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ABSTRACT: Health care reform devotes substantial attention to resuscitating the small group health insurance markets that serve employers with fewer than fifty full time employees. Unfortunately, a number of interweaving provisions embedded within the Affordable Care Act create strong incentives that, starting in 2014, will tend to undermine this market and, in the process, increase the fiscal cost of reform. First, small employers with predominantly low-income employees will tend to opt out of the small group market. Second, small employers with mixed-income employees will have strong incentives to offer coverage that is neither technically “affordable” or of “minimum value” in order to preserve the availability of premium and cost-sharing subsidies on the individual market for their low-income employees. Third, small employers with unusually low-risk employees will have strong incentives to self-insure any group plan they do offer in order to avoid cross-subsidizing higher-risk groups. Analyzing these risks collectively, this Article offers a number of recommendations for saving the small group market. For instance, it argues that the SHOP exchanges that are intended to organize the small group market in 2014 must strategically target the weaknesses of self-insurance by offering simple and risk-free coverage options that facilitate employee choice. They must also market this coverage aggressively in light of insurance brokers’ likely financial incentives to push self-insurance on small employers. Additionally, state and federal lawmakers should explore various possibilities for making small employers both more likely to offer group coverage and, if they do offer group coverage, to do so through SHOP exchanges rather than self-insured plans. Possibilities explored by this Article include amending the terms of the premium and small business tax credits, regulating stop-loss insurance, and imposing various restrictions or penalties that are aimed at preventing churning between the self-insured and small group markets.

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Private health insurance is sold in three distinct markets: large group, small group, and individual. Traditionally, the large group market has operated well, allowing virtually all large employers to offer reasonable coverage to their employees. By contrast, the individual market has proven disastrous in most states, resulting in innumerable difficulties for people seeking to purchase health insurance directly from insurers. The small group market, which serves employers with fewer than fifty full-time employees, has long been situated between these two polar extremes: it both suffers some of the difficulties of the individual market while enjoying some of the advantages of the large group market.

Faced with this tripartite division, the Affordable Care Act (ACA) adopts an intermediate approach towards reforming the small group market. On one hand, the ACA subjects the small group market to many of the same new insurance rules that it applies to the individual market, including requiring the provision of “essential health benefits,” limiting permissible medical underwriting to age and smoking status, and instituting minimum medical loss ratios. It also requires the establishment of SHOP exchanges to help organize the small group market, just as it does in the individual market. On the other hand, though, the ACA preserves small employers’ freedom not to offer coverage, provides more limited new subsidies to support SHOP exchanges than it provides for individual exchanges, and leaves small employers free to “self-insure” in order to avoid many of the regulatory requirements that they would otherwise face.

This Article argues that this mixed approach to regulating the small group market will subject it to substantial instability starting in 2014, when many of the ACA’s most important reforms become effective. First, the ACA’s reforms are likely to encourage many small employers with predominantly low-income employees to opt out of the small group market, despite small business tax credits that were explicitly designed as an incentive for these firms to both offer and subsidize group coverage. This is a result of the ACA’s intertwined regulation of the individual and small group markets, which will actually make low-income employees of

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1 See KENNETH ABRAHAM & DANIEL SCHWARCZ, HEALTH INSURANCE SUPPLEMENT TO ABRAHAM’S INSURANCE LAW AND REGULATION 3 (2012).
2 See David A. Hyman & Mark Hall, Two Cheers for Employment-Based Health Insurance, 2 YALE J. HEALTH POL’Y L. & ETHICS 23, 30 (2001).
5 See ACA §§1001, 1201, & 1302.
6 Id. § 1311.
7 See Part I, infra.
8 See Part II.A, infra.
small employers worse off if they are offered affordable employer coverage that provides “minimum value.” By virtue of being offered such coverage, low-income employees will become ineligible for very substantial premium and cost-sharing subsidies on the individual market that dwarf the tax benefits they would receive from employer-sponsored coverage. This incentive for certain small employers not to offer coverage to low-income employees is unprecedented, and is a largely unappreciated consequence of the ACA. Yet it will have the impact of increasing the fiscal cost of the ACA while decreasing the stability of the small group market.

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

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

These sources of instability pose substantial and under-appreciated obstacles to the future of the small group market. But this Article argues that these obstacles are not insurmountable. State and federal lawmakers have numerous opportunities to mitigate these risks and preserve a vital segment of the private health insurance market. One important component of this response has been described extensively elsewhere: states can, and should, regulate the provision of stop-loss insurance, which makes self-insurance a realistic option for most small employers by insulating them from genuine risk associated with their employees’ medical expenses. Standing alone, however, this reform is unlikely to save the small group market.

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

12 See id.
13 See Jost & Hall, supra note 11; Mark A. Hall, Regulating Stop-Loss Coverage May Be Needed To Deter Self-Insuring Small Employer From Undermining Market Reforms, 31 HEALTH AFF. 316 (2012).
14 See Part IV, infra.
This Article proceeds as follows. Part I begins by providing background regarding small-group coverage and the ACA’s reforms of that market. Part II then describes the risks to the small group marketplace stemming from employers’ incentives to offer coverage. Part II shows why small employers with low-income employees will tend to opt out of the small group market and how small employers with mixed-income employees can exploit the ACA’s rules to maximize public subsidies for their employees. Part III then explores the threats to the small group market related to self-insurance, and shows how this threat interacts with those described in Part II to further decrease the stability of small group markets and SHOP exchanges. Finally, Part IV explores various potential responses to these threats, including the regulation of stop-loss coverage as well as numerous complementary strategies.

I. THE ACA’S REFORM OF SMALL GROUP MARKETS

A. Small Group Markets Pre-ACA

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

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

Third, and most importantly, the cost and availability of small employer coverage can be disproportionately affected by the poor health

15 Kaiser Comm’n on Medicaid & the Uninsured, Changes in Health Insurance Coverage During the Great Recession 2007-2010 6 (2012), available at http://www.kff.org/uninsured/upload/8264.pdf (reporting that 60.4% of nonelderly Americans were covered under an employer plan in 2010, down from 70.6% in 2000).
status of just one or two employees. Large employers can be insured at community average rates because the law of large numbers tends to ensure that their employees’ overall health care expenses are similar to those of the broader community. Small employee groups do not have this same feature. Their employees’ aggregate health care costs can be dramatically impacted by a single employee’s high-cost medical condition. And federal law prevents an employer from discriminating on the basis of health status with respect to a group plan’s eligibility, premiums, or services. A small employer is unable, therefore, to exclude high-risk employees from coverage, or charge the employee a higher premium for coverage. Because small group policies are typically purchased on a yearly basis, small employers often face significant premium increases following years in which an employee becomes considered high-risk. The extreme premium volatility caused by medical underwriting in small groups is thought to contribute significantly to many small employers declining to offer coverage in the first place, or dropping coverage as premiums rise in response to increased risk within the small group.

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

Health reformers have nonetheless remained interested in increasing small group offer rates, for at least two reasons. First, the individual market for health insurance in most states has historically been even less attractive than the small group market, particularly for individuals with negative health history or risks. Although individual health insurance markets vary significantly by state, most suffer from significant adverse selection – meaning that the population that buys coverage has a higher

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22 Id. at 693-94.
23 KAIER FAMILY FOUND., supra note 16, at 36 (finding the offer rates for the smallest employers fell from 58% in 2010 to 48% in 2011).
risk level than the population as a whole.\textsuperscript{25} Such adverse selection not only increases premium levels, it also leads insurers to engage in various risk management techniques that limit coverage or increase costs for individuals with poor health histories.\textsuperscript{26} These techniques, which include excluding coverage for pre-existing conditions and rescinding coverage when an individual becomes high risk, also end up harming healthy individuals who find coverage unavailable once it is needed.\textsuperscript{27} Group insurance coverage is thought to suffer from less adverse selection than the individual market.\textsuperscript{28}

Another reason that reform efforts have focused on increased small employer offer rates is because there are tax benefits that are available exclusively to employer-provided coverage – thereby increasing small group coverage affordability compared to individual coverage. Health insurance provided by an employer can be paid entirely with pre-tax income, whereas coverage purchased by an employee on the individual market without employer involvement needs to be paid for with after-tax dollars.\textsuperscript{29} This tax benefit not only makes employer-provided coverage more affordable for all employees,\textsuperscript{30} but it also has the added benefits of encouraging employers to contribute to coverage and encouraging low-risk employees to opt for coverage they might otherwise find too expensive given their risk level.\textsuperscript{31} The better-functioning group market, combined with exclusive tax benefits of the group market, lead many reformers to focus coverage expansion efforts on the small group market. As will be discussed below, the ACA continues the tradition of small group reform, but does so in a very complicated way that is unlikely to generate significant coverage gains among small employers.


\textsuperscript{26} See id.

\textsuperscript{27} See \textsc{Kenneth Abraham & Daniel Schwarcz}, \textit{Health Insurance Supplement to Abraham's Insurance Law and Regulation} 3 (2012).

\textsuperscript{28} See, e.g. Hall, \textit{supra} note 21, at 689, 692-3.

\textsuperscript{29} See I.R.C. §§106, 125 (providing that both employer and employee contributions towards employer provided health insurance coverage can be excluded from an employee’s income). No similar provision exists for individual coverage purchased directly by an employee. Self-employed individuals may, however, deduct health insurance premiums paid from their taxable income. See I.R.C. §162(l).


\textsuperscript{31} For a more detailed discussion of the impact of the tax benefit for employer-provided coverage on risk pooling, see Amy B. Monahan, \textit{The Complex Relationship Between Taxes and Health Insurance}, \textit{in Tax Law & Policy: Beyond Economic Efficiency} (David Brennen & Karen Brown, eds. 2012).
B. The Regulation of Individual and Small Group Markets Post-ACA

The potential strengths of small group markets coupled with their historical shortcomings made them a core target of the ACA.32 Because of the interconnections between small group and individual markets, understanding the ACA’s potential effects on the former requires considering its regulation of the latter.

