming 2010), available at http://ssrn.com/abstract=1624311 (“Although voters were promised ‘if you like your coverage, you can keep it,’ PPACA is likely to cause further unraveling of EBC, unless significant modifications are made to its design.”); KENNETH ABRAHAM & DANIEL SCHWARCZ, HEALTH INSURANCE SUPPLEMENT TO ABRAHAM’S INSURANCE LAW AND REGULATION 32 (5th Ed. 2010). In one poll, various employers were asked to state their level of agreement with the statement that “Our organization would be better off if we dropped employee health care coverage and simply paid the fine.” 52.5% surveyed strongly disagreed, 15.3% somewhat disagreed, 18% somewhat agreed, and 14.1% strongly agreed. disagreed, 15.3% somewhat disagreed, 18%
individual health insurance markets – wherein consumers purchase health insurance as individuals, just as they typically purchase auto and homeowners insurance – will prove to be a relatively attractive option starting in 2014, thus blunting the labor market impact to employers of abandoning group coverage.

This Article raises a different, but potentially even more distressing, risk regarding the future of employer-provided health insurance. It argues that there is a substantial prospect that ACA will lead some, and perhaps many, employers to offer their employees health insurance plans that are designed to appeal to relatively young and healthy employees but prove unattractive to employees who are older, less healthy, or otherwise high-cost. ACA’s regulatory scheme grants employees of any size substantial latitude to design such plans, so long as they self-insure their employees’ coverage. An appropriately designed plan could induce high-cost employees to seek coverage through the newly reformed individual insurance markets while simultaneously exposing low-risk employees to limited risk if they unexpectedly become sick. It could thus produce a disproportionately low-risk employer group by “dumping” high-risk employees onto individual insurance markets. Contrary to an apparently widely shared misconception, such high-risk employees would be free to purchase coverage in the health insurance exchanges that ACA creates to organize individual insurance markets.

Although almost entirely unrecognized in the public debate leading up to ACA or in the regulatory fray since that time,
ACA’s failure to limit such employee dumping has the potential to substantially impair health care reform. Most importantly, employer dumping of high-risk employees could undermine the exchanges on which individual markets are expected to operate by rendering the pool of policyholders seeking coverage in exchanges disproportionately risky. Such adverse selection, in turn, would simultaneously lower coverage rates and increase the cost to the federal government of subsidizing coverage for low and moderate income individuals.  

Second, employer dumping of high-risk employees could undermine health care reform by subverting the principle of risk sharing that is at the core of reform. Rather than forcing the community as a whole to shoulder the burden of individuals’ poor health, employer dumping would allow low-risk employees to avoid their statutory responsibility to cross-subsidize the health care costs of the less fortunate. This, in turn, could undermine the willingness of the broader American population to shoulder the expenses of our country’s sick population.

In one sense, the risk of employer dumping of high-risk employees is hardly exotic. In fact, dumping of high-risk policyholders is merely a subset of the larger insurer practice of classifying risks. Such risk classification not only limits the risk to insurers of adverse selection, but also allows insurers to attract profitable business and avoid unprofitable policyholders. In many cases, insurers classify risks directly, by linking eligibility, premiums, or benefits to information they observe about the risk presented by individual policyholders. Left unregulated, health insurers thus base premiums on applicants’ predicted health care usage and decline to offer coverage altogether to certain high-risk applicants. They similarly link benefits to observable policyholder characteristics by excluding coverage for pre-existing conditions and searching for rationales to rescind coverage for those who develop substantial medical needs.

In addition to these forms of direct risk classification, insurers can allocate risks indirectly, by designing their coverage and marketing to appeal disproportionately to individuals with

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10 It is for these reasons that commentators have warned that adverse selection is the primary threat to insurance exchanges. See Tim Jost, Consumer Friendly Exchanges, Testimony for July 22-23, 2010, Interim Meeting of the National Association of Insurance Commissioners on Health Care Reform Implementation, Washington, D.C. available at http://naic.org/committees_b_exchanges.htm (“The biggest threat to the success of the exchanges will be adverse selection…”).

11 See generally KENNETH ABRAHAM, DISTRIBUTING RISK 64-100 (1986).
certain risk characteristics.\textsuperscript{12} Such indirect risk classification does not require insurers to make explicit distinctions regarding individual policyholders, but instead relies on policyholders “revealing” their own risk characteristics through their insurance purchasing decisions. For example, a policyholder who selects a policy that covers only acute catastrophic expenses, preventive care, and gym membership is likely to be less risky (i.e. healthier), on average, than a policyholder who selects “gold-plated” coverage, especially if the former is marketed towards a young and physically fit demographic.

Perhaps the central premise of health care reform is that insurers should be prohibited from competing through both direct and indirect forms of risk classification. Such classification punishes those with poor health records and increases uncertainty for all policyholders who may eventually become high-risk themselves. It also directs insurers’ cost-control efforts in socially unproductive directions. Prevented from classifying risks, insurers may turn to more desirable means of cost savings, such as improving the efficiency of health care delivery.

ACA’s approach to eliminating risk classification differs dramatically with respect to individual insurance markets and employer markets. ACA radically reforms individual insurance markets to eliminate risk classification. Starting in 2014, all health insurers will be prohibited from denying coverage to an applicant, limiting coverage of an individual’s pre-existing conditions, rescinding a contract for unintentional misstatements, or pricing coverage based on various health related factors.\textsuperscript{13} ACA also places substantial limitations on indirect risk classification in individual health insurance markets. Most importantly, ACA requires all such insurers to offer a robust set of minimum “essential health benefits,” thus constraining the capacity of insurers to create bare bones plans that appeal only to low-risk


\textsuperscript{13} Insurers will be required to price coverage on a modified-community rating basis, where premiums can vary only based on age, family size, tobacco use, and geographic area, and even then only within certain ranges. See ACA § 1001, (adding § 2712 to Public Health Services Act (PHSA)) (rescissions); ACA § 1201 (adding § 2704 to PHSA) (preexisting conditions); ACA § 1201 (adding § 2702 to PHSA) (guaranteed availability); ACA § 1201 (adding § 2703 to PHSA) (guaranteed renewability); ACA §1201 (adding § 2705 to PHSA) (premium pricing) Limited exceptions apply to insurers’ obligations to accept new policyholders that are not relevant to this analysis. These include the prospect that an insurer is financially unstable and thus must stop accepting policyholders. See ACA §1201 (adding §§ 2702-03 to PHSA).
individuals. Additionally, ACA creates various risk-adjustment provisions that attempt to limit the financial impact on insurers of attracting relatively healthy or unhealthy policyholders.

By contrast, ACA does little to impact risk classification in the employer market, especially for employers that self-insure the costs of their employees’ coverage. With respect to direct forms of risk classification, this is because pre-ACA federal law already prohibited group health plans from discriminating on the basis of health status with respect to eligibility, premiums, and benefits. There was consequently little need for ACA to alter these rules. But ACA also does virtually nothing to impact indirect risk classification by most employers. In particular, both self-insured and large employers are exempt from the requirement to offer essential health benefits. Similarly, ACA’s “risk adjustment mechanisms” do not impact self-insured employers’ incentives to engage in indirect risk allocation, although they may well impact the incentives of large employers who choose not to self-insure.

The rationale for largely preserving the status quo regulation of indirect risk classification by employers had nothing to do with pre-existing legal rules, which left employers almost completely free to design their plans as they wished (and thus to indirectly classify risks). Rather, it was seemingly premised on the fact that, prior to ACA, employers generally did not engage in indirect risk classification. To the contrary, they were usually willing to encourage the pooling of all their employees’ health risks. Doing so ensured robust protection and security for their employees, whose only alternative was often a dysfunctional individual insurance market. Moreover, the costs of such risk pooling to low-risk employees were partially offset by various tax benefits.

Starting in 2014, however, employers’ incentives will change dramatically. In contrast to their historical willingness to shun risk classification, employers will suddenly face dramatic incentives to design their plans so that their employees who are most likely to incur high medical expenses voluntarily choose to

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14 ACA §1201 (adding §2707 to the PHSA) (“A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.”).

15 See Mark Hall, The Three Types of Reinsurance Created by Federal Health Care Reform, 29 HEALTH AFF. 1168 (2010).

16 See infra Part I. B.2.

17 See §1201 (adding §2707 to the PHSA).

18 See infra Part I.B.3.d.

19 See infra Part I.B.3.

20 See, e.g., David A. Hyman & Mark Hall, Two Cheers for Employer-Based Health Insurance, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 30-31 (2001).
purchase coverage on the individual market. The key change from an employer perspective is that, once ACA’s major reforms take effect, the individual health insurance market should be an attractive alternative for high-risk employees, who will be able to acquire comprehensive coverage at the same rates as healthy individuals. To the extent this is the case, employers may not suffer substantial labor market consequences for failing to offer complete coverage for those who are high risk. Moreover, employers who can successfully design their plans to induce high-risk employees to seek coverage on the individual market can ensure lower premiums for their low-risk employees as well as higher salaries for all their employees. They can also provide their low-risk employees with a “cheap” way to comply with ACA’s so-called individual mandate. Finally, they can also avoid paying any penalty themselves under the so-called employer mandate. These benefits, the Article argues, are likely to outweigh the other costs associated with encouraging high-risk employees to purchase coverage on the individual market, at least for some, and perhaps many, employers.

This Article proceeds as follows. Part I begins by providing a more detailed and comprehensive discussion of how and why ACA permits self-insured employers to dump high-risk employees onto individual insurance markets. Part II then describes the incentives employers will face, starting in 2014, to take advantage of these loopholes. It describes how an appropriately designed employer plan can simultaneously induce high-risk employees to opt for coverage through the exchange while providing sufficient security and benefits to low-risk employees so that they will retain employer provided coverage. Part III concludes by examining the implications of employer dumping for the success of health care reform and offering several different potential solutions to the prospect of employer dumping of high-risk employees.

I. ACA, Social Solidarity, and the Prospect of Employer Dumping

One of the central visions underlying ACA is social solidarity; that it is appropriate to share medical risk within the community, and that individuals should not be financially penalized based on the “bad luck” of poor health. To a large

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21 See infra Part II.A.2.
22 See id.
23 See id.
degree, this philosophy was already built into large group health insurance markets prior to reform through the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). By contrast, insurers operating in pre-reform individual markets were often free to compete with one another by refusing to insure sick people, charging higher premiums to those with health risk factors, and excluding coverage for preexisting conditions and particularly expensive treatments. Given these disparities, it is hardly surprising that ACA was designed to have a substantially more dramatic effect on individual insurance markets than group markets. This Part describes the various ways in which ACA alters both individual and group markets, focusing on provisions that potentially impact the prospect of employer dumping. It shows that while ACA goes to great lengths to prevent risk classification in individual markets, it does virtually nothing to prevent indirect forms of risk classification in self-insured group markets.

A. ACA’s Reform of Risk Classification in Individual Markets

ACA promises to fundamentally remake individual insurance markets. This Section describes ACA’s reforms of these markets that are intended to eliminate insurers’ incentives and capacity to classify risk in favor of directing their energies to competing on more socially productive grounds (such as decreasing the cost of care and limiting administrative expenses). It first provides a brief overview of the state of individual insurance markets prior to reform. It then explores how ACA impacts both direct and indirect forms of risk classification in these markets.

1. Pre-ACA Individual Markets

Like most insurance markets, individual health insurance markets prior to reform were regulated almost entirely at the state level. States varied dramatically in how tightly they regulated these markets. Most states, however, allowed insurers in individual insurance markets to engage in some forms of risk classification. At its most fundamental level, risk classification involves pricing insurance based on the expected health care costs of a particular policyholder. But because the risks of some policyholders can be difficult to predict or are predictably exorbitant, risk classification can also involve refusing to insure

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certain policyholders or insuring them only with respect to specific types of costs or conditions.

Insurance economists have long recognized that, in addition to direct forms of risk classification, insurers can also indirectly classify policyholders by offering particularized sets of benefits that disproportionately appeal to certain types of policyholders. Such indirect risk allocation does not require insurers to make explicit distinctions regarding individual policyholders, but instead relies on policyholders “revealing” their own risk characteristics through their insurance purchase decisions. Thus, an insurer wishing only to insure young, healthy people might attract them by offering policies that have high deductibles for hospitalizations, premium discounts for frequent gym usage, and exclusions for drugs that are disproportionately used by the elderly or sick.

Risk classification is central to the operation of insurance markets ranging from life insurance to property insurance to health insurance. In the absence of such classification, insurance markets are at risk of adverse selection, wherein those who seek insurance are disproportionately high-risk. In the health insurance context, this might involve individuals only seeking coverage once their risk for developing a need for high-cost medical care is high. If the insured population consists disproportionately of high-risk individuals, insurance companies will respond by raising premiums. As premiums rise, only individuals with higher levels of risk will find insurance purchase worthwhile, in response to which insurers will raise premiums even higher. In extreme cases, adverse selection can cause insurance markets to collapse completely in a “death spiral” when insurers are unwilling to offer coverage at all due to the high risk levels of the individuals desiring coverage. Even when adverse selection does not pose such dire risks – as is often the case – risk classification is an important mechanism by which insurers compete. Insurers that can more accurately predict policyholders’ health care costs can win the business of low-risk individuals and avoid issuing coverage to high-risk individuals.


Although risk classification is commonplace in insurance markets, it has historically produced significant failures in individual health insurance markets. Individuals with a negative health history or risk factors were often unable to obtain affordable health insurance or were denied coverage altogether. And those who did acquire coverage were subject to preexisting condition exclusions and the prospect of rescissions. Insurers often retained substantial discretion to define preexisting conditions broadly and to rescind coverage even for innocent, and potentially irrelevant, omissions or misstatements in policyholders’ applications for coverage.

2. ACA’s Prohibition on Direct Risk Classification in Individual Markets

Starting in 2014, ACA will fundamentally change the individual market by prohibiting virtually all direct methods of risk classification in individual insurance markets. At that time, all health insurers will be prohibited from denying coverage to an applicant, limiting coverage of an individual’s pre-existing conditions, or rescinding a contract for unintentional misstatements once coverage has been granted. Insurers will be required to price coverage on a modified-community rating basis, where premiums can vary only based on age, family size, tobacco use, and geographic area, and even then only within certain ranges.

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29 See Light, supra note 25, at 2503-07.
30 Except where the individual had coverage for at least 18 months, most recently under an employer group plan, and has not had a break in coverage of 63 days or more. 29 U.S.C. §1181.
31 An investigation and hearing by the House Committee on Energy and Commerce in 2009 found that insurers often abused their authority to rescind policies in order to avoid paying expensive claims, targeting patients with breast cancer, lymphoma and numerous other serious conditions for rescission and praising employees for terminating the coverage of such policyholders. Additionally, it concluded that insurers frequently rescinded coverage based on trivial omissions in policyholders’ applications that were often unrelated to the policyholder’s illness. See Committee on Energy & Commerce, Case Studies: Examples of Health Insurance Companies Rescinding Individual Policies (7/27/09). See also Committee on Energy & Commerce Staff, Memorandum to Members and Staff of the Subcommittee on Oversight and Investigations: Supplemental Information Regarding the Individual Health Insurance Market, June 16, 2009, available at http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf (finding 20,000 rescissions by three large insurance companies over five years, saving those insurers $300m in claims).
32 See note 13, supra.
33 ACA § 1201 (adding §2701 to the PHSAct). Note that premiums will only be allowed to vary by 3 times for age, which is much less than current disparities.
Prohibiting the use of these devices raises significant adverse selection concerns. After all, if insurers are required to offer coverage to everyone who applies, at basically average rates, with no exclusion of pre-existing conditions, it would be tempting (and rational) for individuals to wait to purchase health insurance coverage until it is needed. Obviously this would have disastrous effects on the market, so ACA requires that all individuals purchase health insurance coverage unless they “cannot afford coverage,” meaning that the individual’s “required contribution . . . for coverage . . . exceeds 8 percent of such individual’s household income…” In order to make coverage affordable for a larger number of individuals, ACA also provides refundable tax credits for individuals with income between 100% and 400% of the federal poverty level as well as cost-sharing subsidies.

3. ACA’s Efforts to Limit Indirect Risk Classification in Individual Markets

ACA’s prohibitions on the most obvious risk classification methods -- including medical underwriting, preexisting condition exclusions, and premium rating – are not sufficient to eliminate insurers’ capacity to classify risks. Recognizing this, ACA supplements its direct prohibitions on risk classification with various measures that also prevent indirect classification by insurers.

a. Plan Design

First, and most importantly, ACA places various restrictions on the content of insurers’ coverage. These restrictions include prohibitions on annual or lifetime limits as well as a requirement to cover preventive services in full with no cost sharing. Additionally, and most significantly, ACA requires all insurance issued on the individual market to cover “essential health benefits” (“EHBs”). The requirement to offer EHBs contains three based on age. See Helen Darling, Health Care Reform: Perspectives from Large Employers, 29 HEALTH AFF. 1220 (2010).

34 ACA § 1501 (adding §5000A to the Internal Revenue Code of 1986 (“IRC”)). Individuals without coverage for a period of longer than three months face a penalty equal to the greater of $695 per individual per year (up to a maximum of three times that amount, $2,085, per family) or 2.5% of household income. Id.

35 ACA §§ 1401 (adding §36B to IRC),1402.

36 The effectiveness of these attempts to limit indirect risk classification depends largely on how these measures are implemented. For one analysis of this issue, see Testimony of Stephen Finan, Director for Policy at the American Cancer Society Cancer Action Network, to NAIC Committee on Health Exchanges (July 22-23, 2010).
parts: (1) a requirement to offer coverage for the treatments and services determined by the Secretary to constitute EHBs, (2) a limitation on the cost-sharing that can be imposed on such benefits and (3) a requirement to offer three different levels of coverage. ACA delegates to the Secretary of Health and Human Services the responsibility for defining the substantive coverage terms of EHBs, but the statute specifies that EHBs must include coverage for hospitalization, emergency services, prescription drugs, and laboratory services (among others). The most significant guidance given to the Secretary in defining EHBs is a requirement that they be equal in scope to those offered by a “typical employer plan.”

Although these coverage mandates for plans operating in the individual market can be defended in various ways, one of their key functions is to limit insurers’ capacities to indirectly classify risks. By establishing a relatively high coverage floor, these rules limit the capacity of insurers in individual markets to design their plans to appeal primarily to low-risk individuals.

b. Provider Networks and Exchanges

A second way in which ACA limits the prospect of indirect risk classification is through the establishment of insurance exchanges for the individual market. An exchange is simply an entity that helps organize an underlying market and facilitate comparison-shopping by buyers. ACA requires each state to establish an exchange to be administered either by a government agency or non-profit corporation. It is expected that a substantial amount of the individual insurance market will operate on these exchanges. In part this is because they are designed to improve consumer shopping and help replicate various economies of scale found in large group markets. Additionally, though, individuals can only receive federal subsidies for coverage when they purchase coverage on the exchanges.

37 See ACA §1302. Out of pocket expenses (the amount that an individual must spend out-of-pocket on covered care, including co-payments, deductibles, and other out-of-pocket expense) must be limited to approximately $5,950 for individual coverage and $11,900 for family coverage. See id. at §1302(c).

38 For a lengthier discussion of essential health benefits, see Amy B. Monahan, Initial Thoughts on Essential Health Benefits, N.Y.U. REV. OF EMP. BENEFITS & EXECUTIVE COMPENSATION (forthcoming 2010).

39 Starting in 2014, each state must establish such an exchange to facilitate the purchase of health insurance. ACA § 1321. See generally Jost, supra note 10.

40 If a state does not choose to establish an exchange, the federal government is authorized to establish one for that state’s residents. See ACA § 1321.

41 Exchanges are directed to work with the Department of Treasury to get the amount of the credit advanced and paid directly to the insurer, negating the need for the individual to pay the amount and be reimbursed only when the individual files her tax return for the year. See ACA §§1411 & 1412.
Individual insurance plans offered in state Exchanges must meet additional criteria regarding plan design, which are encompassed in the requirement that they be “Qualified Health Plans.”[^42] Most importantly, qualified health plans must “ensure a sufficient choice of providers.”[^43] Like the limitations on benefit designs described above, this restriction on plans’ network of providers imposes another obstacle on insurers that are inclined to indirectly classify risks. For instance, they prevent insurers from developing a network of providers who are located predominantly in geographic areas with a comparatively young or healthy population.

Additionally, officials are endowed with discretion in deciding which plans can be offered through an exchange.[^44] While it is not yet clear the basis on which exchange officials will exercise such direction, it is likely that one of the central factors they are likely to evaluate is whether plans offered in the exchange are attempting to indirectly classify risks. To the extent that regulators or exchange operators perceive this to be the case, they could ban a carrier from the exchange, and thus substantially limit its capacity to compete in the individual market.

c. Risk Adjustment Mechanisms

A third – and potentially the most important – set of mechanisms that ACA employs to discourage indirect risk classification by insurers in the individual markets are various risk adjustment mechanisms. Two of these arrangements operate as temporary reinsurance programs for insurers in individual insurance markets.[^45] Reinsurance essentially provides insurance for insurers.[^46] First, ACA establishes a temporary reinsurance program that protects insurers in individual markets against the risk that their policyholders will disproportionately suffer from expensive conditions.[^47] Second, ACA also reinsures insurers in both the individual and small group markets against the risk that their medical costs will be greater than 103% of expectations.[^48]

[^42]: See ACA §1301.
[^43]: See ACA §1311(c)(1)(B).
[^44]: See ACA §1301 (defining a “qualified health plan” to be offered by a health insurance issuer that is “licensed and in good standing” and that complied with “such other requirements as an applicable Exchange may establish”).
[^45]: See Mark Hall, *The Three Types of Reinsurance Created by Federal Health Care Reform*, 29 HEALTH AFF. 1168 (2010). A third reinsurance program ends prior to 2014 and involves reinsurance for the expenses that employers incur in providing health benefits to early retirees. See id.
[^47]: ACA § 1341.
[^48]: ACA § 1342.
Both programs limit insurers’ incentives to classify risks by blunting the potential that the failure to indirectly classify risks will result in higher than anticipated costs.\textsuperscript{49}

In addition to these reinsurance programs, ACA also establishes a prospective risk assessment mechanism. This program extends indefinitely, and charges low actuarial risk plans a penalty while providing payments to high actuarial risk plans.\textsuperscript{50} Unlike the two reinsurance programs, this risk assessment program not only mitigates the impact to insurers who end up with high-risk policyholders but also taxes insurers who end up with low-risk policyholders. It therefore both limits the potential negative consequences of failing to engage in indirect risk classification and minimizes the potential gains to insurers that successfully use indirect risk classification to attract low-risk policyholders. Overall, it is abundantly clear that ACA is specifically designed to tightly control risk classification in the individual market.

**B. ACA’s Reform of Group Markets and the Capacity of Employers to Dump**

In contrast to the individual market, employers engaged in relatively little risk classification prior to ACA. For this reason, ACA does little to alter the risk-classification landscape with respect to employers.\textsuperscript{51} This Part first provides some background on the employer market prior to ACA, and then explores how ACA impacts both direct and indirect forms of risk classification in these markets. It shows that ACA largely leaves in place preexisting federal laws that prevent direct forms of risk classification in group markets, such as discrimination in premiums or cost sharing among different policyholders. But it also demonstrates that ACA leaves employers who choose to self-insure their health plans largely free to engage in various forms of indirect risk classification.

**1. Background on Employer Plans Pre-ACA**

Employer-based health insurance has historically enjoyed several substantial advantages to individual insurance coverage. First, employers hire employees for reasons unrelated to health

\textsuperscript{49} Hall acknowledges that the primary purpose of section 1341 is to blunt adverse selection, but suggests that the purpose of 1342 is instead to limit actuarial uncertainty. Both programs, however, simultaneously accomplish both goals, and identifying which goal is primary is a difficult exercise.