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

Many of the ACA’s small group market reforms also apply to individual insurance markets. Starting in 2014, the pricing, offering, and renewal of policies in both markets will be strictly regulated. Health insurers will be required to offer coverage to every applicant,33 forbidden from excluding any pre-existing conditions,34 and allowed to cancel or decline to renew coverage in very limited circumstances.35 In both markets, insurers will be permitted to vary price based only on four factors: age, geographic location, tobacco use, and family size.36 The extent to which premiums can vary based on tobacco use will be constrained to a 1.5 to 1 ratio, and age-based premium variation will be similarly limited to a 3 to 1 ratio.37 Importantly, these rules limit insurer pricing of small group policies, but they do not apply to the individuals who comprise the small group. Preexisting federal law requires that employees are charged premiums for group coverage that do not vary based on health status.38

The ACA also substantially regulates the content of health insurance policies in individual and small group markets beginning in 2014. It requires plans in these markets to cover the benefits defined as “essential health benefits” by the Secretary of Health & Human Services,39 and limits cost-sharing in various ways. Plans are prohibited from utilizing lifetime or annual benefit limits with respect to any essential health benefits.40 In addition, individual and small group plans are required to limit the overall cost-sharing imposed by a plan (also referred to as an out-of-pocket maximum) to the cap imposed on high-deductible health plans offered in conjunction with a health savings account.41 In 2012, the out-of-pocket limit on such plans is $6,050 for individual coverage and

33 ACA §1201 (adding §2702 to the P.H.S.A.).
34 Id. (adding §2704(a) to the P.H.S.A.).
35 Id. (adding §§2703 and 2712 to the P.H.S.A.).
36 Id. (adding §2701 to the P.H.S.A.).
37 Id.
39 ACA §§1201 (adding §2707 to the P.H.S.A.),1301, and 1302.
40 ACA §2711.
41 ACA §1302(c)(1).
$12,100 for family coverage.\textsuperscript{42} Notably, the ACA imposes an additional cost-sharing restriction that applies only to small employer plans, but not individual plans: small group plans may not have deductibles that exceed $2,000 for individual coverage or $4,000 for family coverage.\textsuperscript{43}

Plans in the individual and small group market are also subject to several rules designed to ensure that a sufficient amount of premiums are spent on medical care, and that plans do not compete by trying to cherry pick healthier-than-average enrollees. Plans in the individual and small group markets must spend 80\% of premium dollars on medical losses, leaving a maximum of 20\% for administrative expenses and profits (these requirements are labeled “medical loss ratio” requirements, or MLR rules).\textsuperscript{44} Any amounts spent in excess of that 20\% must be refunded to policyholders.\textsuperscript{45} The ACA also establishes a risk adjustment mechanism that applies to both individual and insured group plans.\textsuperscript{46} This program extends indefinitely, and charges low actuarial risk plans a penalty while providing payments to high actuarial risk plans in order to discourage insurers from competing for low-risk enrollees.\textsuperscript{47}

For both the individual and small group markets, the ACA will create so-called insurance exchanges in each state, with the goal of simplifying and streamlining insurance purchasing decisions. States will have the option of keeping the individual and small group markets separate, or merging them into a single market, and can also merge the individual and small group exchanges if desired.\textsuperscript{48} Regardless, plans offered on an exchange must be “qualified health plans” that meet the requirements described above and provide actuarial value that ranges from 60\% to 90\%.\textsuperscript{49} In order to help consumers compare insurance options, plans are classified by actuarial values that are labeled bronze (the lowest actuarial value plans, at 60\%), silver (70\% actuarial value), gold (80\% actuarial value), and platinum (90\% actuarial value).\textsuperscript{50} While insurers are permitted to offer plans outside of the exchange, both individual and small group plans offered outside of the exchange must still comply with all of the regulations described in this section.\textsuperscript{51} As is explored more fully in Part III, small employers may circumvent many of the ACA’s provisions by electing to self-insure their health plans.

\textsuperscript{42} Rev. Proc. 2011-32.
\textsuperscript{43} ACA §1302(c)(2).
\textsuperscript{44} ACA §1001 (adding §2718(b)(1)(A) to the P.H.S.A.). Large group plans are subject to a higher medical loss ratio of 85\%. Id.
\textsuperscript{45} Id.
\textsuperscript{46} ACA §1343. The ACA also establishes two temporary reinsurance programs designed to protect insurers against high risk enrollees. See ACA §§1341 and 1342.
\textsuperscript{47} ACA § 1343, 124 Stat. at 212–13 (to be codified at 42 U.S.C. § 18063).
\textsuperscript{48} ACA §§ 1311(b)(2) & 1312(c)(3).
\textsuperscript{49} Id. §1302.
\textsuperscript{50} Id. §1302(e).
\textsuperscript{51} Id. §1201 (adding § 2707 to the P.H.S.A.).
2. The ACA’s Subsidies and Taxes in Individual and Small Group Markets

The ACA contains a complex mix of incentives and penalties with respect to both an employer’s decision to offer coverage, and an individual’s decision to elect coverage. The ACA’s most well-known, and controversial, provision (the “individual mandate”) imposes a financial penalty on individuals who have affordable coverage available to them and decline to purchase it.52 Coverage is considered affordable if the premiums are equal to or less than eight percent of the individual’s household income.53 The penalty for failing to purchase such coverage is equal to the greater of (1) $695 per person in her household, up to a maximum of $2,085 and (2) 2.5% of household income.54 Public coverage, individually-purchased coverage, and employer coverage can all exempt individuals from this penalty.55

In order to increase the number of individuals who have access to affordable coverage, the ACA provides substantial subsidies in the form of tax credits for the purchase of individual health insurance coverage through an exchange.56 The credits are available to individuals with household income between 100 and 400% of the federal poverty limit (“FPL”), and are calculated on a sliding scale that specifies the percentage of income an individual will be required to pay for coverage.57 The credit is equal to the difference between the amount the individual is required to pay and the actual cost of the second-lowest-cost silver-level plan available to her.58 The ACA also provides reductions in cost-sharing for individuals with household income between 100 and 400% FPL who elect silver-level coverage on an exchange.59

Individuals who are offered employer coverage that is affordable and provides “minimum value” are not eligible for these tax credits or cost sharing subsidies.60 Employer coverage is considered affordable if the employee’s share of premiums does not exceed 9.5% of the employee’s

52 ACA §1501 (adding §5000A to the I.R.C.).
53 Id. (adding § 5000A(e)(1) to the I.R.C.).
54 Id. (adding §5000A(c) to the I.R.C.).
55 Id. (adding §5000A(f) to the I.R.C.).
56 Id. §1401 (adding §36B to the I.R.C.).
57 Id. §1401 (adding §36B(b) to the I.R.C.).
58 To illustrate, assume that a single individual has household income exactly equal to 200% FPL. That individual would be entitled to a tax credit equal to the difference between the premium for silver-level coverage available to her and 6.3% of her household income, thereby ensuring that the individual only has to pay 6.3% of household income in order to purchase silver-level coverage. The credit is not, however, limited to silver-level coverage. The individual can take the credit and use it to purchase coverage of any level with the exchange. If the individual chooses to purchase coverage that is either more or less generous than the silver-level coverage on which the credit is calculated, her share of premiums would be either lower or higher than the 6.3% assumed.
59 ACA §1402.
60 Id. §1401 (adding §36B(c)(2)(C) to the I.R.C.).
household income.\textsuperscript{61} For example, if an employee earns $22,340 per year (currently 200\% of the federal poverty level), but is eligible for employer-provided coverage, she could receive a premium tax credit only if the required contribution for her employer coverage exceeds $2,122 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.\textsuperscript{62}

Although the ACA imposes potential financial penalties on employers that fail to provide health care coverage to employees,\textsuperscript{63} small employers with fewer than fifty full-time employees are not subject to these penalties.\textsuperscript{64} Instead, the ACA provides some small employers with a limited incentive to voluntarily offer coverage. Beginning in 2010, employers with fewer than 25 full-time equivalent employees and average wages of less than $50,000 were potentially eligible for a tax credit.\textsuperscript{65} In order to qualify, the employer must provide health insurance to employees and pay at least 50\% of the cost of such coverage.\textsuperscript{66} Initially, the maximum credit available was 35\% of the employer-paid portion of the premiums.\textsuperscript{67} Beginning in 2014, the maximum amount will increase to 50\% of the employer-paid premiums but will only be available for two consecutive years.\textsuperscript{68} The net result is that the maximum number of years an employer may receive the credit is six years (four years from 2010 through 2013, and two years beginning in 2014 or thereafter).

In addition to this temporary subsidy, the ACA allows small employers to provide exchange-based coverage as a cafeteria plan benefit.\textsuperscript{69} Cafeteria plans allow employees to pay for certain qualified benefits with pre-tax dollars.\textsuperscript{70} Even if an employer does not make any contribution to an employee’s health insurance, such plans can save employees substantial sums by allowing them to pay for insurance using

\textsuperscript{61} Id.
\textsuperscript{62} Id. § 1401(a).
\textsuperscript{63} Effective in 2014, the ACA imposes a monetary penalty on employers with more than 50 full-time employees who do not offer health insurance coverage, or who do offer coverage but at least one of their employees receives a tax credit or cost sharing reduction. ACA §1513 (adding §4980H to the I.R.C.). Employers that do not offer coverage and have at least one full-time employee who receives a premium tax credit face an annual fee of $2,000 per full-time employee, excluding the first 30 employees from the assessment. \textit{Id.}
\textsuperscript{64} Id.
\textsuperscript{65} ACA §1421 (adding §45R to the I.R.C.).
\textsuperscript{66} In order to receive the maximum credit, the employer must have ten or fewer full-time equivalent employees that are paid average annual compensation of $25,000 or less per full-time employee. \textit{See id.}
\textsuperscript{67} Id.
\textsuperscript{68} Id.
\textsuperscript{69} ACA §1515 (adding §125(f) to the I.R.C.).
\textsuperscript{70} In recent years, there has been interest at the state level in requiring employers to offer their employees the ability to purchase individual health insurance through a cafeteria plan. \textit{See} Mark A. Hall et al., \textit{Using Payroll Deduction to Shelter Individual Health Insurance from Income Tax}, 46 \textit{HEALTH SERV. RES.} 348 (2010).
pre-tax dollars. Prior to the ACA, there was uncertainty regarding whether such cafeteria plans could be used to pay for individual, rather than group, health insurance.\footnote{Hall & Monahan, \textit{supra} note 30, at 257-59.} The ACA resolves this uncertainty by providing that cafeteria plans can only be used to pay for exchange-based health insurance coverage if a small employer offers its employees “the opportunity to enroll through such an Exchange in a qualified health plan in a group market.”\footnote{ACA §1515 (amending I.R.C. §125). If a state elects, beginning in 2017, to allow large groups to participate in the exchange, those large employers would also have the ability to use a cafeteria plan to pay for exchange-based coverage.} While regulations have yet to be issued providing the precise contours of this provision, the implication is that a small employer eligible to participate in an exchange could designate one or more group plans offered on the exchange to employees, and those employees could pay their share of the premiums for such coverage on a pre-tax basis through the employer’s cafeteria plan. In no event, however, could a cafeteria plan be used to pay for individual coverage purchased through an exchange.\footnote{See \textit{id}.}

Finally, all employers, regardless of size, are potentially subject to an excise tax on high-cost plans starting in 2018. This so-called “Cadillac Tax” is equal to 40% of the amount by which an employer group health plan premiums exceeds certain dollar amount thresholds.\footnote{ACA §9001 (adding §4980I to the I.R.C.). The term “group health plan” includes not only standard medical plans, but also health reimbursement arrangements, health flexible spending accounts offered through a cafeteria plan, and health savings accounts. \textit{See} I.R.C. §4980I(d). Notably, it excludes stand-alone dental and vision plans from its reach. Stand-alone dental and vision plans are also included in the definition of group health plan under 5000(b)(1), but are specifically exempted from the excise tax provisions. \textit{See id.}} In analyzing whether the dollar amount threshold is met, the cost of all applicable group health plans of an employer are aggregated.\footnote{I.R.C. §4980I(d).} The excise tax generally applies to the extent that the annual cost of such plans exceeds $10,200 for self-only coverage or $27,500 for coverage other than self-only coverage.\footnote{Multiemployer plans get a special break that provides that all multiemployer plan coverage shall be considered to be coverage other than self-only coverage. I.R.C. §4980I(b)(3)(B)(ii). A multiemployer plan is a plan that is contributed to by more than one employer pursuant to a collective bargaining agreement. \textit{See} I.R.C. §414(f).}

The ACA’s various individual and employer-level penalties and incentives are difficult to parse because they are both varied and intertwined. Part II below will explore how the ACA’s regulations and incentives are likely to affect a small employer’s decision to offer its employees health insurance coverage.
II. SMALL EMPLOYERS AND THE DECISION TO OFFER GROUP COVERAGE POST-ACA

The rate at which employers offer their employees some form of health insurance is often broken down by employer size. In 2011, for instance, health insurance was offered by 48% of employers with between 3 and 8 employees, 71% of employers with between 10 and 20 employees, 85% of employers with between 25 and 49 employees, and 93% of employers with between 50 and 199 workers. Among employers with over 200 employees, 99% offered their employees health insurance. The correlation between employer size and the propensity to offer group health coverage is both strong and persistent over time.