\textsuperscript{50} ACA § 1343.

insurance, so the insured group tends to enjoy a near community-level risk profile. In other words, employees’ health risks generally mirror the community at large, especially for large employers, creating a natural risk-pooling mechanism. Second, because of the administrative efficiencies associated with group purchase, overhead costs (referred to as “loading charges” in the insurance industry) have historically been substantially lower for employer-provided coverage than in the individual market. Large employers, once again, disproportionately benefit from such economies of scale. From an employee’s perspective, the employer also performs valuable “informational intermediation” by performing the health insurance search and aggregation functions, reducing the health insurance decision-making costs that employee’s face. Third, and perhaps most importantly, the cost of employer-provided health insurance is excluded from both federal income and payroll tax. As a result, employer-provided health insurance enjoys an effective federal subsidy, which is not generally available to individual insurance purchases. By lowering the cost of coverage, this subsidy encourages low-risk individuals to accept coverage in group plans that they might otherwise find too generous. The subsidy thus helps to ensure that such plans do not suffer from adverse selection. Employers frequently contribute significantly to the cost of coverage, further encouraging low-risk employees to join to plan.

Aside from the Internal Revenue Code, employer-sponsored plans are principally governed by the federal Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA regulates many aspects of plan administration, reporting, disclosure, and remedies. However, it only lightly regulates the

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52 Estimates suggest that group plans spend 5-10% of premiums on administrative costs, while such costs are equal to 30-40% of premiums in the individual market. Mark V. Pauly & Len M. Nichols, The Nongroup Health Insurance Market: Short on Facts, Long On Opinions and Policy Disputes, HEALTH AFF. W325, W326 (Oct. 23, 2002).
53 See Hyman & Hall, supra note 20, at 30.
54 I.R.C. § 106. Most states follow the federal tax treatment and exempt such payments from state income tax as well.
55 Only self-employed individuals may deduct the cost of individual health insurance purchases. See I.R.C. §162(f)(1)(B).
56 On average, workers pay only 17% of the cost of single coverage, and 27% of the cost for family coverage. KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS, 2009 ANNUAL SURVEY 68, exh. 6.1., available at http://ehbs.kff.org/pdf/2009/7936.pdf. The majority of workers are employed by firms that contribute at least half of the premium cost. Id. at 81, exh. 6.15.
57 Employer plans are also affected by various federal income tax regulations, some of which mirror provisions in ERISA. Because the federal tax treatment does not directly impact use of risk classification, discussion of the tax code provisions that affect group health plans is largely omitted from this Article.
substance of group health plan coverage. At present, it contains just four such requirements: minimum hospital stays following childbirth, breast reconstruction following mastectomy, a limitation on the exclusion of pre-existing conditions, and a mental health parity requirement. ERISA also incorporates the non-discrimination provisions of HIPAA, which prohibit group health plans from discriminating on the basis of health factors with respect to eligibility, benefits, or premiums.

In addition to this federal regulation, employers that purchased group insurance policies rather than self-insuring were also indirectly subject to state insurance regulation. Under pre-ACA law, states were free to regulate the content of coverage that insurers offered to employers under the states’ general authority to regulate insurance markets. States exercised this authority regularly, enacting numerous coverage mandates requiring insurers to cover benefits ranging from chiropractor services to hearing aids for children.

By contrast, ERISA forbids states from extending any of these insurance laws to employer plans that “self insure” their employees’ coverage. At its most basic level, an employer self-insures a plan where it retains liability to pay plan benefits rather than transfer that risk to an insurance company. Historically large employers have been much more likely to self-insure than small employees, as the size of their workforce tends to ensure that employees’ health care expenditures will be relatively steady over time, thus decreasing the need to shed risk to a third-party insurer. Increasingly, however, mid-size and even small employers have opted to self-insure and purchase stop-loss insurance to protect themselves from the risk that their employees will experience unusually high claims in a given year. Stop-loss insurance, a

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58 A plan may exclude coverage for a pre-existing condition for a maximum of 12 months. That maximum exclusion period is reduced by the amount of any prior creditable coverage the individual had. For example, if an individual had coverage under an employer plan for 12 months and then switched employers and became covered under the new employer’s plan without a break in coverage, the new employer’s plan could not enforce any pre-existing condition limitation for that employee.

59 29 U.S.C. §§ 1181, 1185, 1185a, & 1185b.


form of reinsurance, reimburses the employer once claims under the plan exceed a specified level either on an individual participant or plan-wide basis. 64 Self-insured plans do not lose their exemption from state insurance regulation when they purchase stop-loss insurance. 65 The end result is that nearly all employer plans are subject to the requirements of ERISA and HIPAA, but they are subject to state regulation only if the employer purchases a group insurance policy to fund benefits.

2. ACA’s Regulation of Direct Risk Classification in Group Markets

Although ACA extends some of the protections against direct risk classification that existed prior to reform, it largely leaves in place the pre-reform regime described above. For instance, ACA’s guaranteed issue requirements and prohibition on rescissions apply to all employer plans, whether insured or self-insured, but its premium pricing restrictions 66 apply only to the individual and small group markets. This makes sense because HIPAA’s existing requirements regarding premium setting are in fact stricter than ACA’s, prohibiting premium setting based on all health related factors, including age and tobacco use. 67 ACA does technically subject employers to its provisions prohibiting discrimination against enrollees based on health status, though this is largely duplicative of employers’ responsibilities under HIPAA.” 68 Similarly, while ACA eliminates the capacity of employers’ to use preexisting condition exclusions, this is much less of a shift for large group markets as HIPAA already substantially limited the use of such clauses in the employer context. In the end, ACA changes little about the ability of employers to directly classify risk because such restrictions were already largely in place.

3. ACA’s Regulation of Indirect Risk Classification in Group Markets

For similar reasons – why fix what is not broken? – ACA also does relatively little to address the prospect that employers – particularly those that are self-insured – will implement health

employees, 88% of covered workers are enrolled in self-insured plans. Id. In firms with 3-199 employees, 15% of covered employees are enrolled in self-insured plans. Id.

64 Parades, supra note 63, at 249-50.
66 See supra Part I.A.2.
68 ACA § 1201 (adding § 2705 to the PHSA).
insurance plans that are designed to disproportionately appeal to low-risk employees. Much to the contrary, ACA seems to assume that employers will continue to offer relatively generous plans, as it directs the Secretary of HHS to define essential health benefits so that they are no less generous than a typical employer plan. This Section reviews the provisions of ACA that potentially implicate the capacity of employers to engage in indirect underwriting by designing plans that disproportionately appeal to low-risk employees.

a. Plan Benefits

ACA’s requirements regarding the substance of plan benefits vary based on whether the employer purchases insurance or self-insures. Group coverage for small employers is subject to the same requirement as individual insurance markets. By contrast, neither large group insurance plans nor self-insured employers are required by ACA to offer “essential health benefits” to their policyholders.69 Instead, these plans are subject to only a few specific requirements, each of which apply broadly to all insurance plans and group health plans. First, all employer plans must offer full coverage, with no cost sharing, for all preventive health services.70 Second, employer plans must cover routine patient care costs of individuals participating in clinical trials.71 Third, ACA sets overall limits on the maximum out-of-pocket spending a plan can require per participant per year, although these out-of-pocket annual limits apply only to the covered benefits that an employer plan provides.72 Fourth, the statute restricts annual and lifetime caps on coverage, although it does not require employers to offer any particular benefits. Interestingly, these provisions do prohibit large and self-insured employers from placing annual and lifetime caps on essential health benefits starting in 2014.73 As a result, while large and self-insured employers need not offer essential health benefits at all, they cannot offer limited forms of these benefits that are subject to lifetime or annual limits.

Large employers who purchase a group insurance policy will, however, remain subject to state insurance regulation. As a result, the ability of such plans to design benefits in order

69 See supra Part I.A.3.a.
70 The only other coverage requirement in ACA applicable to employer plans appears to be contained in section 10103, adding section 2709 to the PHSA, which requires group plans to provide coverage for individuals participating in approved clinical trials.
71 ACA § 10103 (adding § 2709 to the PHSA).
72 ACA § 1201 (adding § 2707(b) to the PHSA).
73 ACA § 10101 (adding § 2711 to the PHSA).
indirectly classify risks will vary based on the flexibility of state regulation. Self-insured plans, on the other hand, will enjoy nearly complete freedom to design benefits to classify risk. To take an extreme example, a self-insured employer could implement a health plan that covered preventive services, the four coverages required by ERISA, routine patient care costs of individuals participating in clinical trials, and nothing else.

Alternatively, a self-insured plan could simply exclude coverage for specific high-cost conditions – such as AIDS, diabetes, and hemophilia. While potentially an issue under the Americans with Disabilities Act\textsuperscript{74} (the “ADA”), which prohibits discrimination with respect to disability, employer health plans may employ a “disability-based distinction” provided that the plan provision is not being used as a “subterfuge” to intentionally violate the ADA. A disability-based distinction is a “subterfuge” where it is not justified by the costs associated with the disability. For example, a plan may refute a claimed subterfuge by showing that the disparate treatment is justified by legitimate actuarial data or where the challenged provision is necessary to “prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan or in the premiums.”\textsuperscript{75} This gives employers a tremendous amount of discretion in carving out entire categories of treatment because nearly all such exclusions are premised on cost. In the end, neither ACA nor other existing sources of law substantially restrict the ability of self-insured plans to engage in indirect risk classification through design of plan benefits.

\textbf{b. Provider Network}

ACA leaves employers (whether insured or self-insured) largely free to design their provider network however they see fit.\textsuperscript{76} It provides only that a “group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law.”\textsuperscript{77} This provision does “not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.”\textsuperscript{78} Rather, it requires simply that a plan not discriminate against non-medical

\textsuperscript{75}EEOC Interim Guidance on Application of Americans with Disabilities Act of 1990 to Employer-Provided Health Insurance, Part III, C, 1, d (6/8/93).
\textsuperscript{76}ACA § 1201 (adding § 2706 to the PHSA).
\textsuperscript{77}Id.
\textsuperscript{78}Id.
practitioners, such as chiropractors, acupuncturists, massage therapists and midwives. At the extreme, employers are free to implement an HMO-style plan wherein enrollees are required to seek care only from employee-doctors within the HMO.

c. Wellness Plans

Unlike insurers in the individual market, employers of all sizes are permitted under ACA to establish “wellness programs” for their enrollees. Wellness programs creates incentives for enrollees to take measures to promote health or prevent disease, usually by offering premium rebates, cost-sharing reductions, or financial perks in exchange for demonstrable measures to improve health. Perhaps the most common example of such a program is one that pays a portion of an enrollee’s gym memberships if she visits the gym a specified number of times each month. Although designed to incentivize healthy living among policyholders, wellness programs provide employers with yet another risk classification tool because of their ability to lower costs for comparatively healthy enrollees.

ACA permits two different types of wellness programs. First, it permits wellness programs that are not “based on an individual satisfying a standard that is related to a health status factor” and are “made available to all similarly situated individuals.” Examples falling in this category include gym membership reimbursement, a diagnostic testing program, and a smoking cessation program. Second, it permits wellness programs that are “based on an individual satisfying a standard that is related to a health status factor,” but only under much more stringent conditions. These include the requirement that any reward “not exceed 30 percent of the cost of employee-only coverage under the plan” and that the program is “reasonably designed to promote health or prevent disease.” A program meets this later requirement if “the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating

79 ACA provides in section 2705 that a “program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.” (emphasis added).
81 ACA §1201 (adding § 2705(j) to the PHSA).
82 Id.
83 Id.
based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.”

A reward for actually quitting smoking would be an example of this latter type of program.

d. Risk Adjustment Mechanisms

ACA largely excludes employers, especially those that are self-insured, from the risk-sharing arrangements that are designed to mute insurers’ incentives to attract comparatively healthy risks. First, and most importantly, self-insured employers (but not employers who purchase insurance) are specifically exempt from participation in the permanent Prospective Risk Assessment mechanism, which charges low actuarial risk plans a penalty while providing payments to high actuarial risk plans. In the long term, then, ACA provides no mechanism that would impact the financial benefits a self-insured employer might derive from dumping high-risk employees on the individual market or otherwise not insuring such individuals.

Second, both self-insured employers and employers who purchase insurance coverage are also largely (but not entirely) unaffected by the two temporary reinsurance programs that ACA establishes in part to limit the incentive to indirectly classify risk. With respect to both programs, employers are ineligible to receive any reinsurance payments if their enrollees are disproportionately costly – indeed both provisions are specifically labeled as reinsurance programs for plans “in individual and small group markets.” But in the case of the of the reinsurance program established in section 1301, which reinsures insurers in the individual market with a disproportionate share of policyholders with high risk conditions, contributions must be made by “third party administrators on behalf of group health plans” in addition to other insurers. Moreover, while ACA delegates to the Secretary of Health & Human Services the authority for determining the amounts of these contributions, it provides that they “may be based on... the total costs of providing benefits to enrollees in self-insured plans.”

As such, it is possible – but by no means certain

84 Id.

85 ACA § 1343 (“Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).” (emphasis added)).

86 ACA § 1341(b)(3).
that employers with relatively low-cost enrollees (including those that self-insure) would owe a larger contribution to this reinsurance program for the three years that it is operating.

e. General Anti-Dumping Provisions

Although ACA creates and extends various rules prohibiting explicit forms of direct risk classification by employers, it does not supplement these rules with a broader standard prohibiting such classification. This is perhaps surprising, as ACA contains precisely such a broad standard in its provisions governing the creation and operation of temporary high-risk pools.87 These pools are temporary insurance programs designed to cover individuals with pre-existing conditions or who have been uninsured for six months until 2014, when they can purchase coverage in the individual market without penalty for their high risk status.88 In the provisions establishing this mechanism, ACA instructs the Secretary of Health and Human Services “to establish criteria for determining whether health insurance issuers and employment based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual’s health status.”89 If either an insurer or employer is found to have engaged in such dumping, it shall be responsible for “reimbursing the program under this section for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program.”90 The statute is crystal-clear, however, that these generalized anti-dumping rules apply only to dumping on to high-risk pools, and have no application to potential dumping onto individual insurance markets starting in 2014. First, these antidumping rules are contained in Section 1101 of ACA, which solely concerns temporary high-risk pools. Indeed, the provision is entitled “Immediate Access to Insurance for Individuals with preexisting conditions” and its “general purpose” is to “establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.”91 Accordingly, all of the sub-sections of Section 1101, including the anti-dumping provisions, solely

87 ACA § 1101(e).
88 ACA § 1101.
89 ACA § 1101(e)(1).
90 ACA § 1101(e)(2).
91 ACA § 1101(a).
concern the temporary high-risk programs. Second, the anti-dumping provisions themselves contain remedial provisions that repeatedly reference “the program.” The “program” is a clear reference to the “temporary high risk health insurance pool program” introduced in the “general purpose” section at the outset of the statutory provision. In sum, there is no plausible reading of Section 1101 under which its anti-dumping provisions can be understood to extend to the prospect of employer dumping of high-risk employees on to the individual markets in 2014 and beyond.

II. Employer Dumping Strategies

As Part I makes clear, employers generally, and particularly those that self-insure, have substantial legal room under ACA to design plans that disproportionately appeal to relatively healthy employees, so long as they do not engage in more direct forms of risk classification. Moreover, self-insured employers are not subject to ACA’s risk adjustment mechanisms that are designed to offset any potential financial gain that can be achieved through such indirect risk classification. This Part explores how an employer would go about designing and implementing a dumping strategy, starting with general considerations before offering specific examples of how an employer might structure a plan designed to dump high-risk employees.

A. General Considerations in Plan Design

1. Getting High-Risk Employees onto the Exchange

The core purpose of an employer dumping strategy is to cause high-risk employees to opt out of employer coverage and seek coverage on the individual insurance market, likely via an insurance exchange. Contrary to several different publicly available summaries of health care reform, high-risk employees

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92 Various summaries of ACA suggest, or affirmatively proclaim, that only individuals who do not have access to affordable employer coverage will be eligible to purchase coverage via the Exchange. See, e.g., KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE EXCHANGES, http://www.kff.org/healthreform/7908.cfm (stating that "ACA requires most individuals to have health insurance beginning in 2014. It authorizes entities known as American Health Benefit Exchanges, which states will establish by January 1, 2014, to make plans available to qualified individuals and employers. Qualified individuals include U.S. citizens and legal immigrants who are not incarcerated, and who do not have access to affordable employer coverage.") See also FOLEY & LARDNER LLP, WILL PROPOSED HEALTH INSURANCE EXCHANGES WORK AND BE AFFORDABLE?,
will indeed have the option of purchasing coverage in state-run exchanges. This is because ACA provides that any “qualified individual” may purchase coverage through an exchange.\(^93\) A qualified individual, in turn, “means, with respect to an Exchange, an individual who is seeking to enroll in a qualified health plan in the individual market offered through the exchange and resides in the State that established the Exchange.”\(^94\) The only individuals who are explicitly excluded as qualified individuals are those who are incarcerated and those who are not lawful residents of the country.\(^95\) There are no eligibility restrictions placed on employees with access to employer coverage.

In many ways, the coverage options in the individual market will be highly desirable to high-risk employees. In contrast to their employer plan, all plans in the individual market will be tightly regulated to ensure that they provide EHBs and a robust provider network – plan elements that are crucially important to high-risk individuals. Moreover, at least some plans in the exchange will presumably offer “platinum” level coverage, which must provide “benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.”\(^96\) Insurers who wish to participate in the exchange must in fact offer at least one plan at the “gold” level, which provides benefits that are actuarially equivalent to 80 percent of the full

http://www.foley.com/publications/pub_detail.aspx?pubid=7033 ("The Exchanges will initially be open only to individuals who work at companies no more than 100 employees or that do not provide insurance, the self-employed and unemployed, non-Medicare-covered retirees, and small businesses."). Some commentaries do correctly identify exchange eligibility. See, e.g., Blue Cross Blue Shield, Detailed Summary of Patient Protection and Affordable Care Act (PPACA), P.L. 111-148 and Health Care and Education Reconciliation Act (HCERA), P.L. 111-152, p. 16 (4/22/10) (listing under “exchange eligibility” for individuals, “any legal resident not incarcerated). The confusion of commentators appears to stem from several sources. First, under Massachusetts Health Care Reform, coverage via the Connector is indeed limited to those who do not have the option of affordable employer provided coverage. Second, a number of the draft proposals for Federal health care reform, including the versions of the House bill (H.R. 3200) and the Senate Health, Education, Labor, and Pensions (HELP) did apparently limit exchange eligibility to those without access to affordable employer provided coverage. See TIMOTHY STOLZFUS JOST, HEALTH INSURANCE EXCHANGES: LEGAL ISSUES 10 (2009), available at http://www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Papers/Insurance_Exchanges.pdf.

\(^93\) ACA § 1301(d)(2)(A) (“An Exchange shall make available qualified health plans to qualified individuals and qualified employers.”).

\(^94\) Id.

\(^95\) ACA § 1312 (f)

\(^96\) ACA § 1302(d)(1)(D). While platinum level coverage is permitted to be offered within the exchange, an insurer is not required to offer such coverage in order to participate in the exchange.
actuarial value of the benefits provided under the plan. Additionally, some plans in the individual market may have a reputation – made accessible through the various transparency provisions applicable to exchanges – for providing particularly good care for the specific ailment or condition applicable to the high-risk employee. Finally, and most importantly, unlike in the pre-ACA world, high-risk employees will be eligible to purchase this coverage at the same rates as healthy individuals, with no need to worry about pre-existing condition exclusions or rescissions.

Although coverage through the exchange will be both available and attractive to high-risk employees, it will undoubtedly cost more to the employee than coverage under the employer’s plan. First, by electing individual coverage, individuals would lose their employer’s contribution to their health insurance expenses, which is often quite substantial. At the same time, they would not be eligible for government subsidies through the exchange so long as their employer’s plan is “affordable” and provides “minimum value.” Second, employees would need to pay the premiums for coverage through the exchange with after-tax dollars, even though their premiums for employer-provided coverage can be paid with pre-tax dollars. As such, a major consideration in devising an effective employer dumping strategy is the extent to which the employer offsets these costs of electing coverage in the individual market, thus making individual coverage an attractive option for high-risk employees.

97 ACA § 1301(a)(1)(C) requires a “qualified health plan” to offer at least one gold level plan. ACA § 1302(d) defines gold coverage.
98 See ACA § 1311(c).
99 On average, workers pay only 17% of the cost of single coverage, and 27% of the cost for family coverage. KAFER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS, 2009 ANNUAL SURVEY 68, exh. 6.1., available at http://ehbs.kff.org/pdf/2009/7936.pdf. The majority of workers are employed by firms that contribute at least half of the premium cost. Id. at 81, exh. 6.15.
100 An employee who is offered coverage by her employer is eligible for a premium tax credit only if she otherwise satisfies the eligibility criteria and if her required contribution for employer coverage exceeds 9.5% of her annual household income, or if the plan fails to provide “minimum value,” meaning the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs. ACA § 1401(a). The term required contribution means “in the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible-employer-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage.” ACA § 1501(b) (adding § 5000A(e) to the I.R.C.).
101 Employers must establish a cafeteria plan pursuant to section 125 of the Internal Revenue Code if they want to allow the pre-tax payment of health insurance premiums. See Mark A. Hall & Amy B. Monahan, Paying for Individual Health Insurance through Tax-Sheltered Cafeteria Plans, 47 INQUIRY (forthcoming 2010).
2. The Complicated Desires of Low-Risk Employees

In order to be effective, an employer dumping strategy must avoid inducing substantial numbers of low-risk employees to opt for coverage through the exchange. After all, if the low-risk individuals leave along with the high-risks, the employer plan will not improve its overall risk profits. Two inter-related concerns could might cause low-risk employees to seek coverage through the exchange rather than the employer plan. First, low-risk employees may also be quite risk-averse. Second, low-risk employees may unexpectedly and quickly become high-risk employees. A low-risk but risk-averse individual will not want to enroll in a plan that does not adequately cover her needs in the event that she becomes high-risk.

These concerns suggest that an effective employer dumping strategy must provide reliable coverage for any medical costs that are not foreseeable within a year’s time of when they are incurred, such as an unexpected illness or accident. Under ACA, current employees are only eligible to purchase coverage through an exchange during (i) a qualifying change in status (such as a change in employment or family status), or (ii) an annual open enrollment period. As such, an individual who is enrolled in her employer’s plan cannot, mid-year, simply elect to switch to exchange-provided coverage if she develops a health condition that enjoys better coverage in an exchange-plan than in her employer’s plan. Such an individual would have to wait until the next open enrollment period to switch to exchange coverage, which could be up to twelve months. At the same time, however, risk averse, low-risk employees who opt for an employer plan need not be concerned about their coverage in the event that they suddenly expect to incur large medical expenses in more than a year’s time. This is because one year is the maximum period of time it would take an employee to acquire comprehensive coverage in the exchange at the same price as low-risk individuals, with no preexisting condition exclusions.

3. The Individual and Employer “Mandates”

A final key consideration in designing an effective employer dumping strategy is the degree to which it would trigger tax penalties under the so-called individual and employer “mandates.” First, individuals may owe a tax penalty under ACA

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102 See Siegelman, supra note 27, at 1204.
103 ACA § 1311(c)(6).
104 Assuming, of course, that their high risk does not stem from tobacco use.
if they do not possess “minimum essential coverage.”105

Surprisingly, though, ACA appears to define employer-provided coverage to automatically constitute minimum essential coverage for individuals, despite the minimal requirements applicable to such plans. In particular, section 5000A(f) of the Internal Revenue Code, as added by ACA, provides that minimum essential coverage includes an “eligible employer plan.”106 An “eligible employer-sponsored plan” is then defined in a way that seems intended to include all “group health plan[s].”107 Federal regulations make clear that a “group health plan” includes self-insured employer plans.108 In other words, even though self-insured employers enjoy near complete freedom in determining the composition of their plans, such coverage likely automatically constitutes “minimum essential coverage” that satisfies the individual purchase mandate for covered employees.