This Part argues that beginning in 2014, the propensity of small employers to offer group health coverage will correlate less with size than with the income profile of their employees. This Part explains that conclusion. It argues that because of tax credit eligibility provisions, small employers with predominantly low-income employees will face strong incentives to drop coverage completely starting in 2014. By contrast, it shows that small employers with predominantly high-income workers will have strong incentives to offer some form of group coverage. Finally, it shows that small employers whose employees vary significantly in their income levels will face more complicated incentives, but are likely to favor offering coverage. However, they are likely to design that coverage so that it is either not “affordable” with respect to low-income employees or does not provide “minimum value.”

A. Small Employers with Predominantly Low-Income Employees

Starting in 2014, small employers whose employees are predominantly low income will generally opt not to offer any form of employer sponsored coverage. There are four contributing elements to this prediction.

The first, and most important, is that employers of predominantly low-income employees will generally make their employees worse off by offering coverage. This is because individuals who are offered employer coverage that is “affordable” and provides “minimum value” are not eligible for either premium tax credits or cost sharing subsidies on the individual insurance exchanges. This effect is unprecedented: never before has an employer potentially made its employees worse off simply by offering health insurance coverage. Yet, this effect has received remarkably little attention in the academic literature.

78 Id.
79 See id.
80 ACA §1401 (adding §§36B(c)(2)(B) & (C) to the I.R.C.).
81 There are, of course, notable exceptions. See David Gamage, How the Affordable Care Act Will Create Perverse Incentives Harming Low and Moderate Income Workers, TAX L.
Although the amount that low-income employees of small employers would forfeit in public subsidies as a result of being offered coverage depends on numerous factors, it is certain to be quite large. For instance, if we assume an annual premium of $4,780 for silver level coverage in 2014, an employee making 200% of the federal poverty limit, or about $22,000, would lose an estimated $3,396 in health insurance premium subsidies.\(^{82}\) Because the credit is based on the maximum percentage of income that an eligible individual will be required to pay for silver-level coverage, if premiums are higher than currently anticipated the credits will be even larger. Importantly, while the credit is calculated on the basis of the second-lowest-cost silver plan, the employee would be free to choose any plan offered within the exchange. Thus, if the individual chose a bronze level plan with an annual premium of only $4,100, she would still receive the $3,396 tax credit and would only be required to pay $704 out of pocket for such coverage.

In addition to losing valuable premium tax credits, the same low-income employees would lose valuable cost-sharing subsidies. Under the ACA, individuals eligible for premium tax credits who elect silver-level coverage will receive cost-sharing reductions. An individual who earns 200% FPL, for example, would be eligible to have her out-of-pocket maximum reduced by two-thirds, and the percentage of expenses that a plan pays increased to 87%.\(^{83}\) If we assume that the out-of-pocket maximum in 2014 will be $6,350,\(^{84}\) the individual in our example would have her out-of-pocket maximum reduced to approximately $2,115, significantly limiting that individual’s risk exposure. Similarly, the individual’s co-insurance amounts would be reduced if she were to incur medical expenses above the deductible.

Although declining to offer group coverage would forfeit certain tax benefits, these tax benefits would pale in comparison to subsidies on an insurance exchange for low-income employees. Employees only have the ability to pay for health insurance coverage with pre-tax dollars if they are offered that coverage by an employer.\(^{85}\) As a result, individuals who must purchase their own coverage on the exchange, even if subsidized with premium tax credits, must pay their share of the premium with after-tax dollars. For low-income employees, however, the ability to pay premiums on a pre-tax basis is extremely unlikely to outweigh the benefit of the premium tax credit and cost-sharing subsidies that are available. Most

\(^{82}\) The individual would then be entitled to a tax credit equal to the difference between $4,780 (the silver plan premium) and $1,386 (6.3% of household income), which is $3,396.

\(^{83}\) ACA §1402.

\(^{84}\) This estimate of the out-of-pocket maximum in 2014 was obtained from THE HENRY J. KAISER FOUND., PATIENT COST SHARING UNDER THE AFFORDABLE CARE ACT 2 (2012), available at http://www.kff.org/healthreform/upload/8303.pdf.

\(^{85}\) See I.R.C. §§ 106 & 125.
low-income employees have no federal income tax liability resulting in the tax exclusion for employer-provided coverage being valuable only for the payroll tax exemption. As a result, the exemption would be worth 7.65% of the premium amount. If the employer were to provide coverage with a $5,000 premium, the tax benefit associated with group coverage would only be worth $383, much less than the premium tax subsidy (estimated at $3,396 above) they could receive in the absence of an employer’s offer of coverage.

A second factor that may contribute to employers with low-income employees choosing to drop coverage is that doing so will potentially produce an additional benefit for employees. In particular, some low-income employees would not be subject to the individual mandate at all in the absence of affordable employer coverage, because even with the tax subsidies, coverage might be deemed unaffordable. Yet these employees would be subject to the mandate if they were offered affordable sponsored coverage. Thus, by offering coverage, it is possible that a small employer would cause its employees to be subject to the individual mandate. For an employee who would not otherwise purchase insurance, an employer offer of affordable coverage would therefore financially harm the employee.

The third basis for our prediction that small employees with low-income employees will drop coverage is that, starting in 2014, they will feel much less of a moral obligation to offer group coverage. Small employers often cite moral obligations to employees as one of the reasons they offer group coverage. This is understandable: in the current system, an individual who does not have coverage and becomes sick can suffer dire financial consequences not only in the short term through unpaid medical bills, but also in the long-term because insurers in most states can

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86 In 2008, over 30% of all income tax filers faced no federal income tax liability. See KYLE MUDDY, INDIVIDUAL INCOME TAX RATES AND SHARES, 2008 24 (2008), available at http://www.irs.gov/pub/irs-soi/11intr08winbul.pdf (finding that only 63.6% of federal income tax returns filed in 2008 were taxable returns).

87 Payroll taxes are imposed on all wages. See I.R.C. §§ 3101(b)(6) & 3111.

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

89 Premium tax credits under the ACA are based on the maximum percentage of income an eligible individual is required to pay for the second-lowest-cost silver plan available to her. For those individuals with income above 250% FPL, the maximum percentage is 8.05%, rising to 9.5% at 300% FPL and thereafter. The threshold for affordability for purposes of the individual mandate is 8% of income. As a result, even if a tax-credit-eligible individual selects bronze level coverage, she may still avoid the individual mandate if her share of the premium after tax credits exceeds 8% of her income. If her employer were to offer her coverage that required a payment of only 7% of income, she would be subject to the mandate and would either have to elect coverage or pay a monetary penalty. For more detail on the mechanics of the individual mandate, see Amy B. Monahan, On Subsidies and Mandates: A Regulatory Critique of ACA, 36 J. CORP. L. 781 (2011).

90 See, e.g., Fronstin & Helman, supra note 19, at 7 (finding that 77% of small businesses stated that a major factor in their decision to offer health insurance was that “it was the right thing to do”).
deny coverage based on health history and risk. However, both of these factors should begin to shift in 2014, when the consequences of being uninsured change significantly. Recall that core provisions in the ACA require insurers to offer coverage to individuals without any preexisting condition exclusions or premium adjustments based on medical condition. This means that anyone who becomes sick and does not have coverage can easily acquire coverage, at community average prices, although that person might have to wait until the next open enrollment period.\textsuperscript{91} This significantly limits, but does not entirely eliminate, the harm that can result from a lack of coverage – potentially making small employers less likely to offer coverage than they are under the status quo.

The final explanation for our prediction that small employers with predominantly low-income employees will choose not to offer coverage in future years is that they are neither required nor particularly rewarded for so doing. As previously noted, small employers are not subject to the employer mandate, and face no penalty associated with failing to offer group coverage. Instead, the ACA offers limited time tax credits to qualifying small businesses that not only offer coverage but subsidize such coverage.\textsuperscript{92} To be eligible for this incentive, the employer must have fewer than twenty-five full time employees, and average wages of less than $50,000.\textsuperscript{93} This credit has been available since 2010, but its utilization has been far short of expectations.\textsuperscript{94} Despite estimates that somewhere between 1.4 million and 4 million employers were eligible for the credit, fewer than 200,000 claimed it in 2010.\textsuperscript{95}

While the amount of the small business tax credits will increase to up to 50\% of the employer’s contributions to premiums starting in 2014, its use by small employers is not likely to increase and may actually decrease. Recall that the credit is available for a maximum of two years beginning in 2014. The limited duration of the credit makes it unlikely that it alone would result in any employers that were not previously offering group coverage to begin offering such coverage. This is because setting up a health insurance program for one’s employees inevitably involves a number of fixed costs that are much more economical if they are spread over a longer period of time. Additionally, employers are likely aware of the fact that, as a result of the endowment effect, it may be harder to drop coverage once it has decided to offer it than for the employer to not offer

\textsuperscript{91} See ACA §1311(c)(6) (requiring the Secretary of HHS to establish an annual open enrollment period for the individual market exchanges).

\textsuperscript{92} ACA § 1421 (adding §45R to the I.R.C.).

\textsuperscript{93} Id.

\textsuperscript{94} In 2012, the Government Accountability Office (GAO) released a report finding that only 170,300 small employers claimed this credit. Gov’t Accountability Office, Small Employer Tax Credit: Factors Contributing to Low Use and Complexity (2012), available at http://www.gao.gov/assets/600/590832.pdf.

\textsuperscript{95} Id. at 9.
coverage in the first place. And for those small employers that already offer coverage, the two-year tax credit is unlikely to inhibit those employers with low-income employees from dropping coverage – or at most it will inhibit them from dropping coverage for a maximum of two years.