Similarly, the employer mandate poses minimal obstacles to an employer’s dumping strategy. Employers who offer a group health plan only owe a penalty under ACA when their employees receive subsidized coverage through the exchange. But employees are not eligible for subsidies if they have the option of “affordable” employer-provided coverage that provides “minimum value.”109 An employer plan is unaffordable for this purpose only if the employee’s required contribution for coverage exceeds 9.5% of her

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105 ACA § 1501(b) (adding § 5000A to the I.R.C.).
106 Id.
107 ACA § 1501(b) (adding § 5000A(e) to the I.R.C.). The provision provides that "The term ‘eligible employer-sponsored plan’ means, with respect to any H. R. 3590—131 employee. Some commentators have raised the prospect that this definition does not automatically mean that a “group health plan” is an “eligible employer-sponsored plan” because parts (A) and (B) modify the term “group health plan” as well as “group health insurance coverage.” This prospect is discussed more fully in Part III.B, infra.
108 75 Fed Reg 35459 & n. 1. ("The term ‘group health plan’ includes both insured and self-insured group health plans.").
109 See ACA § 1513. In that instance, they would pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each full-time employee, excluding the first 30 employees from the assessment. For example, if an employer with 60 employees offers coverage, but five employees are eligible for and receive a premium tax credit through the exchange, the employer would face a fee of $15,000 (the lesser of (1) the number of employees receiving the credit multiplied by $3,000 and (2) the number of employees minus 30, multiplied by $2,000). A separate formula applies when an employer does not offer coverage and has at least one full-time employee who receives a premium tax credit. In that case, the employer faces a fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. For example, if the employer has 70 full-time employees, its penalty would be calculated by subtracting 30 from 70, and multiplying the resulting 40 by $2,000, for a total of $80,000 per year.
annual household income, which the employer can easily control in setting employee premiums. And the term “minimum value” refers not to the scope of benefits offered, but to a requirement that the plan pay at least 60% of the costs of the benefits that are covered by the plan. These thresholds are no more difficult for a plan to meet by virtue of the fact that it is designed to appeal primarily to low-risk employees and therefore has significant gaps in coverage for long-term conditions. As a result, an employer plan designed to dump high-risk employees would avoid any liability under the employer mandate so long as its coverage is “affordable” and provides “minimum value.”

B. Specific Employer Dumping Strategies

In order to successfully dump high-risk employees, employers must design a plan that is unappealing to high-risk employees, but appealing to low-risk employees. The major obstacle in accomplishing the former is the fact that high-risks who elect coverage in the individual market will face higher premiums, as they will lose their employer’s contribution as well as the tax benefits of employer-provided coverage. By contrast, to accomplish the latter, the employer plan must provide reliable coverage for any risks that cannot be anticipated a year in advance. Additionally, to avoid liability under the employer mandate, the employer’s coverage must be both “affordable” and provide “minimum value.” Finally, the employer’s plan must accomplish all this while (i) avoiding any explicit discrimination among its employees, (ii) providing full preventive benefits with no cost-sharing, (iii) imposing no annual or lifetime limits on any essential health benefits (although it need not offer essential health benefits at all), and (iv) requiring cost-sharing of no more than approximately $6,000 for individuals and $12,000 for families.

Clearly, an effective employer dumping strategy is not simple to construct. At the same time, though, this Section demonstrates various ways that motivated employers could thread this needle. In doing so, it focuses on self-insured plans, as an employer seeking to implement a dumping strategy would enjoy important benefits from self-insuring – including both avoiding state regulation and ACA’s risk adjustment mechanisms.

\[\text{110 ACA §1401(a). For example, if an employee earns $21,640 per year (currently this is 200% of the federal poverty level), but is eligible for employer-provided coverage, she could receive a premium tax credit only if the required contribution for her employer coverage exceeds $2,055.80 per year (9.5% of her income). A plan fails to provide minimum value if the plan’s share of the total allowed costs of benefits provided under the plan is less than 60% of such costs.}\]

\[\text{111 ACA §1401(a).}\]

\[\text{112 See supra Part I.B.3.}\]
1. Free Choice Vouchers

The first step in designing an employer dumping strategy is to limit the prospect that high-risk employees will stick with employer coverage simply because of the premium differential between such coverage and coverage on the exchange. As noted above, exchange coverage is almost certain to be more expensive than employer coverage because (1) employers, on average, pay the majority of employees’ health insurance premiums and (2) employer-provided coverage, whether paid for by the employer, employee, or some combination, can be paid on a pre-tax basis.

In order to offset these factors, employers seeking to dump high-risk employees on to the individual market can offer employees who opt for coverage in the individual market with a payment equaling the employer’s ordinary contribution to employees’ health insurance expenses. For example, if the employer typically contributes $5,000 per year for each employee covered by the employer’s plan, the employer would simply provide the employee with a direct payment of $5,000 for use on the exchange. In fact, ACA already incorporates this concept, which it labels a “free choice voucher.” Indeed, ACA requires employers to offer such vouchers to employees when the employee’s contribution to the employer-sponsored plan is between 8 and 9.8 percent of the employee’s income for the taxable year and the employee would be eligible for subsidies through the exchange. Employers seeking to dump high-risk employees could simply make such free choice vouchers available to all employees who opt to purchase coverage on the exchange rather than through the employer.

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113 See note 56, supra, and accompanying text.
114 See I.R.C. §§ 106 and 125. In addition, as noted earlier, employees will not be eligible for federal premium subsidies, even if their income would otherwise qualify them for a subsidy, because of the fact that affordable employer coverage is available to them.
115 Note that the term “free choice voucher” is used in ACA to refer to a specific requirement that employers provide employees within certain income limits who face certain contribution requirements for an employer’s plan with a “free choice voucher” to help fund exchange-based individual insurance purchases. What we are proposing below is not within the statute’s provisions for “free choice vouchers” but follows the same general principles.
116 ACA § 10108.
117 Ideally, employers looking to dump high-risk employees on to exchanges would offer supplemental payments only to high-risk employees for making this switch. Thus, an employer might offer the supplemental payment to any employee who incurred more than $50,000 in medical costs in the past year. However, this type of plan design would almost certainly violate HIPAA, as well as ACA’s own non-discrimination provisions.
An employer could ensure that these free choice vouchers were tax free to employees by establishing a “health reimbursement arrangement” (“HRA”).\textsuperscript{118} The HRA would provide each participating employee with a set contribution each year, which the employee could then apply to the purchase of individual health insurance in the exchange. The amount an employee received under the HRA could be excluded from her taxable income provided that the arrangement is solely employer-funded, reimburses the employee for qualifying medical expenses, is not made available to an employee for any other purpose, and the employee could not elect at any time to receive a distribution of the amount in cash.\textsuperscript{119} For purposes of an HRA, health insurance premiums are qualifying medical expenses.\textsuperscript{120} An employer could even set up a debit card program related to the account so that the employees would not have to pay the premiums themselves and then seek reimbursement, in order to relieve any cash flow problems that might result from such an arrangement.\textsuperscript{121} By utilizing an HRA, the employer can equalize the tax treatment of employer payments for group health plan participants and those who are being dumped.

Free choice vouchers provided through an HRA will mitigate, but not eliminate, the differential in cost between employer provided coverage and coverage through the exchange. Employees who seek coverage on the individual market would still face a tax disadvantage because they could not pay their share of the premium with tax-free dollars.\textsuperscript{122} However, an employer could potentially “gross up” such employees in order to compensate them for the loss of tax benefits. Such gross-ups would produce entirely new costs to an employer when an employee opts for coverage through the exchange.\textsuperscript{123} In many cases, though, a gross up will not be necessary: many high-risk individuals will presumably be willing to incur a tax penalty in order to acquire substantially more generous coverage.

\textsuperscript{118} Under section 10108 of ACA, free choice vouchers to qualifying employees do not count as taxable income. But the free choice vouchers described here would be paid to non-qualifying employees, and so would count as taxable income.

\textsuperscript{119} IRS Notice 2002-45.

\textsuperscript{120} Id.

\textsuperscript{121} See Rev. Rul. 2003-43.

\textsuperscript{122} For example, if the employee’s share of the premium is $1,000 per year, and the employee faces a combined federal income, state income, and payroll tax rate of 30%, paying the premium on an after-tax basis would cost the employee $300 more per year than paying on a pre-tax basis through an employer’s cafeteria plan.

\textsuperscript{123} The actual cost to an employer would vary significantly based on the income levels of its employees.
One additional consideration is that premiums for coverage within the exchange may be higher than premiums for the employer-provided plan precisely because the coverage in the exchange will be more generous. As above, an employer concerned that this cost-difference will discourage migration by high-risk employees can cover this price differential between employer coverage and exchange coverage by increasing the size of the free choice voucher. But in many cases, incurring this cost may not be necessary to induce high-risk employees to opt for exchange coverage, assuming that the exchange plan is substantially more valuable to the high-risk employee than the employer plan. Moreover, making the employer’s contribution via a free choice voucher more generous than the employer’s contribution to its own coverage carries with it the risk that low-risk employees will also opt to purchase individual policies.

In sum, employers can incorporate into their plan various measures that substantially mitigate the cost difference to employees of purchasing coverage in the exchange rather than purchasing employer provided coverage. These efforts may come with an increased cost if the employer chooses to gross-up the employee’s premium payment or increase employer contributions. For these reasons, an employer dumping strategy is only desirable if the cost savings from dumping an employee on to the exchange are larger, on average, than the costs of doing so. This, in turn, requires the employer’s plan to successfully produce sorting of different risks. In particular, if the employer’s plan proves relatively unattractive even to low-risk employees, then the employer runs a risk of inducing too many employees to purchase coverage through the exchange and shouldering increased cost as a result. But if the plan design is successful at sorting risks, very significant cost savings can be achieved.\textsuperscript{124}

\textbf{2. Benefit and Cost-Sharing Structure}

Having roughly leveled the cost-differential between employer provided coverage and exchange coverage, an employer seeking to dump high-risk employees must carefully design its benefits and cost-sharing structures to appeal to low-risk employees but not high-risk employees. To accomplish the former, the plan should provide generous benefits with no cost

\textsuperscript{124} As an extreme example, take the statistic that three-quarters of all medical expenditures are incurred by individuals with chronic conditions (Catherine Hoffman et. al, \textit{Persons with Chronic Conditions: Their Prevalence and Costs}, 276 JAMA 1473, 1477 fig. 1 (1996)). If an employer could successfully encourage all of its employees with chronic conditions to opt for coverage in the individual market instead of the group plan, the employer’s group plan could reduce its costs by 75%.
sharing for all medical expenses that a relatively healthy person might incur. ACA already requires full coverage for preventive services, but an employer might also provide full coverage with no cost sharing for services such as dermatology visits, wellness screenings, and sports-medicine related treatments. Similarly, it might provide full coverage for optometry expenses.

As discussed above, the more difficult, and more important, component of designing an employer dumping plan is to make the plan unattractive to high-risk insureds without scaring off low risk, but risk-averse, policyholders. Recall that participants in an employer’s plan may need to wait up to 12 months to switch into an individual plan in the exchange given the annual open enrollment period in exchanges. As such, a plan design that provided inadequate coverage for acute episodes would likely cause low risk, but risk averse, individuals to opt for coverage in the exchange, especially if such coverage were subsidized by the employer as described above. Employers who either increase their contribution or gross-up employee premium payments for those who participate in the exchange will need to minimize the number of non-high-risk employees who opt for exchange coverage in order to keep the tax burden manageable. As such, their plans must provide adequate coverage for acute health care expenses as well as for the initial stages of illnesses, but nonetheless provide quite limited care for large expenses that can be anticipated a year or more before they are incurred.

One way to meet these specifications is for the employer plan to include maximal levels of cost sharing requirements for all medical services that are associated with chronic conditions. Thus, the plan could require a high deductible with respect to hospitalization, surgery, drugs used for chronic conditions, and in-home medical equipment. The precise amount of the deductible would likely vary depending on the employee population and their average income level. From the perspective of a high-risk individual, of course, these cost sharing arrangements would be quite burdensome. At the same time, though, these cost-sharing arrangements should not be sufficient to cause low risk, but risk-averse, policyholders to opt for coverage in the exchange. This is because the maximum amount they would owe is capped, the likelihood of owing that amount is low (by assumption), and they

125 For individuals who participate in their employer’s medical plan through a cafeteria plan (i.e., individuals who pay premiums of a pre-tax basis), they would not be permitted to drop employer coverage mid-year absent a qualifying change of status. Having to pay for the employer plan when it is no longer useful is, however, a less significant issue than potentially not being able to obtain coverage on the exchange.

126 Recall that the ACA does cap cost sharing requirements even for self-insured plans.
will always be free to opt for coverage through the exchange if
their riskiness changes.

A second approach to designing an employer plan to
produce dumping of high-risk employees is simply to exclude
altogether care for conditions that can in most circumstances be
readily anticipated. There are numerous illnesses and diseases
wherein there is a substantial gap between diagnosis and illness.
For instance, HIV positive individuals often find out of their status
well before they develop full blown AIDS, especially if they
receive regular screening and preventative care. Moreover, the list
of diseases that can be reliably anticipated is only growing: for
instance, a recent report finds that Alzheimer’s can be predictably
diagnosed well before its onset.\footnote{See Gina Kolata, Spinal Fluid Test is Found to Predict Alzheimers, N.Y.
TIMES, Aug. 10, 2010, A1.} Similarly, many diseases are
degenerative, meaning that the affected tissues or organs
progressively deteriorate over time. Examples include
Huntington’s diseases, diabetes, Parkinson’s disease, inflammatory
bowel disease (IBD), Crohn’s disease, osteoarthritis, and
rheumatoid arthritis. Here too, there is often a substantial gap
between diagnosis and the time during which an afflicted person is
likely to incur substantial medical expenses.

Yet a third approach for an employer seeking to dump
high-risk individuals while not scaring off risk-averse low-risk
individuals is to exclude coverage for care that can easily be
postponed or that is usually only necessary in the latter stages of
chronic diseases or conditions. For instance, it might be possible
to exclude certain treatments, such as dialysis, that typically are
only needed in the later stages of kidney failure, caused by a wide
variety of diseases. Similarly, an employer plan might cover the
diagnosis of conditions such as autism, but specifically exclude
long-term treatment via behavioral therapy. Yet another example
is that the plan might exclude gastric-bypass surgery and other
forms of treatment that are “last-resort” options for a condition.

Employers who are less sensitive to the labor market
consequences of changing their health plan may be willing to
employ a more aggressive dumping strategy. In particular, they
may offer employees only the option of a health reimbursement
arrangement funded with an amount equal to the employer’s
typical employee contribution to the group health plan and design
their plans with larger gaps in coverage that may indeed scare
away some risk-averse employees. For instance, such employers
may refuse to cover various essential health benefits at all, such as
hospitalization, non-preventive lab and blood work, or pharmacy
costs. Taking this approach will likely cause many of their low
risk, but risk averse, employees to opt out of employee coverage.
But this prospect is much less troubling to an employer who chooses not to absorb any increased costs such as a higher employer contribution of premium gross-ups. And so long as the group of workers who migrate to the exchange are less healthy on average than those who do not, the employer will come out ahead if the labor market consequences of that decision are not significant.

Ultimately, motivated employers will enjoy tremendous discretion in seeking to develop a specific benefit plan that carves out expensive long-term treatments and conditions without jeopardizing the financial security or health of low-risk individuals who unexpectedly develop medical needs during the year. Indeed, employers will have several years, copious data, and various sophisticated intermediaries studying this issue to help them develop such a plan, if they so desire.

3. Limited Provider Networks

Another important facet of plan design that is available to an employer seeking to dump high-risk employees is its provider network. Unlike plan benefits and cost sharing, ACA imposes virtually no restrictions on an employer’s network of providers. Consequently, motivated employers will have substantial freedom to select providers who appeal to low-risk employees but not to high-risk employees. Once again, there are multiple different ways in which an employer could accomplish this. Perhaps the best option is for the employer to maintain a wide-open network of primary care doctors and dermatologists and other providers who do not specialize in treating those with chronic conditions. It might contract with providers with short wait times, attractive offices, and strong customer service, or even with concierge-type practices. At the same time, it could maintain a tightly controlled network of providers when it comes to surgeons, oncologists, nephrologists and similar types of doctors.

It is possible that risk-averse employees might be driven to purchase coverage in the exchange by a restricted network of specialist doctors, given the risk that they might become high risk and need to wait up to 12 months to switch into the exchange. If so, the employer can simply place large cost-sharing requirements on provider visits outside of the network. However, because ACA imposes aggregate cost-sharing limits even on self-insured plans, and cost-sharing limits may be an important facet of benefit design as described above, the employer instead simply might make it

128 See supra Part I.B.3.b.
inconvenient and difficult to see out-of-network providers. For instance, it might require pre-approval from a primary care physician, or it might insist upon a referral from its own in-network specialist. It might also place a cap on the number of times a policyholder can permissibly see an out-of-network specialist, although it is conceivable (but unlikely) that such a cap could be characterized as an aggregate or lifetime limit.

4. Wellness Programs

Employers seeking to induce high-risk employees to seek coverage through the exchange will have various opportunities to exploit wellness programs to reduce the cost of coverage for low-risk employees (and, correspondingly, to increase it for high-risk employees). Recall that ACA permits two types of employer wellness programs. First it permits all programs that are not tied to a health related status. Although not specifically tied to health related status, these types of programs may be disproportionately utilized by employees who are relatively low risk and thus help facilitate indirect risk classification. For instance, gym memberships are likely to be utilized more by relatively healthy employees. As a result, a wellness program that offers premium discounts for gym usage may disproportionately appeal to low-risk employees.

Second, ACA also permits, under more limited conditions, wellness programs that are explicitly linked to health related factors. The prospect that employers might exploit these types of programs to differentially benefit low-risk employees is self-evident. An employer might, for example, offer a wellness reward for obtaining a cholesterol level below average, or for maintaining a healthy weight. However, ACA’s attempts to limit this usage of wellness programs are not particularly likely to be effective. In particular, although the statute prohibits the usage of such programs when they are “a subterfuge for discriminating based on a health status factor,” this provision seems almost impossible to apply in practice. The core problem is that in order to incentivize healthy living, a wellness program must provide benefits only to those who are, in fact, healthier. Thus, while there is certainly risk to an employer that seeks to implement a wellness program based on health related status, this risk ultimately seems limited.

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131 See supra Part I.B.3.c.
132 ACA §1201 (adding § 2705(j) to the PHSA).
133 Id.
5. Other Employer Signals

To these rather explicit design features could be added the more subtle informal pressure that an employer could place on its high-risk employees to avail themselves of the option to purchase coverage on the exchange. There might well be little reason for the employer not to be explicit with its employees about its plan. The employer could explain that it offers the best coverage around when it comes to routine care and episodic emergency care. At the same time, because it knows that its coverage is not suitable for those with chronic or persistent conditions, it subsidizes the costs of purchasing individual coverage. Moreover, the employer might go so far as to explain to employees that it is in their collective self-interest for those with chronic or persistent conditions to opt for coverage through the exchange. Doing so costs high-risk employees no more that they would otherwise pay, provides them with more appropriate coverage, and helps keep costs low and salaries high.

None of this informal messaging would violate either ACA itself or pre-ACA law. In explaining the relative costs and benefits of employer provided coverage and coverage through the exchanges, the employer is not in any way discriminating among its employees. Rather, the employer is simply presenting employees with relevant information about an important choice. As a result, explaining the reasons behind the structure of the employer plan and the availability of the supplemental payment does not seem legally problematic.

III. Scope, Implications, and Solutions

Parts I and II laid out both the legality of employer dumping and the various strategies that employers might use to accomplish such dumping. This Part considers the implications of employer dumping as well as various potential solutions to the problem. Section A begins by considering the extent to which employers will ultimately find a dumping strategy preferable to either dropping coverage altogether or providing comprehensive coverage. Although predicting employer behavior is an inherently speculative enterprise, it argues that there is a substantial risk that many employers will be drawn to some version of the dumping

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134 Employers could choose to offer the supplemental payment for anyone that declines enrollment in the group health plan, but it would seem more likely that an employer would want to ensure that the employee has some other form of health insurance coverage because of the positive association between such coverage and work attendance and performance.
strategies described in Part II. It argues that such wide-spread employer dumping could imperil the future of health care reform by undermining the sustainability of individual insurance markets and insurance exchanges. Section B concludes by exploring both regulatory and statutory solutions to the problem of employer dumping.

A. Implications and the Magnitude of Employers’ Incentives to Dump

Any amount of employer dumping of high-risk employees poses a public policy problem for health insurance reform. Employers who dump high-risk employees strike directly at the spirit of health care reform, which embraces social solidarity in the sharing of medical risks. Not only is employer dumping of high-risk employees fundamentally unfair, but it risks undermining the willingness of the general population to embrace the notion that all must contribute their fair share to paying for our country’s sick and elderly population. Indeed, a robust psychological literature suggests that peoples’ willingness to cooperate with legal rules that require sacrifice crucially depends on the degree to which they perceive others to do the same. In other words, to the extent that some actors are perceived to “cheat” the system, others are less likely to play by the rules themselves.

Unfortunately, the risks associated with employer dumping are not limited to unfairness or counterproductive norm-development. Much to the contrary, employer dumping also jeopardizes the economic viability of health care reform writ large by threatening the individual insurance markets and exchanges that ACA establishes to organize these markets. If employers dump disproportionately high-risk employees on to individual markets, then premiums for all policyholders will rise to reflect the worse-than-average risk pool. Such adverse selection will not only increase premiums, but will decrease coverage rates, both by making coverage less affordable and by exempting a greater percentage of the population from the individual mandate. Individuals would not bear the burden of these rate increases alone. So too would the federal government, whose statutory obligations to subsidize health insurance premiums increases in lock step with

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135 One relevant literature in this respect concerns various social dilemma games, such as the ultimatum game, which consistently find that people are conditional cooperators: “They are willing to cooperate, but their continuing cooperation depends on what others are doing, the intentions of others, and how well others are doing (for better or worse) relative to themselves.” See generally Mark F. Schultz, Fear and Norms and Rock & Roll: What Jambands Can Teach Us About Persuading People to Obey Copyright Law, 21 BERKELEY TECH. L.J. 651 (2006).
increases in overall premiums. These risks can be contrasted with those associated with employers dropping coverage altogether: such a result would not adversely impact exchanges or the individual market, as it would not alter the composition of the risk pool in these markets.

The threat of adverse selection driven by employer dumping depends entirely on the number of employers who pursue a dumping strategy and the size of these employers. If only a few small employers utilize a dumping strategy, then the amount of adverse selection that will result will likely be trivial. By contrast, if a dumping strategy becomes prevalent among large employers, then the adverse selection that could result would be catastrophic. As such, the remainder of this Section analyzes how prevalent dumping is likely to be among employers, and which employers are most likely to be attracted to such a strategy. Although predicting the future is always a dangerous enterprise, the Section argues that there is a real risk that employers generally, and large employers in particular, are likely to find a dumping strategy appealing in 2014.

1. Employers’ Pre-ACA Incentive to Offer Generous Coverage

Historically, employers have had strong incentives to design robust health insurance plans that provide generous coverage to all of their employees. There are several interwoven explanations for this fact. First, prior to the ACA most individual health insurance markets failed to offer a desirable source of health insurance, especially for high-risk individuals. If an employer were to pursue a dumping strategy in this environment, high-risk employees would find coverage on the individual market to be largely unavailable or exorbitantly priced. Not only would this harm high-risk employees, but it would leave low-risk employees subject to substantial risk. In the pre-ACA world, once a person became sick, their options for coverage changed dramatically.

As a result, employers who offered limited coverage in the pre-ACA world would risk experiencing substantial labor market costs as a result. Employers compete for labor in a competitive marketplace and employees historically weighed health insurance benefits heavily in their labor market decisions precisely because their options in the individual market have historically been quite poor. Unlike insurance policyholders in many markets, employees are likely to have a relatively easier time assessing the quality of their health insurance coverage as they interact with other policyholders (i.e. co-workers) on a consistent basis and are often

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136 See ACA § 1401.
quite familiar with their insurance experiences.\textsuperscript{137} These labor market effects may be exacerbated by the fact that the individuals who are most likely to be high-risk may also be disproportionately senior employees – precisely those most valuable to an organization. In competing for senior talent, employers would be hesitant to take action that put them at a disadvantage compared to their competitors.