Before concluding, it is important to briefly mention why our conclusion regarding the propensity of small employers with predominantly low-income employees applies only to small employers, and not simply to all employers. Without a doubt, some of the motivating factors we mentioned do apply regardless of employer size, such as the changing moral motivations behind offers of health insurance. And it is also true that low-income employees of large employers will lose federal tax and cost-sharing subsidies if they are offered affordable coverage that provides minimum value. But the key difference is that small employers are subject to the employer mandate. By contrast, large employers are subject to the mandate, and the amount of the associated penalty for that employer is specifically tied to the subsidies that its employees receive on an individual insurance exchange. As a result, a larger employer could not simply drop group coverage and allow its employees to reap the benefits of the premium tax credits. Doing so would result in an annual penalty that is equal to approximately $2,000 per employee. A large employer is therefore likely to be better off using that amount of money to subsidize its own health plan or to increase employee wages. At the very least, the cost-benefit calculation is much more difficult for large employers contemplating completely dropping coverage. For small employers, however, it seems clear that those with predominantly low-income employees will find the decision to not offer coverage beginning in 2014 to be an easy one.

**B. Small Employers with Predominantly High-Income Employees**

In contrast to the situation described above, small employers with predominantly high-income employees are likely to have substantial incentives to offer coverage after 2014. This prediction is premised on four core factors. First, employers will not jeopardize the availability of public subsidies for their high-income employees by offering coverage because those employees would not be eligible for any subsidies on individual insurance exchanges in the first place. For employers with household income above 400% FPL, neither premium nor cost-sharing

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97 See ACA § 1513 (adding §4980H to the I.R.C.).

98 See id.
subsidies will be available.\textsuperscript{99} And even for those at the top-end of the subsidy range, roughly between 350\% under 400\% FPL, the subsidies may not easily outweigh an offer of employer-provided coverage given that the subsidy amount declines as an individual’s income level approaches 400\% FPL.\textsuperscript{100} For example, an individual earning 399\% FPL would be entitled to a premium tax credit of $535 if we again assume that premiums for silver-level coverage will be $4780 in 2014.\textsuperscript{101} And that individual’s out-of-pocket maximum would be reduced by only one-third, with the plan’s cost-sharing average moved up to only 70\%. As a result, for small employers whose employees’ incomes are either greater than or near 400\% FPL, their decision to offer group coverage should not be significantly affected by the ACA’s premium or cost-sharing subsidies.

Second, for small employers with relatively high-income employees, the value of the tax exclusion for employer-provided coverage is significant. Assume again that the employer provides coverage with a $5,000 premium.\textsuperscript{102} The full value of that coverage is excluded from an employee’s income for purposes of federal, state, and payroll taxes, resulting in an implicit subsidy of at least $2132 for an employee in the top income bracket.\textsuperscript{103} Not offering employer coverage of some sort – even if the employer did not contribute to coverage in any way – would cause high-income employees to forfeit this subsidy. Indeed, the tax subsidy is one of the primary reasons why employer sponsored coverage is as dominant as it is, and nothing about this subsidy will change after health care reform is implemented. While it is true that employers of low-income employees must trade off the tax exclusion for employer coverage against the premium tax credit and cost-sharing subsidies, employers of high-income employees face no such trade-off.

Third, in 2014, core provisions of the ACA should make a small employer’s size matter much less in its decision to offer coverage. Currently, even small employers with predominantly high-income employees may not offer group coverage because of the high costs that can result from even a single employee with a serious health condition.\textsuperscript{104} This should change when the ACA’s guaranteed issue and rating restrictions become effective in 2014. At that time, small employers will no longer face group medical underwriting, but will instead be guaranteed of the ability to purchase group coverage at nearly community average prices. At the same time, SHOP exchanges, and perhaps MLR

\textsuperscript{99} See ACA §§ 1401 & 1402.
\textsuperscript{100} See id. § 1401.
\textsuperscript{101} See id.
\textsuperscript{102} This assumption is loosely based on the average cost of employer-provided coverage in 2011. See KAISER FAMILY FOUND., supra note 16, at 20 (finding that the average cost of employee-only coverage in 2011 was $5429).
\textsuperscript{103} Calculated by author using a combined federal income and payroll tax rate of 42.65%.
\textsuperscript{104} See KAISER FAMILY FOUND., supra note 16, at 41 (reporting that 55\% of small businesses cited high cost as the most important reason that they did not offer group coverage).
requirements, should help to reduce the administrative expenses traditionally assumed with small employer coverage. All of this means that the countervailing costs of small group coverage that may have historically overwhelmed the above tax benefits for small employer group coverage will be substantially reduced.

Finally, high-income employees are much more likely to value the option of employer-sponsored health insurance than low-income employees. In part, this is because these employees are more likely than their low-income counterparts to have assets that they would like to protect from medical creditors, and from potential bankruptcy if their assets are insufficient to fully pay their medical bills. But it is also because high-income individuals tend to use their health insurance more than low-income individuals. The one caveat here is that some high-income employees may be subjected to the individual mandate if their employer offered group coverage, but otherwise exempt from the mandate. For this to be true, the individual would have to face an individual premium on the exchange that exceeds 8% of household income (thereby making coverage unaffordable for purposes of the mandate), while her employer offers coverage the employee share of which is less than 8% of her income. While this modestly cuts against our argument, we believe that it is ultimately of little consequence given the benefits that group health insurance provide to high-income employees.

C. Mixed-Income Small Employers

For many of the reasons discussed in the preceding two sections, small employers with a substantial number of both high- and low-income employees will face a complicated decision about whether or not to offer coverage. Offering coverage will tend to be in the interests of their high-income employees, but very well may be against the interests of their low-income employees.

An attractive option for small employers who fit this mold is for them to offer coverage to all of their employees, but to structure that coverage so that it either does not provide “minimum value” (what we will refer to as the “minimum value strategy”) or is not “affordable” (what we will refer to as the “affordability strategy”) with respect to low-income employees. Either strategy would preserve the ability of their low-income employees to receive subsidies on an individual exchange while allowing their high-income employees to receive the tax benefits of employer-provided coverage. This is because individuals are only eligible for subsidies on an individual insurance exchange if they do not have the

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105 It is also the case, however, that very high-wealth individuals may have sufficient assets to self-insure any medical expenses.
106 See, e.g., Barak D. Richman, Health Insurance Expansions: Do They Hurt Those They are Designed to Help?, 26 HEALTH AFF. 1345 (2007).
107 ACA § 1401(a), 124 Stat. at 216–17 (adding § 36B(c)(1)(C) to the I.R.C.).
option of employer sponsored coverage that is both affordable and provides minimum value. 108

Under the minimum value strategy, a small employer would structure its plan so that its actuarial value was below 60%. 109 This would mean that the plan would, for an average population, pay less than 60% of the cost of covered services. Such a plan would require significant cost-sharing through deductibles and co-insurance requirements. 110 The minimum value strategy is therefore only likely to be pursued by employers whose high-income employees would find a high-cost sharing plan desirable. It should be noted, though, that such plans are becoming increasingly common, reflecting the growth of consumer-driven health care. 111 Moreover, high-deductible plans for high-income employees actually make good economic sense, because they preserve the benefits of consumer-driven health care (limiting the risk of ex post moral hazard) without the costs of that approach (shifting excessive risk on to employees).

Employers that desire to pursue the minimum value strategy are in fact likely to find the standard consumer-driven plan design to be a convenient way to create a low-actuarial value plan. A consumer-driven health plan typically involves a tax-favored savings account, known as a health savings account (or HSA), combined with a high-deductible health plan. 112 In employer-sponsored consumer-driven plans, the employer typically contributes some amount to the employee’s health savings account, 113 while the employee can also make additional pre-tax contributions to such accounts. While there is not yet final guidance on this issue, preliminary guidance from the IRS suggests that while employer HSA contributions will be taken into account for purposes of actuarial value, employee contributions will not be. 114 As a result, an employer pursuing the minimum value strategy could set up a consumer-driven plan with no employer contribution to the HSA, thereby lowering actuarial value. Nothing, however, would prevent the employer from raising employee wages (and even suggesting to employees that they might want to contribute the wage increase to their HSA). This subtle change in the

108 See id.
109 As we explain later, to accomplish this a plan would need to self-insure. See infra Part III.B.2.
110 See Henry J. Kaiser Family Found., What the Actuarial Values in the Affordable Care Act Mean 4 (2011), available at http://www.kff.org/healthreform/upload/8177.pdf (showing various estimates of 60% actuarial value plans under the Affordable Care Act, with deductibles that range from $2,750 to $6,350 for single coverage).
111 See Kaiser Family Found., supra note 16, at 57 (reporting that 23% of firms that offer group health plans offer a consumer-driven plan).
114 See IRS Notice 2011-73.
funding of the HSA may be all that is necessary to turn a plan that provides minimum value into one that does not.

While we believe that this approach may have wide appeal among small employers, the minimum value strategy is likely to be particularly attractive for employers with relatively healthy employees, as the expected cost sharing amounts for these employees would be correspondingly low. The ability, however, to manipulate HSA contributions to defeat minimum value will likely broaden the appeal beyond simply those with low expected costs. But in the end, no matter how it is structured, the minimum value strategy allows low-income employees to claim premium tax credits and cost-sharing subsidies, while still permitting higher income employees to receive group coverage on a pre-tax basis. Not insignificantly, it also provides high-income employees with the ability to satisfy the requirements of the individual mandate at low cost.\footnote{An individual satisfies the requirements of the individual mandate if she is covered by “minimum essential coverage.” ACA §1501. Any employer-provided coverage is considered “minimum essential coverage.” See id. (adding §5000A(f) to the I.R.C.). As a result, a less-expensive, low-actuarial value plan would give employees the ability to satisfy the mandate at comparatively low cost.}

The affordability strategy is somewhat simpler to implement than the minimum value strategy, and has the advantage of allowing the employer to offer a group plan that offers high levels of coverage, if desired. Under the affordability strategy, the employer would first determine at what employee income level it desired to preserve subsidies. It might choose to preserve the option of subsidies for all employees making less than 400% FPL, or it might choose a lower threshold given that the subsidies as employees approach 400% FPL are relatively small. Once that threshold is chosen, the employer needs only to ensure that employees with incomes falling below the chosen threshold are required to pay annual premiums that exceed 9.5% of their income.\footnote{Note that while an employer would set contribution rates based on employee income, eligibility for tax credits is actually determined based on household income, which would include not only the employee’s income, but also the income of any spouse or dependent children. As a result, the employer might set the employee contribution rate so that it exceeds 9.5% of the chosen income threshold, but not all of the employer’s employees with income under the threshold will necessarily be eligible for premium tax credits, because a spouse’s income may result in household income that is too high. This is not a serious impediment to the affordability strategy. Rather, it shows its flexibility. By structuring the plan so that it will not result in any employees who would otherwise be eligible for premium tax credits losing their credits, no employee is harmed. And the availability of the group plan ensures that high-income employees continue to enjoy pre-tax purchasing.} For example, if an employer desired to ensure that all employees with income equal to or less than 300% FPL would remain eligible for premium tax credits and cost-sharing subsidies, it would set employee contributions for the group plan at or above $3,184 (which is just above 9.5% of 300% FPL – which in 2012 is $33,510). If the employer wanted to preserve tax credits for all employees at or below
400% FPL, the employee’s contribution would need to be at or above $4,245.

To see how these two strategies might work, it is helpful to work through a simple example of each. Assume that a small employer, Widget Company, has twenty employees who are all the same age and non-smokers. Ten of these employees make 200% FPL and ten have household incomes of 500% FPL. Assume first that Widget decides to sponsor a group health plan, but not to pursue either the affordability or minimum value strategies described above. In fact, Widget pays the entire premium. As described earlier, if the cost of coverage is $5,000 per individual, then group coverage will provide the low-income employees with approximately $383 in tax benefits and high income employees with approximately $2132 in tax benefits. The federal subsidy that results simply from the fact that group coverage can be paid for with pre-tax dollars is $25,150.

Now assume that the small employer adopts the affordability strategy. To do so, it could offer to pay only 50% of the costs of coverage (or some lesser amount), requiring its employees to pay the remaining $2500. Because $2500 is more than 9.5% of the low-income employees’ wages ($22,000), these employees would be eligible for subsidies on the exchange because they would not have the option of “affordable” employer coverage. They would thus be able to receive $3,396 in health insurance premium subsidies each. The high-income employees would still opt for group coverage and would still receive a tax benefit of $2132 each. The total federal subsidy under the affordability strategy would be $55,280; $33,960 in premium tax credits and $21,320 in federal tax subsidies resulting from pre-tax purchasing. In addition, the employer’s costs have decreased by $25,000.

Under these assumed numbers, a very similar result could be reached if the employer opted to pay for 100% of the costs of its employees’ coverage, but offered a consumer-driven plan with high deductibles and co-pays that did not provide minimum value. Assume, for example, that the employer offers a plan with a $3000 annual deductible that requires

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117 Economists have explained that an employer’s contribution to health insurance premiums constitute part of an employee’s wages. See Lawrence Summers, Some Simple Economics of Mandated Benefits, 79 AM. ECON. REV. 177 (1989). Therefore, if Widget decreases its contribution to health insurance premiums by $2500 it should raise employee wages by an equal amount. Employees can, in turn, pay their required $2500 contribution to coverage with pre-tax dollars through a cafeteria plan. See I.R.C. §§ 106 & 125. As a result, while the employer has technically reduced its contribution towards coverage, an employee is no worse off.

118 In the previous example, Widget had been paying the full premium cost of $5,000 for all twenty employees, for a total cost of $100,000. By decreasing its contribution to coverage to $2500 per employee, half of its employees decline group coverage in order to elect cheaper, exchange-based coverage. But recall from Note 117, that Widget has also raised employee wages by $2500 per individual. The end result is that Widget is paying $50,000 more in wages, but $75,000 less in health insurance premiums, saving a total of $25,000.
employees to pay 30% of all costs once the deductible has been satisfied. Assume further that the annual premium for this plan is $3000 per employee. As under the affordability strategy, low-income employees would be likely to opt for coverage on the exchange, because the premium tax credits combined with richer coverage are likely to be more attractive than the employer plan. High-income employees are still likely to stay in the group plan in order to keep the tax advantage unless, of course, they anticipate consistently high medical expenses – an issue that will be discussed in more detail in Part III below. Overall, under this minimum value strategy, the federal subsidy would be $48,255; the same $33,960 in premium tax credits as above, and a reduced $12,800 in tax subsidies resulting from pre-tax purchasing of group coverage. Overall health insurance costs would, however, be reduced. While the cost of exchange-based coverage would remain unchanged from the affordability example, the drop in group premiums reduced overall health insurance costs by $20,000. The employer’s overall costs should be slightly reduced under the minimum value strategy compared to the affordability strategy.

To be sure, the tradeoffs in these approaches would depend substantially on the age and smoking status of the various employees, an issue that the above example assumes away. First, these factors could influence the amount of the public subsidies that the low-income employees would receive on the exchange. If low-income employees also tended to be older smokers, this would increase the benefits of this approach because the exchange subsidies are determined based on the maximum percentage of income an individual is required to pay for silver-level coverage. If an employee is older or a smoker, she is still required to pay the same percentage of income as a younger non-smoker; the premium tax credit simply increases. By contrast, the subsidies might not be as large if the low-income employees were younger, non-smokers. Second, these factors could have distributional consequences among the

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119 These numbers are loosely based on estimates of a 60% actuarial value plan modeled by Towers Perrin. See Henry J. Kaiser Family Foundation, supra note 110, at 4.
120 For some low-income employees who are young and healthy and do not anticipate incurring any significant medical expenses, the fully-subsidized employer plan may in fact be more attractive than partially-subsidized exchange-based coverage. For those individuals that do not anticipate significant medical expenses, lower premiums are more attractive than richer benefit coverage.
121 The drop in overall health insurance costs is attributable to the reduction in overall group premiums from $5,000 in the affordability example, to $3,000 in the minimum value strategy, under the assumption that ten employees will elect group coverage in either scenario.
122 Compared to the affordability example, where the employer paid only $2500 in premiums, the employer is now contributing $500 more per employee. As a result, wages should decrease by $500 per employee. The net result is that the employer pays $10,000 less in wages compared to the affordability example, but pays $5,000 more in health insurance contributions (an additional $500 per employee, with an assumed ten employees electing group coverage).
employer’s employees. If, for instance, the low-income employees were young and non-smoking, then high-income employees would be forced to pay more for group coverage because they would not have young, non-smoking employees in the group pool to subsidize their costs.

Before we move on, it is important to note that an employer that offers low-income employees affordable coverage that offers minimum value would actually place itself at a disadvantage in the labor market. An employer offering an affordable plan that offers minimum value would presumably have to subsidize that coverage in order to make it affordable, whereas an employer pursuing either the affordability or minimum value strategy would have the federal government subsidize the health insurance coverage for its low-income employees. As a result, an employer offering affordable group coverage with minimum value would have higher labor costs than its competitors that shift such employees to exchanges. This is further exacerbated if the employer’s subsidy, while creating “affordability” is not actually as generous as the available tax credit. Recall that employer coverage is “unaffordable” when the employee’s contribution exceeds 9.5% of income, whereas an individual earning 200% FPL would be eligible for a premium tax credit that limits the individual’s cost for silver level coverage to 6.3% of income. In those cases, the employer would presumably have to raise the wages of low-income employees to make up for any premium tax credit and cost sharing subsidies that such employees would lose by virtue of being offered affordable coverage. If the employer allows the gap between its plan and the exchange-based plans to persist, it may lose such workers to other firms that do not offer affordable coverage.123 On the flip side, if the employer declines to offer a group plan in order to preserve the tax subsidies for low-income employees, it would need to raise the salaries of high-income employees in order to account for the lost tax exclusion. One possible result is that the ACA may cause some firms to sort by income level. We may see fewer mixed income firms than exist today.

D. The Impact of Small Employers’ Coverage Decisions

Primarily because of the eligibility provisions for the premium tax credits and cost-sharing subsidies, along with the fact that small employers face no penalty for failing to offer coverage, small employers with predominantly low-income employees will drop group coverage. It is essentially the only rational choice for such employers; doing otherwise would forfeit thousands of dollars that would otherwise be available from the federal government. Similarly, small employers with mixed income employees are likely to continue to offer group coverage, but to structure

such coverage so that it is either unaffordable or does not offer minimum value. Because the end result of these two phenomena is that low-income individuals will receive coverage on the individual market, rather than through their employer, the size of the small group market will be smaller than many have anticipated.

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

In addition to these effects on SHOP exchanges, the strategies described in this section could also have quite negative impacts on the fiscal implications of the ACA. Small employers’ efforts to preserve their employees’ eligibility for individual subsidies on insurance exchanges – either by dropping coverage completely or pursuing either the affordability of the minimum value strategy – will, of course, have the impact of increasing the federal government’s obligations to provide subsidies to these individuals. This will raise the costs of providing these subsidies above estimates.\textsuperscript{124} The Part below explores yet another serious threat to the viability of the small group market, the threat that small employers that offer group coverage post-2014 will leave the insured market in favor of self-insured arrangements.

\section*{III. Self Insurance and the Small Group Market Post-ACA}

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

\textsuperscript{124} CONGRESSIONAL BUDGET OFFICE, PAYMENTS OF PENALTIES FOR BEING UNINSURED UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010).
collapse. This Part explores the likely expansion of self-insurance in the small group market post-ACA, and examines its potential effect on market viability.

A. Background on Self-Insurance

A self-insured health plan is one in which the employer has retained liability for paying claims rather than transferred that liability to an insurer. Historically, the principal attraction of self-insurance has been that it allows employers to escape state insurance regulation – particularly mandated benefit laws – under ERISA’s preemption rules. It also allows employers to escape certain state taxes.

Although self-insuring provides both regulatory and tax relief, it can be costly to establish and maintain. With respect to costs, employers who self-insure generally hire third party administrators (TPAs), who are usually insurers, to operate all non-risk-bearing elements of the health benefit plan, such as processing claims and paperwork. They also often purchase stop-loss insurance, which limits an employer’s risk with respect to unpredictably high claims by transferring such risk to an insurer. Such stop-loss insurance can be structured to protect employers either if any individual employee incurs claims above a specified threshold or if the aggregate claims of all employees exceed a specified threshold. Either way, these thresholds are termed attachment points, and function much like deductibles in ordinary insurance policies. In some cases, stop-loss insurers can apply a different attachment point to a particular employee or refuse to include that employee’s costs in coverage at all, a phenomenon known as “lasering.”

Even where a self-insuring employer purchases stop-loss coverage, the employer still retains some risk of loss. First, the employer retains any risk below the attachment point of stop loss coverage. Second, and much less appreciated, the employer is liable for medical plan claims even if the stop loss carrier does not reimburse the employer. This might occur if the stop loss insurer becomes insolvent. Alternatively, this might occur if the

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126 Self-insured employers are not subject to state-level health insurance premium taxes.
128 Id.
129 Id. at 10. Assume, for example, that an employer self-insures its health plan, but has purchased a stop-loss policy with an aggregate attachment point of $100,000. The employer would be at risk for the first $100,000 of claims under the medical plan, after which the stop-loss carrier would reimburse the employer for claims paid under the medical plan.
130 Id.
131 See id. at 21.
stop loss insurer refuses to pay a claim on the basis that there was a material misrepresentation in the employer’s application or a policy exclusion applies.