The federal tax code further reinforced the tendency of employers to offer generous coverage. As previously mentioned,\textsuperscript{138} the federal tax code permits both employer and employee contributions toward employer-provided health care to be excluded from federal income and payroll taxes. The tax exemption makes such benefits more valuable than an equal amount of cash compensation (which of course is taxable) and this is thought to lead to employers offering plans with generous benefits and low out-of-pocket payments.\textsuperscript{139} Together with the labor market benefits, the tax benefits associated with employer-provided coverage lead many employers to not only offer health benefits, but also to offer generous coverage and a high-level of employer subsidy for such benefits.

2. Employers’ Incentive to Dump in the Post-ACA World

Starting in 2014, when most of ACA’s key provisions become effective, employers’ incentives will shift dramatically. Many employers in the post-ACA world are likely to have an incentive to dump employees in the ways described in Part II. A key reason why is that a dumping plan that met the parameters described in Part II would not harm high-risk employees or subject low-risk employees to meaningful risk. Although high-risk employees would find employer-provided coverage undesirable (by design), they would have various attractive, affordable options for comprehensive coverage in the exchange. Low-risk employees, by contrast, would in many ways enjoy better coverage than they otherwise would under an ordinary employer plan. This is because the employer dumping strategy will include various bells and whistles designed to appeal to low risks. Yet it will simultaneously provide sufficient coverage to provide them with security during the time it will take to transition to exchange coverage if they do become high risk.

\textsuperscript{137} The difficulty that individuals have in assessing the quality of coverage in property/casualty markets is explored in Daniel Schwarez, \textit{Regulating Insurance Sales or Selling Insurance Regulation}, 94 MINN. L. REV. 1707 (2010.).

\textsuperscript{138} See supra Part I.B.1.

\textsuperscript{139} See Amy B. Monahan, \textit{The Promise and Peril of Ownership Society Health Care Policy}, 80 TUL. L. REV. 777, 782-86.
At the same time, employers who design their plans to induce dumping of high-risk employees will experience decreased health insurance costs for two independent reasons. First, the costs of funding their employees’ health insurance should decrease dramatically to the extent that high-risk employees opt out of employer-provided coverage. Indeed, it is well known that a substantial percentage of health care costs are attributable to a small fraction of the insured population: 2% of the American population is responsible for over 40% of medical expenditures and 10% of the population account for 69% of its costs. While some of these expenses are the result of sudden and accidental events that are not predictable ex ante, many are not: indeed, 60 – 75% of health expenditures are associated with people with chronic medical conditions. These numbers suggest that even if employer dumping works imperfectly, with some high-risk employees retaining coverage and some low risk employees purchasing coverage in the exchange, an employer can generate substantial cost-savings from a dumping strategy.

Second, an employer dumping strategy should independently decrease the costs of providing health care to employees because it will contain more gaps in coverage than traditional employer plans. As described above, a key feature of dumping strategies is that they provide relatively limited coverage for those with long-term chronic conditions in order to induce high-risks to opt into the individual market. Although the employer plan will likely need to be abnormally generous in other respects in order to retain low-risk individuals, the extent to which chronic conditions drive health care costs makes it clear that the cost-savings from gaps in coverage will outweigh the increased costs of generous coverage for low risks.

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140 See Thomas Rice, The Economics of Health Reconsidered at 95-96 (1998); Karen Davis, Consumer-Direct Health Care: Will It Improve Health System Performance?, 39 Health Services Res. 1219, 1223 (2004). At the other end of the spectrum, 50% of individuals account for only 3% of health care outlays, all with expenditures under $350 (data from 1997). Id.

141 Alain C. Enthoven, Employment-Based Health Insurance is Failing: Now What?, Health Affairs, May 28, 2003 at 238. See also Catherine Hoffman, Dorothy Rice & Hai-Yen Sung, Persons with Chronic Conditions: Their Prevalence and Costs, 276 JAMA 1473, 1477 fig. 1 (1996) (Individuals with chronic conditions account for three-quarters of all medical expenditures). Analysis of the 1998 MEPS data shows that almost four in five health care dollars (78%) are spent on behalf of people with chronic conditions. Gerard Anderson & Jane Horvath, The Growing Burden of Chronic Disease in America, 119 Public Health Reports 263, 264 (2004). People with chronic conditions are the heaviest utilizers of medical care: 96% of home health, 88% of prescriptions, 72% of physician visits, and 76% of inpatient hospital stays are attributed to people with chronic conditions. Id. fig. 1. Most of the utilization is by people with two or more chronic conditions: 80% of home health, 67% of prescriptions, 48% of physician visits, and 56% of inpatient stays. Id.
Figure 1 below illustrates how the basic money flows in the status quo and under an employer dumping strategy would work.

**Figure 1: Cash Flows under Status Quo versus Employer Dumping**

**Status Quo**

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Employer <-> Low-Risk Employees <-> $\downarrow$ $\rightarrow$ High-Risk Employees

Employer $\leftarrow$ $\rightarrow$ $\rightarrow$ $\rightarrow$ $\rightarrow$
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**Employer Dumping**

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Employer $\leftarrow$ $\rightarrow$ Low-Risk Employees $\rightarrow$ $\rightarrow$ $\rightarrow$ $\rightarrow$ Individual Insurance Purchasers

Employer $\rightarrow$ $\rightarrow$ $\rightarrow$ $\rightarrow$ High-Risk Employees $\rightarrow$ $\rightarrow$ $\rightarrow$ $\rightarrow$
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The funds that a dumping strategy can generate should benefit not only employers who dump high-risk employees, but also the employees themselves. Of course, low-risk employees would be able to pay premiums for their coverage that disproportionately reflect a low risk pool, contrary to the central aim of ACA. But employees more generally – including high-risk employees – would likely benefit from the decreased costs to employers or paying for health care. This is because most economists agree that health care costs are simply part of employees’ total compensation, and thus that decreased health insurance costs will translate into increased salaries.\textsuperscript{142}

These benefits of dumping are likely to make it a more attractive option for many employers than opting to simply get out of the health care business entirely.\textsuperscript{143} First, employers with fifty or more employees who dropped coverage altogether might owe a substantial tax as a result of the employer mandate.\textsuperscript{144} By contrast, as described above, employers who dump high-risk employees can entirely avoid any tax penalty as a result. Second, a dumping strategy provides low-risk employees with an attractive, cheap way to satisfy the individual mandate by allowing them to

\textsuperscript{142} See Lawrence Summers, Some Simple Economics of Mandated Health Benefits, 79 AM. ECON. REV. 177 (1989).
\textsuperscript{143} See Hyman, supra note 5.
\textsuperscript{144} See ACA § 1513 (adding 4980H to the I.R.C.).
avoid cross-subsidizing high-risk individuals.\footnote{See supra Figure 1.} In that sense, a dumping strategy allows employers to effectively provide additional income to low-risk employees that is actually paid by the public at large rather than the employer.

Nor is the attractiveness of a dumping strategy likely to substantially diminish over time. Widespread and persistent dumping might well cause substantial adverse selection in the individual markets. This, in turn, might cause employers who dump to suffer the same labor market repercussions that existed prior to ACA. But this is unlikely. Even in the event of substantial adverse selection from widespread employer dumping, employers would still be likely to reap a financial benefit by dumping high-risk employees onto the exchange. The basic attraction of dumping stems from the fact that it causes the general insured population to cross-subsidize the costs of the employer’s high-risk employees. As such, so long as there is a minimum level of participation in the individual market by low and average risk individuals, there will still be benefits of dumping.\footnote{Assume, for example, that a high-risk individual has projected annual medical expenditures of $20,000. As long as the premiums in the individual market are below $20,000 (which they should be with decent participation levels by non-high-risk individuals), the employer stands to gain by dumping even if the employer pays the full cost associated with exchange coverage.} Because the individual market will be subsidized for individuals with household incomes below 400% of the federal poverty limit, there is reason to believe that it will retain enough low and average risk individuals in the long run to at least partially subsidize even a substantial number of high-risk individuals who are dumped by employers into the exchange. In this sense, it is not subsidized individuals that will feel the negative effects of dumping, but rather the federal government who will bear the cost of rising premiums. This also means that the market equilibrium is unlikely to return to its pre-ACA state with significant labor market consequences associated with failing to provide comprehensive coverage for high-risk individuals.

To be sure, a dumping strategy may also carry with it various costs. First, an employer who dumped its high-risk employees onto an exchange might risk reputational harm from media scrutiny. After all, it is not uncommon for companies, particularly large companies, to receive negative press regarding sub-standard health insurance practices.\footnote{See, e.g., Michael Barbaro, Wal-Mart’s Detractors Come in from the Cold, N.Y. TIMES, June 5, 2008, at C1.} An employer who pursued a dumping strategy could be characterized as avoiding its “fair share” and harming the general public by dumping its high-risk employees for others to cross-subsidize. The magnitude of
this reputational risk is difficult to quantify. However, it may not be easy for the general public to identify employers who pursue a dumping strategy. At the very least, a dumping strategy is likely to appear less devious to an average citizen than entirely eliminating coverage: after all, an employer that pursues the dumping plans we describe in Point II will still offer many of its employees coverage, and the dynamics that make dumping so pernicious are not exactly easy to explain.

Second, an employer that dumped its high-risk employees may risk generating negative employee sentiment. Although a properly designed dumping strategy should not in fact harm either low risk or high-risk employees, it is possible that employees will nonetheless view the plan in a negative light. This is an especially large risk to the extent that high-risk employees do not opt for coverage on the exchange and are then denied coverage under the employer plan. Moreover, even if employees do sort themselves appropriately, they may view their employer’s efforts to shuttle high-risk employees into the individual market as an indication that their employer does not “care” about the health burdens of its employees.  

Third, an employer looking to implement a dumping strategy would need to incur various administrative expenses. For instance, it would need to pay for stop loss insurance and for the costs of setting up a self-insured plan. It would need to administer a program for providing pseudo free choice vouchers through HRAs to employees who opt for coverage on the exchange. And it would likely need to employ a sophisticated employee benefits consultant to monitor the effectiveness of its dumping strategy and adjust its plan according to its employees’ particular characteristics and risk preferences.

Different employers will obviously weigh these costs differently. Many small employers, for instance, are likely to find the administrative costs of implementing a dumping strategy to be substantial. At the same time, the benefits of dumping may be reduced for small employers. Such employers are exempt from the

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148 There is evidence that many employers provide health care coverage because “it is the right thing to do.” See, e.g., Paul Fronstin, Small Employers and Health Benefits: Findings From the 2002 Small Employer Health Benefits Survey, EBRI ISSUE BRIEF, January 2003 at 7, fig. 6 (77% of small employers survey in 2002 reported “it is the right thing to do” as a major reason for offering a health plan). At the same time, employers routinely make changes that negatively impact employee health care coverage. See, e.g., KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS, supra note 56, at 186, exh. 13.2 (listing various changes surveyed employers would consider making to their health plan in the next year; for example, 40% of respondents indicated that they were somewhat likely or very likely to increase the amount employees pay for copays or coinsurance.).
employer mandate (if they have fewer than fifty employees). Additionally, a small employers’ pool of employees may not be large or diverse enough to make the benefits of a dumping strategy compelling. For example, if a small employer has 25 employees, all of whom are in excellent health with no known risk factors, dumping would offer no benefit. Alternatively, an employer with 40 employees, 4 of whom are high risk, may have difficulty designing a dumping strategy that effectively targets those four high-risk employees.

Large employers that employ relatively unskilled labor and do not have substantial reputational capital are particularly likely to be drawn to a dumping strategy. Most large employers already self-insure their group health plans, and therefore would not face start-up costs that are as high as non-self-insuring employers. Additionally, large employers should have an easier time successfully segregating low from high risks due to the size of their risk pool. These employers also face the greatest potential penalty under the employer mandate if they were to simply drop employer coverage.