Given these risks, large employers have been historically much more likely and able to self-insure than small employers because of their superior ability to bear risk. Large employers have a big enough employee population to be able to predict risk relatively accurately, meaning that they are much less dependent on stop loss insurance than small employers. In addition, large employers have greater financial resources to absorb the costs of slightly higher-than-expected medical losses. Stop loss coverage is in fact much less common among the largest self-insuring employees for these reasons.132

By contrast, small employers have rarely chosen to self-insure in the past precisely because of the increased risk and fixed costs of doing so. In fact, it is estimated that only 7.9% of firms with three to forty-nine employees that offered a group health plan were self-insured in 2010.133 In the rare instances when small employers have self-insured, they almost always rely on stop-loss coverage.134 In the absence of such coverage, a small employer’s business may be jeopardized by a single employee or employee family member becoming very sick.

B. Benefits to Small Employers of Self-Insuring in 2014

1. General Advantages

Even while the ACA was being designed, policymakers understood that the law might increase the tendency of small employers to self-insure. Indeed, the ACA itself contains a provision requiring that the Secretary of HHS undertake a study examining the extent to which the ACA’s insurance market reforms are likely to encourage small and midsize employers to self-insure.135 The reason is that, starting in 2014, the benefits of self-insuring will increase substantially, particularly for small employers. In particular, self-insurance will allow small employers to escape the requirement (i) that offered coverage include essential health benefits, (ii) that they participate in risk-adjustment programs, (iii) that their insurance comply with medical loss ratios, (iv) that all premium increases be reviewed, and (v) that deductibles not exceed $2,000 for an individual and $4,000 for a family.

There are a variety of reasons why small employers may desire to escape these provisions of the ACA. Two of these reasons have been

132 See id. at 14 (estimating that 7.9% of smallest firms offered a self-insured health plan, whereas 80.4% of the largest firms did so).
133 Id.
134 Id. at 19-20.
135 ACA §1254 (although the section is entitled “Study of Large Group Market,” it contains provisions requiring that the risk of self-insurance in the small group market is studied). For the report that was issued in compliance with this statutory requirement, see EBNER ET AL., supra note 127.
well-developed elsewhere, and so are only briefly discussed here.\(^{136}\) First, and most generically, regulation imposes compliance costs and limits flexibility. Being able to avoid these requirements by self-insuring could allow an employer to save money and maintain flexibility in designing its plans. Indeed, very similar considerations have historically prompted many large employers to self-insure.

Second, self-insuring would allow small employers with a relatively low-risk population to avoid cross-subsidizing higher-risk small employers. Such employers, in essence, need only pay “premiums” that are based on their own employees’ health rather than the health of the entire pool of individuals in the small group market. The size of this benefit depends on the risk level of the employer’s workforce: for small employers with very healthy employees who incur few claims, this benefit could be very substantial.\(^{137}\) And because self-insured employers are exempt from the ACA’s prospective risk assessment mechanism, such employers will not have to subsidize plans with higher risk employees.\(^{138}\)

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

While the above reasons for self-insuring apply to any small employer that desires to sponsor a group health plan in 2014 and thereafter, self-insurance is also highly relevant to those small employers with mixed-income employees that desire to pursue either the affordability or minimum value strategy in order to preserve the tax credit eligibility of its low-income employees. Employers that want to pursue the minimum value strategy must self-insure, as all small group plans are required by the ACA to provide a minimum of 60% actuarial value, whether they are offered within or outside of an exchange, thereby automatically satisfying the “minimum value” standard.\(^{139}\) There are, however, no such limitations on self-insured plans.\(^{140}\)

An employer that self-insured would have numerous options for designing its plan so that it did not, in fact, provide “minimum value.” Although the ACA mandates that small group plans cannot use

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\(^{137}\) For an overview of potential state responses to the issue of small employers self-insuring, see Hall, *supra* note 136.

\(^{138}\) ACA §1343.

\(^{139}\) ACA §§ 1201 (adding §2707 to the P.H.S.A.) & 1302(a).

\(^{140}\) Under proposed IRS guidelines, employers would determine this by using a government devised “calculator” that would allow them to enter information about the plan’s benefits, coverage of services, and cost-sharing terms and would then apply that information to claims data reflecting typical self-insured employer plans. IRS Notice 2012-31, available at http://www.irs.gov/pub/irs-drop/n-12-31.pdf.
deductibles any larger than $2000 for an individual or $4000 for a group, a self-insured plan can employ much larger deductibles – any amount up to the out of pocket limits of $5950 for individual coverage and $11,900 (in 2010 dollars).\textsuperscript{141} Using large deductibles is a very simple way for a small employer to keep the minimum value of a plan below 60%, because in a typical self-insured population, the vast majority of people will not exceed this deductible. As previously mentioned, small employers that embrace consumer-driven health care ideas are particularly likely to pursue this minimum value strategy, especially if they happen to have low-risk employees.

Self-insurance could also be attractive to employers pursuing the affordability strategy. Recall that this strategy relies on an employer sponsoring a group plan with an employee’s share of premiums set at an amount that results in coverage being considered unaffordable for all employees with household income below a certain threshold. Some employers could pursue this strategy without self-insuring, simply by adjusting their contribution to coverage so that employees’ share of premiums equal or exceed desired thresholds. But this strategy may be difficult if the employer wants to ensure unaffordability for employees at the high-end of the premium-subsidy threshold or feels labor market pressure to contribute some amount towards premiums. Such an employer would be put in the awkward position of needing to shop for a more expensive plan simply to ensure unaffordability. A self-insuring employer can avoid this problem simply by calculating the required contribution of its employees so that this contribution is equal to an amount larger than 9.5% of the income of highest paid employee for whom it wants to preserve coverage on the exchange. Because such plans are not subject to the MLR rules, a self-insuring employer can change whatever premiums it wants, regardless of actual medical expenses. And any “excessive” charge would redound to the benefit of the employer rather than a third-party insurer.\textsuperscript{142}

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

While the premium tax credits are likely to drive mixed-income firms to pursue either the affordability or minimum value strategy, it is important to note that there is likely to be an added benefit of pursuing the minimum value strategy which will reinforce the likelihood that employers may find such a strategy attractive in the first place. By designing and implementing a low actuarial value plan, employers will be creating a perhaps unintended incentive for any employees with high-

\textsuperscript{141} See ACA §1302(c).
\textsuperscript{142} It is important to keep in mind that while insured plans can only vary premiums based on two specific health factors, age and tobacco use, actual health risk is much broader. So an employer that self-insures enjoys cost savings from all low-risk employees, not just those that are young non-smokers.
health risks to decline employer coverage and instead seek coverage through the individual exchange. Such plans will tend to be unattractive to those with significant medical needs because a low-actuarial value by necessity involves high levels of cost-sharing. For employees with reason to know they will incur significant medical expenses, it would be better to pay more in premiums in return for lower cost-sharing of medical expenses. For an employer pursuing the minimum value strategy, this further increases the benefits of self-insuring. Not only has the employer provided its low-income employees with access to premium tax credits while providing its high-income employees with affordable group coverage that can be purchased with pre-tax dollars, but it has also made its group plan even more affordable by decreasing its risk profile.

We have argued elsewhere that large employers are likely to actively pursue strategies that are specifically designed to dump high-risk employees onto individual exchanges. Small employers may be unlikely to engage in the type of sophisticated analysis that we think large employers are likely to pursue in order to shed the risk and cost of high-risk employees. They are, however, likely to understand that a low-actuarial cost plan will be unattractive to anyone with significant medical needs. And even if this does not enter into the employer’s initial decisionmaking process for its health plan in 2014, those employers that pursue the minimum value strategy beginning in 2014 are likely to see the lowered group health plan costs that result, not just from offering a low-actuarial value plan, but offering a low-actuarial value plan that only the healthy employees choose to enroll in. If these results are then shared within the small employer community, SHOP exchanges may see further erosion as more small employers elect to pursue a minimum value strategy.

C. Reduced Risks of Self-Insuring in 2014

While the potential benefits to small employers of self-insuring will increase in 2014, the downsides of doing so will decrease significantly at the same time. The primary reason for this change is that small employers who opt to self-insure in 2014 will face dramatically reduced risk from the prospect of their employees becoming sick. Historically, the risk of self-insuring has largely been conceptualized as short term: in any given year, premiums charged might be insufficient to pay the cost of employees’ covered medical expenses. But self-insuring has always involved a long-term risk as well: over time, covered medical expenses of the employee population could systematically increase if just a few people in that population became quite sick or had a child or spouse who became quite sick. Stop loss coverage was no solution to this risk, as such

144 See EIBNER ET AL., supra note 127, at 9-10.
coverage is itself risk-rated. The reason that commentators rarely focused on this risk was that it was not generally unique to self-insurance. Outside of a few states that regulated medical underwriting in the small group market, small employers often bore this long-term risk even if they purchased traditional coverage because insurers would adjust their premiums upward in response to any increased risk of the insured group.

Starting in 2014, however, the long-term risk associated with self-insuring will be largely eliminated as a result of the ACA’s reforms of small group markets. The ACA requires insurers in the small group and individual markets to price their policies without taking into account any health-related information other than age and tobacco use. Consequently, a self-insured small employer that perceived the cost of self-insuring to be increasing due to the deteriorating health of its workforce could simply abandon the decision to self-insure and purchase coverage at community average rates on the small group market. Historically this option was not available because the coverage acquired on the small group market would reflect the health risk level of the small group. However, by eliminating such medical underwriting in the small group market, the ACA indirectly also eliminated the long-term risk that has historically accompanied self-insuring.

To be sure, not all of the risk of a self-insurance strategy would dissipate as a result of this change. First, small employers who self-insured would still face the short-term risk that their employees would incur larger than expected medical costs before the employer could switch to conventional small group coverage. However, this risk can be reduced, but not eliminated, through the purchase of stop-loss insurance. Second, self-insuring small employers would face new strategic risks from uncertainties surrounding the anticipated costs and benefits of a self-insurance program, as the magnitude of the benefits and the costs of self-insuring are hard to predict. On the cost side, the expense of purchasing stop loss insurance, paying a TPA, and complying with legal and regulatory rules would be subject to uncertainty. And the magnitude of the potential benefits described above obviously also depend on numerous unknowns, including the success of individual insurance exchanges, the choices of employees, and the costs of regulatory burdens.

But while some risk would surely remain with a small business’s decision to self-insure, the group of small employers who offer any form of group coverage post-2014 will be disproportionately able to bear these remaining risks. This is because the small employers who are likely to be interested in offering any form of group coverage in 2014 and thereafter


146 ACA § 1201 (adding §2701 to the P.H.S.A.).
are those who have a non-trivial percentage of high-income employees. These small employers are the most likely to be willing to take on some risk from self-insuring if the expected benefits of self-insuring outweigh the expected costs. The reason, in a nutshell, is that firms with higher aggregate labor costs can more easily absorb the type of loss that might be associated with higher than anticipated costs and the resulting burden of shifting to an insured plan.