If a small number of employers successfully adopted a dumping strategy, it is possible that many other employers would follow suit. Some of the specific details of a dumping strategy – such as precisely how large the free choice voucher must be, or exactly which coverages can be safely eliminated without harming low-risk employees – may take time to work out. Employers who follow the lead of others may enjoy decreased costs in experimenting with these variables simply by mimicking the efforts of others. Moreover, the reputational and labor market consequences of dumping high-risk employees are likely to diminish to the degree that such a strategy becomes widespread. As more and more employers follow the dumping trend, a critical mass may be reached where the employer norm “tips” in favor of dumping.

B. Solutions

149 Kaiser Family Found. & Health Research & Educ. Trust, supra 56, at 157, exh. 10.1
150 The penalty is $2,000 per employee, except that the first 30 employees do not incur a penalty. Therefore, while an employee with 100 employees would only face a penalty of $140,000, an employer with 100,000 employees would face a penalty of $199.9m.
151 See, e.g., Cass R. Sunstein, Deliberative Trouble? Why Groups Go to Extremes, 110 Yale L. J. 71, 77 (“People frequently think and do what they think and do because of what they think relevant others think and do.”).
152 See id. at 82.
Given the ease with which employers could structure plans to encourage high-risk employees to opt for individual coverage, and the serious consequences such strategies could have for health care reform generally, it is imperative for lawmakers to preemptively respond to the prospect of employer dumping. Although the most effective responses to the problem of employer dumping are statutory, several regulatory efforts may at least mitigate the scale of the underlying problem.

1. Regulatory Solutions

ACA delegates substantial discretion to various agencies, most notably Health and Human Services, to interpret and enforce its provisions. Given the substantial stake and responsibility that federal agencies have in implementing health care reform effectively, they are in an ideal position to counteract the prospect of employer dumping of high-risk employees. Unfortunately, the best options for limiting the risk of dumping are likely “manifestly contrary to the statute.” Nonetheless, regulators may have some discretion to, at the very least, make employer dumping less economically attractive.

One potential way for regulators to limit the desirability of employer dumping is for them to issue regulations specifying that self-insured plans do not automatically constitute “eligible employer plans” that satisfy the individual mandate. Recall that the statute appears to contemplate the opposite result, providing both that (i) “eligible employer-sponsored coverage” constitutes “minimum essential coverage” and that (ii) “eligible employer-sponsored coverage” includes a “group health plan.” And both interim regulations, as well as the statute itself, make absolutely clear that a group health plan includes a self-insured employer plan.

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153 Chevron USA, Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837, 843-44 (1984). The next section describes various statutory fixes that would clearly prohibit employer dumping. But each of these appear to be beyond the authority of regulators. For example, one possible way to prevent dumping would be to subject self-insured plans to the requirement to provide essential health benefits. Yet the statute is clear that the term “health plan” will not, except as specifically provided, include self-insured plans. ACA § 1301(b)(1)(B). and is similarly clear that “health insurance issuer” does not apply to such plans. ACA § 2715(d)(3)(A) (Defining a health insurance issuer to include “group health plans (other than self-insured plans)”)

154 See Section II.A., supra (explaining ACA § 1501(b) (adding § 5000A to the I.R.C.)).

155 See id.
However, the statute itself actually employs the following definition:

The term ‘eligible employer-sponsored plan’ means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is— (A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or (B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.

This provision can be construed such that requirements (A) and (B) modify both the term “group health insurance coverage” and the term “group health coverage.” Under that construction, group health plans, including self-insured plans, would only constitute an “eligible employer sponsored plan” if they constituted “any other plan or coverage offered in the small or large group market within a State.” Yet this suggests that self-insured plans do not constitute an “eligible employer plan” because ACA defines the small and large group markets in a way that seems clearly to exclude self-insured plans.

Because this interpretation is textually plausible, a court might be willing to defer to regulatory guidance on this issue. Some courts might only permit a regulator to adopt one of these two plausible interpretations, but other courts might permit regulators to adopt a compromise approach that is not clearly contemplated within the statute. One such compromise would be to define a group health plan as constituting an “eligible employer-sponsored health plan” only if it is not designed to produce dumping of high-risk employees. Under this reading, an

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157 2791(e)(2) and 2791(e)(5) of the PHSA.


employer who attempted to dump its high-risk employees would find that its low risk employees were not in compliance with the individual mandate. This, in turn, would largely undermine the employers’ capacity to dump high-risk employees by changing the labor market impact of any such strategy.

A second conceivable regulatory strategy would require the IRS to amend its rulings on Health Reimbursement Arrangements to exclude arrangements that finance individual insurance purchase where a group health plan is also offered. If successful, this would eliminate the ability of employers to offer free choice vouchers on a tax-advantaged basis and therefore increase the costs associated with a dumping strategy. However, once again there does not seem to be a statutory basis for such a distinction. It might be reasonable to interpret the statute to prohibit any health reimbursement arrangements, but reasonably distinguishing between dumping and non-dumping scenarios seems very difficult to accomplish in this context.

Yet a third potential regulatory strategy would be for the EEOC to issue new guidance surrounding disability-based distinctions in health plans that are designed to accomplish employer dumping. Recall that disability-based distinctions run afoul of the ADA only if they are a “subterfuge” to intentionally violate the ADA, which is in turn defined to mean that it is not justified by the costs associated with the disability. The EEOC could further define a “subterfuge” to encompass schemes that attempt to dump those with specified disabilities onto individual insurance markets. Of course, doing this could have broad implications for all employer-based health plans, even those that are not actively pursuing dumping strategies. Moreover, this regulatory solution would merely limit only one element of a motivated employer’s dumping strategy: it would not solve the underlying problem.

2. Statutory Solutions

There are various potential statutory changes that offer solutions to the problem of dumping. The advantages and disadvantages of each are discussed briefly below.

a. Prohibit Employees with Access to Affordable Coverage from Enrolling in the Exchange or Other Individual Coverage

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160 See Section II.B., supra.
161 See Section I.B., supra.
Perhaps the simplest solution to the problem of employer
dumping is to make employees with access to affordable
employer-provided coverage ineligible for the exchange. Indeed,
such a provision was apparently included in earlier versions of
ACA.\textsuperscript{162} Moreover, this is the operable rule in Massachusetts’s
version of health care reform.\textsuperscript{163} Making coverage through the
exchange unavailable to employees with the option of affordable
employer coverage would largely eliminate the incentive that
employers would have to dump high-risk employees, as they
would not have many viable alternatives to employer coverage. As
a result, labor market forces would likely dissuade employers from
adopting this strategy, just as they have in the past.

The one limitation of this option is that ACA does preserve
the possibility of an individual insurance market outside of state-
run exchanges. It is therefore possible that employers might still
seek to dump high-risk employees onto non-exchange individual
markets, which are subject to nearly all of ACA’s prohibitions on
direct and indirect risk classification. Alternatively, ACA could be
amended to provide that individuals with access to affordable
employer-provided coverage cannot purchase individual coverage
at all, whether within or outside of the exchange. While doing so
would solve the problem of employer dumping, this solution
significantly interferes with an individual’s choice of health
insurance. Setting aside the potential problem of employer
dumping, there may be very good reasons why an individual might
prefer individual coverage to that offered by her employer, and we
should be reluctant to interfere with that choice.

\textit{b. Imose Limited Pre-existing Condition Limitations}

Another potential solution to the employer-dumping
problem is to amend ACA to reintroduce the ability of insurers to
impose pre-existing condition limitations for individuals with
access to employer-provided coverage. This option would permit
insurance companies in individual markets to deny coverage for
pre-existing conditions where the individual had access to
affordable employer-provided coverage, but would continue to
prohibit any pre-existing condition limitations within the employer
plan. In other words, if an employee with a chronic condition such
as diabetes was offered affordable employer coverage and
nevertheless sought coverage of the individual market, the insurers
in the individual market would be permitted to exclude coverage

\textsuperscript{162} See text of note 92, \textit{supra}.
\textsuperscript{163} See \textit{An Act Providing Access to Affordable, Quality, Accountable Health
Care, 2006 Mass. Acts Ch. 58} (codified as amended in scattered sections of the
Massachusetts General Laws).
for the treatment of diabetes. This solution once again takes away the viable coverage alternative for high-risk employees and should eliminate the primary motivation for employer dumping. It has the added advantage of continuing to preserve individual choice in most circumstances. However, it also has the potential to jeopardize the health coverage of individuals with chronic health conditions. For example, if the individual’s employer simply elects to offer a bare bones plan (not necessarily a plan designed to dump high-risk employees, but simply a plan that is not very generous), the individual with diabetes would not have a viable coverage alternative in the individual market because insurers could exclude coverage for the individual’s primary medical concern.

c. Enact an Anti-Dumping Provision Applicable to Employers Dumping into the Individual Market

As described above, ACA already contains broad anti-dumping standards applicable to employers who dump high-risk individuals into certain high-risk pools. These rules could be duplicated in the individual market in order to deter employer dumping. The difficulty in this approach would lie in crafting a rule that is clear and certain. ACA’s current anti-dumping rules, which apply only to dumping into the high-risk pool, prohibit the use of monetary or other financial incentives for disenrolling in employer coverage, but delegate to the Secretary of HHS the responsibility for developing and enforcing this provision. Depending on its content, a similar rule might be unattractive in the broader context of potential dumping into the individual market, as there may be legitimate reasons for employers to offer free choice vouchers to all their employees. Moreover, any rule that was contingent on the risk profiles of those individuals who enrolled in individual plans instead of the employer plan might unfairly penalize employers who lacked a motive to dump.

d. Enact Tougher Employer Penalties

The employer penalty provisions in ACA are relatively weak. Most important for present purposes, they only result in a monetary penalty where an employee receives a premium tax credit through the exchange. It is for this reason that an employer can dump its high-risk employees on to the exchange without risking the prospect of paying increased taxes as a result. Enacting tougher or broader employer penalties could help to discourage employer dumping. For example, making the penalty apply to any employee who receives coverage through the exchange, regardless
of his or her income level, would significantly change an employer’s calculus regarding health care benefits. Under such a system, an employer would have a direct incentive to ensure that all employees elected coverage under the employer plan. But the penalty would also have to be sufficiently high per employee to outweigh any financial benefit that may continue to accrue to an employer as a result of dumping a high-risk individual. For example, if individuals with diabetes cost the plan on average $15,000 per year in medical costs, paying a $5,000 penalty plus a $2,000 “supplemental” payment to the individual to subsidize exchange-based coverage may remain attractive. The advantage of amending the employer penalty is that it still preserves individual choice, while changing an employer’s incentive to dump. The difficult of this approach would lie in determining the optimal employer penalty amount and the precise circumstances in which it would apply.

**e. Require All Employer Plans to Offer Essential Health Benefits**

The potential for employer dumping depends in large part on the ability of self-insured plans to cover a limited range of benefits and to vary cost-sharing requirements for different types of benefits. Taking away these freedoms for self-insured plans by regulating them in the same manner as insured plans would thus reduce the prospect of employer dumping.\(^{164}\) After all, a self-insured plan that must cover essential health benefits on the same terms as all other insured plans no longer has the same ability to woo low-risk individuals. Although the plan could still employ other strategies to achieve this result – such as utilizing a limited provider network – it is unclear how effective such a strategy would be on its own at effectively separating high-risk and low-risk employees. Of course, the biggest downside of this approach is that it would likely increase the possibility that an employer would choose to abandon providing any coverage at all. But this may ultimately be a better outcome than large-scale employer dumping of high-risk employees.

**Conclusion**

The primary goal of ACA is to increase dramatically the number of individuals who have health insurance coverage, while

\(^{164}\) Doing so would have additional benefits as well. For a detailed discussion of the arguments in favor of removing the disparate treatment of self-insured plans, see Monahan, *supra* note 61.
preserving the existing system of employment-based coverage for the non-elderly. Achieving this goal is anything but simple, as illustrated in the complex, over two thousand page legislation that puts such change in motion. This Article has identified an important, unintended, and as-yet unnoticed effect of ACA, that employers will, for the first time, have a very strong incentive and ability to design their plans to discourage enrollment by high-risk employees. By doing so, employers and employees will benefit while individual purchasers and the federal government will suffer the consequences. In order to help achieve the goals of health care reform, Congress should act to quickly to eliminate the potential for employer dumping.