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

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

D. The Impact of Small Employers’ Decisions to Self-Insure

The extant literature has raised concerns that the regulatory differentiation between insured and self-insured plans under the ACA will significantly increase rates of self-insurance among small employers. What we have added to that concern is that self-insurance is in fact more likely than many estimates take into account. Employers pursuing either the minimum value or affordability strategies are either required or likely to self-insure, and as we explain above, the risks associated with self-insurance have been lessened by the ACA. Unfortunately, widespread self-insurance among small employers could completely jeopardize the SHOP exchanges. In particular, it could increase the risk-profile of the small businesses that do elect to purchase coverage a small business exchange. Recall that self-insurance is particularly likely to be attractive to low-risk small employers who can thereby take advantage of a better-than-average risk profile. This is true for both small employers with predominantly high-income employees, as well as those with mixed-

147 See Jost & Hall, supra note 136, manuscript at 6-8 (describing the recent growth in the market for small-employer self-insurance arrangements).
148 See id.
income levels that are pursuing the affordability strategy. This means that those small employers who do opt for exchange coverage will tend to be comparatively high risk.

This problem is made even worse by the fact that small employers who initially choose to self-insure, but then observe heightened expenses among their employees, can easily opt back into the SHOP exchange. And, of course, the migration of companies can also work in the opposite direction, so that firms who find that their employees are in fact incurring much fewer expenditures than they are paying in premiums could opt to self insure.

A disproportionate presence of high-income employees in small group markets, as described above, will interfere with the ability of carriers to limit the cost consequences of high-risk policyholders with heightened cost sharing. The spending of high-risk, high-income individuals is much less capable of being restrained by high-cost sharing requirements than the costs of high-risk, low-income individuals. As a result, to the extent that a SHOP exchange is starting to experience adverse selection, it will have limited tools at its disposal to reign in the spending of enrollees.

Another potential consequence of the move by small employers toward self-insured plans is that high-risk individuals may face increased risk of employment discrimination. Recall that for small groups, a single high-risk individual can dramatically increase costs. Stop loss carriers typically medically underwrite such coverage – meaning that they review the health profiles of the individuals whose medical risks are being reinsured. While such actions are prohibited for group health insurance, such carriers also often apply higher individual attachment points for those employees expected to incur higher than average medical expenses. Stop loss carriers are also able to “laser” certain individuals, and exclude them entirely from coverage under the policy. To be clear, these practices do not directly impact the individual; they only impact the employer’s ability to obtain stop-loss coverage for that individual’s losses. But it is easy to imagine that an employer that is told by a stop loss carrier that individual X will not be covered by the stop loss policy may be less enthusiastic about having individual X continue in her employment with the firm. Any firm that fired an individual on such a basis would generally be engaging in unlawful discrimination, but such discrimination in reality presents a serious enforcement problem.

Ultimately, the exit of a significant number of small firms from the group insurance market could very well trigger a “death spiral,” or self-

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150 We are grateful to Professor Tim Jost for bringing this risk to our attention.
151 See American Academy of Actuaries, supra note 145, at 11.
152 See Eibner et al., supra note 127, at 21.
153 Id.
reinforcing trend of adverse selection, in SHOP exchanges. Adverse selection occurs whenever an insurance pool disproportionately contains high-risk individuals. But adverse selection is a much greater risk in small pools, because the influx of high risks can have a much more dramatic impact on overall per/person expected costs. As noted above, because many small employers will opt to drop coverage altogether and have their employees purchase coverage on the individual exchange, it is likely that the SHOP exchange will indeed be small and therefore particularly vulnerable.

IV. SAVING THE SMALL GROUP MARKET

Given the multiple reasons to be worried about the health of the small group market outlined in Parts II and III, this Part presents various potential strategies for preserving the viability of SHOP exchanges. The existing literature on the small group market post-ACA has focused on regulating stop-loss coverage as a key to protecting the small group market.\textsuperscript{155} While regulating stop-loss coverage can help limit the risk of self-insurance, a much broader range of tools are available to counteract damaging strategic behavior by small employers and to ensure that the SHOP exchanges will be competitive against the option of self-insurance. Unlike the regulation of stop loss insurance, these tools can also help limit the risk that small employers will drop coverage entirely.

A. Regulate Stop-Loss Coverage

To date, the primary proposed policy response to the self-insurance risk has been enhanced regulation of stop-loss coverage. Professors Mark Hall and Timothy Jost have been particularly active, and persuasive, in advancing this approach.\textsuperscript{156} Although states cannot directly regulate self-insured employers under ERISA, stop loss insurance is subject to state insurance regulation. By making stop loss insurance less available to small employers, states could decrease the attractiveness of self-insuring to small employers. This is because stop-loss insurance is a practical necessity for a small businesses considering self-insuring, as described above. Proposed state regulatory approaches range from banning stop loss insurance for small employers, to regulating minimum attachment points, to prohibiting stop-loss insurers from risk-rating their premiums on the basis of group risk.

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

\textsuperscript{155} See generally Hall, supra 136; Jost & Hall, supra note 136.

\textsuperscript{156} See Jost & Hall, supra note 136.
much less politically contentious environment because most small employers did not care to self-insure, and thus to purchase stop loss coverage. Similar logic applies to attempts to prohibit stop loss insurers from risk rating, an approach that New Jersey implemented prior to passage of the ACA. This strategy would almost certainly have the same effect as an outright prohibition on stop loss insurance for small businesses, as it would inevitably subject stop loss insurers to substantial adverse selection.

Among the various proposals to reduce self-insurance by small employers, by far the most politically viable is the option of raising stop loss attachment points. Many states already have laws that limit attachment points and the NAIC has a model law on this topic. Almost all of these laws require minimum attachment points that have not been increased in well over a decade, thus failing to keep up with inflation. And there is an intuitive appeal to the notion that a small employer is not really self-insuring if it is passing off almost all of the risk of its employees’ health care expenses on to a third party stop loss carrier. Despite all of these factors, proposals to increase attachment points have gained little traction at the NAIC. And a recent proposal in California to require attachment points to be set at 125% of expected losses has faced sharp resistance from a number of groups.

While raising minimum attachment points for stop loss insurance is a potentially politically viable option, it is also an incomplete solution. Raising the minimum attachment point for stop loss insurance would make self-insuring a riskier proposition for those who do choose to self-insure. But it would still allow small employers to pass off much of their risk to stop loss insurers. At the same time, it would do nothing to change the fact that small employers who are low risk relative to other small employers with similar age and smoking profiles would have a positive expected benefit from self-insuring. Raising minimum attachment points will not, therefore, tend to deter risk-neutral or only moderately risk-averse small businesses from self-insuring.

Additionally, raising minimum attachment points for stop-loss insurance is not without risks. First, to the extent that it fails to deter small businesses from self-insuring, it merely forces small businesses to bear risks that they would prefer to offload. This could indeed harm small businesses without producing any beneficial improvement in health insurance markets. Second, raising attachment points could cause some employers simply to drop coverage entirely rather than turning to SHOP exchanges. Third, and finally, raising minimum attachment points could

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159 See id.
have the perverse effect of increasing the tendency of small employers who originally chose to self-insure to migrate back onto the SHOP exchange at the first sign that their workforce is incurring larger than community-level health expenses. Whereas a self-insured employer with robust stop loss insurance might be willing to continue self-insuring after a single year of larger than expected costs, less stop loss insurance makes this a more dangerous proposition. Perversely, this could actually increase the risk of adverse selection on SHOP exchanges.

Despite these concerns, we believe that raising the minimum attachment points for stop loss insurance to some level at or above expected costs is a sensible proposal. At the same time, we believe that it is limited in its capacity to address the many challenges described above and that, in any event, even this moderate reform of stop-loss insurance will prove politically infeasible in many state legislatures. For these reasons, the remainder of this Part explores alternatives that can either act as a compliment to stop-loss reform if enacted, or can help protect the small group market if such reform is not viable.

B. Designing SHOPs to Compete Against Self-Insurance

Existing literature has tended to focus on counteracting the self-insurance risk by making the option of self-insurance less appealing to small employers. But states must also focus on the flip side of the coin: making SHOP exchanges more attractive, particularly relative to the option of self-insuring. This approach has the benefit of not just counteracting the self-insurance risk, but also counteracting the risk that small businesses will choose to drop coverage entirely. This is particularly important given that limiting the availability of self-insurance by itself may simply cause small employers to drop coverage entirely, particularly given that small employers face no penalty for failing to offer group coverage.

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

Moreover, even with this sizable handicap, we believe that SHOP exchanges can indeed compete effectively against self-insurance if they are properly designed and marketed to small businesses. For this to occur, however, SHOP exchanges must exploit the weaknesses of the self-insurance option, just as brokers and stop loss insurers will undoubtedly attempt to exploit the weakness of SHOP exchanges – that they are limited.
in their capacity to risk-rate small groups. Fortunately, self-insurance has plenty of weaknesses, many of which are capable of overwhelming the advantages of self-insurance, even for small employers with risk profiles that are moderately below what would be expected for small businesses with employees of a similar age and smoking status. In particular, self-insurance is complex, risky, and limits employee choice. By contrast, SHOP coverage can be made simple, risk-free, and choice-enhancing. As explained below, offering and fully supporting a defined contribution model for health insurance may enhance a SHOP exchange’s capacity to offer these benefits as a contrast to self-insurance. Crucially, this response to the self-insurance risk does not require any legislative or even regulatory action.

1. Leverage Employee Choice

Small employers typically cannot offer their employees a choice of health plans. Rather, when a small employer offers group coverage, whether that coverage is insured or self-insured, there is typically only a single option available.\(^1\) This is because there are certain fixed costs associated with supporting more than a single health insurance option, making this option impractical for small employers who cannot spread the cost among numerous employees. By contrast, large employers can, and often do, offer employees a small menu of options from either a single or multiple carriers.\(^2\)

The ACA, however, gives SHOP exchanges the unique ability to provide small employers with an easy way to allow their employees to choose from multiple plans. Under the ACA, small employers can designate multiple options within the SHOP exchange from which their employees can elect coverage.\(^3\) An employer could, for example, allow its employees to elect coverage under any plan offered in the exchange, coverage within certain metal tiers, or just from among individually-specified plans.\(^4\) Under this approach, the employer would presumably make a defined contribution towards coverage, requiring the employee to bear the additional costs of more expensive policies.\(^5\) The employer’s contribution to such a plan would not constitute taxable income and, crucially, the ACA specifies that employees’ contributions to these plans

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\(^1\) KAIser FAMILY FOUND., supra note 16, at 55.

\(^2\) Id.

\(^3\) See Department of Health and Human Services, 45 CFR Parts 155, 156, and 157 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers.

\(^4\) ACA § 1312(a)(2)

\(^5\) The term “defined contribution health plan” has been used to refer to many different types of health plans and arrangements. See PAUL FRONSTIN, PRIVATE HEALTH INSURANCE EXCHANGES AND DEFINED CONTRIBUTION HEALTH PLANS: IS IT DÉJÀ VU ALL OVER AGAIN? 3 (2012), available at http://www.ebri.org/pdf/briefspdf/EBRI_IB_07-2012_No373_Exchgs2.pdf.
can also be paid with pre-tax dollars. By contrast, the ACA is clear that employee contributions towards the purchase of coverage on the individual market must be with after-tax dollars.

Employee choice is a unique competitive advantage that the SHOP exchanges can offer over both traditional group insurance and self-insurance, and they should leverage it to their advantage. Such choice allows employees to select a plan among numerous alternatives that covers their particular providers and provides their preferred mix of premiums, out-of-pocket cost sharing requirements, and covered services. At the same time, it places downward pressure on premiums by ensuring that individuals are fully aware of the financial effects of their choices.

Providing employees with a wide variety of health plan choices is likely to result in a competitive advantage for small employers over those that offer only a single option. In addition, providing such choice also relieves small employers of the weight of responsibility that is inherent in selecting only a single option for employee health care, particularly if employees have negative experiences with the single plan selected.

2. Leverage Limited Risk

Self-insurance will be a risky proposition for small employers. This will be particularly true in states that raise minimum attachment points for stop-loss insurance. But even with low attachment points, there is risk associated with self-insuring because of the prospect that stop-loss insurers will be unable or unwilling to pay claims. If the stop-loss carrier either denies claims or becomes insolvent during the contract period, the employer will generally be left with the liability to pay medical plan claims. There is also some liquidity risk associated with self-insuring. For example, assume that a small employer self-insures, but purchases stop-loss with an aggregate attachment point of $100,000. On January 2\textsuperscript{nd}, an employee is injured in a car accident, and incurs several hundred thousand dollars of covered medical expenses. The employer may need to have $100,000 available to pay those claims in January, rather than having the $100,000 paid over the course of the year, and severe cash flow problems could result for the small business. Finally, there would be some legal and regulatory risk from electing to self-insure – rules governing stop loss insurance could always change, as could the various regulatory exemptions associated with self-insuring.

Purchasing coverage in a SHOP exchange, by contrast, can be pitched to small employers as an entirely risk-free strategy. Any form of

\begin{itemize}
  \item \textsuperscript{166} ACA §1515 (amending I.R.C. §125). If a state elects, beginning in 2017, to allow large groups to participate in the exchange, those large employers would also have the ability to use a cafeteria plan to pay for exchange-based coverage.
  \item \textsuperscript{167} See id.
\end{itemize}
coverage purchased through a SHOP exchange will present no risk to employers that their employees will experience larger than average health care expenses, either because of natural fluctuations in health care expenses or because the small employer’s pool of employees is less healthy than expected. It also relieves small businesses from bearing the risk of insurer insolvency or non-payment, both of which are technically borne by employees but also substantially borne by providers in the case of traditional small group coverage.

SHOP exchanges could further cultivate this competitive advantage by supporting defined contribution arrangements that promote employee choice, as described above. A defined contribution model goes even further than traditional small group coverage in eliminating risk for employers of sponsoring insurance coverage, because it easily allows employers to choose the extent to which they will bear future premium cost increases. For example, if an employer chose to make a $3,000 contribution to each employee’s health insurance choice, it could elect to keep that contribution level year after year, thereby forcing employees to bear any increased premiums. Alternatively, it could choose to increase contributions based on wage inflation or inflation in health insurance costs. Although employers sponsoring traditional group plans also have control over the amount of future premium increases they will bear, a defined contribution model is more consistent with placing this risk on employees because it allows them to select a lower-cost plan in response to premium increases.

3. Leverage Simplicity

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

By contrast, SHOP exchanges can make the process of shopping for and maintaining group coverage extremely simple for small employers, at least if they are properly designed. SHOP exchanges, of course, are specifically meant to make selecting an appropriate small group plan simple by presenting information about different plans in an organized format and in a centralized location. But SHOP exchanges can, and should, do much more than this.
Historically, the small group market has been burdened not only with higher overhead costs imposed by insurers, but also with the regulatory burden that comes along with sponsoring a group health plan. Health plans sponsored by employers are subject to extensive federal regulation, from reporting and disclosure obligations to fiduciary duty requirements, requiring a significant amount of knowledge and imposing a large expense on employers.\textsuperscript{169} Even the presumably simple task of allowing your employees to pay their share of health insurance premiums on a pre-tax basis requires a fair amount of legal know-how. Employers must establish a written cafeteria plan document and administer the plan in accordance with fairly complex rules regarding when and to what extent an employee can change her health plan election during a plan year.\textsuperscript{170}

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

SHOP exchanges could potentially further enhance their simplicity relative to self-insurance by fully supporting defined contribution arrangements. Choosing an appropriate plan is a complicated endeavor for a small business, even if the available options are clearly explained. Unlike individuals, small businesses must expend a substantial amount of effort trying to discern and update their own preferences (i.e. the preferences of their employees as a group). A defined contribution model eliminates this complexity by relieving the employer of the need to select a plan, instead allowing individual employees to make this decision on their own. Indeed, a defined contribution model could limit small employers to making a single decision: how much they want to contribute to their employees’ coverage.\textsuperscript{171} Eventually, the simplicity of this decision could enable small businesses to jettison their insurance brokers.

\textsuperscript{169} See generally 29 U.S.C. §1001 et seq.
\textsuperscript{170} See I.R.C. §125.
\textsuperscript{171} There are, however, reasons why employers might want to be more involved in the decision. Employers may, for example, only want to give their employees choices within certain metal tiers.
4. A Cautionary Note on Defined Contribution Arrangements

While defined contribution arrangements provide a unique competitive advantage for SHOP exchanges, it should be noted that such arrangements may result in adverse selection within the exchange, if low-risk employees self-segregate into lower-cost plans. The ACA attempts to limit this risk by suggesting that employers may make available to their employees only plans within a specific precious metal category. Other options are also available: the risk adjustment mechanisms within the exchange may limit this risk. We view this as a substantial risk of a defined contribution model. However, given the numerous incentives that small employers have to not play ball in the first place, we believe that SHOP exchanges must take on this risk for themselves and manage them to the best extent possible.

C. Broker Incentives and Selling SHOPs Over Self-Insurance

Unfortunately, simply designing SHOPs to compete effectively against self-insurance is not sufficient. Coverage through SHOP exchanges must also be actively marketed and sold to small businesses as a superior alternative to self-insuring. Currently, small employers secure their health insurance coverage almost exclusively through insurance brokers, who help them navigate the complexities of selecting appropriate coverage.172

Brokers, however, are likely to have strong incentives to steer their small employer clients to self-insurance over coverage through a SHOP exchange. Under the MLR rules, broker commissions paid in the small group market are treated as non-medical expenses. As a result, they must be included in the maximum 20% of premiums that can be spent on non-medical expenses – a fact that already has limited the commissions that brokers earn by selling small group contracts. The same limitations do not apply to stop-loss coverage, which is not subject to MLR restrictions. This is particularly troubling because medical loss ratios are quite low for stop loss insurance, in the range of 60 to 65% of premiums. Given all these factors, commissions for stop-loss coverage are likely to be much higher than those available from selling exchange-based coverage. Rules governing “navigators” who help small employers navigate SHOP exchanges may exacerbate this risk.173

173 In particular, navigators need not be insurance brokers and are not allowed to receive different amounts of compensation for directing individuals to different carriers. See National Association of Insurance Commissioners, White Paper on Navigators (2010). Together, these two factors may result in further decreased compensation for insurance brokers who facilitate the purchase of coverage on a SHOP exchange, as compared to the commissions that they can receive from selling self-insurance related products.
While there are potentially good market reasons to be unenthusiastic about self-insurance relative to SHOP coverage, financially-motivated brokers may undermine these facts. They may downplay the complexities, risks, and limitations associated with self-insurance, while emphasizing the potential problems with SHOP coverage. For small employers who have limited knowledge and interest in health insurance markets and a trusting relationship with their broker, this steering could prove extremely effective.

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

A more aggressive, but quite sensible, option for overcoming broker incentives to push self-insurance is to directly regulate commissions paid by stop loss insurers. States could require by legislation that insurance brokers receive the same commissions for selling stop loss coverage than they receive for selling traditional group coverage. Alternatively, they could adopt MLR rules for stop-loss coverage that mimic the ACA requirements for the small group market. A third, and less aggressive option, is for states to pass strong commission-disclosure rules that require brokers to clearly disclose the fact that they have financial incentives to sell stop-loss coverage as an alternative to traditional group coverage. To be sure, many of these approaches are likely to encounter serious political opposition, as brokers are a well-organized lobby and there is not obvious source of counter-pressure in the political process. At the same time, though, the market problems created by differential compensation for insurance brokers are well understood, and were at the root of a massive scandal in the property/casualty insurance industry less than a decade ago. Moreover, the ACA already prohibits the payment of differential compensation for the sale of different products within the exchange. Extending this rule to competing products sold outside of the exchange could be understood as a logical extension of this rule.

D. Additional Regulatory/Legislative Options for States

1. Limit Churning Between SHOP Exchanges and Self-Insurance

Recall that one substantial attraction of self-insurance post-ACA is that small employers can switch to SHOP exchange coverage at any time

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at community average rates. This protects small employers against the prospect that any of their employees will become high-risk in the future. Migration in the opposite direction is also possible: small employers can shift into the self-insurance market from the SHOP exchange if their employees experience comparatively low health care costs. Both types of churning increase the risk of adverse selection on SHOP exchanges by facilitating employers’ capacity to self-insure when low risk and switch to traditional group coverage when high risk. Limiting the capacity of small employers to switch between SHOP coverage and self-insurance could simultaneously make self-insurance a less attractive option while limiting the prospect that those employers who do self-insure could cause adverse selection by opting back into the insured market. There are various ways this might be accomplished.

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

To be sure, this approach would not be perfectly effective. First, stop-loss insurers might try to combat this limitation by designing their policies’ renewals to correspond with open enrollment on the exchange. However, this would require stop loss carriers to issue policies for two-year periods of time, which would place a much greater risk on them (and, indirectly, the small employers who purchase stop loss coverage) that low-risk small groups would become high risk. Second, self-insured small employers

175 See Department of Health and Human Services, 45 CFR Parts 155, 156, and 157 Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers.

176 See Mark Hall & Elliott Wicks, An Evaluation of Colorado’s Small Group Health Insurance Reform laws, at 41, available at http://www.phs.wfubmc.edu/public/pub_insurance/PDF/colorado.pdf (describing an “amendment allows a self-employed individual to choose whether to purchase individual or group coverage. But if someone opts for individual coverage, they cannot switch back to the group market for three years, to prevent adverse selection.”).
who became high-risk could elect simply to drop group coverage altogether, as individuals can enroll at any time on an individual exchange if they have had a change of status in their employer coverage. But this option would penalize any high-income employees because it would deprive them of the ability to pay for coverage on a pre-tax basis. In sum, while limiting enrollment into SHOPs would not solve the churning problem, it could mitigate it substantially by complicating and making more risky the decision to self-insure.

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

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

2. Merge the Individual and Small Group Markets

The ACA explicitly gives states the option to merge their individual and small group markets. Doing so may, in some states, alleviate the negative effects of small employers self-insuring by increasing the size of the small group insured market by bringing in individuals. The effects of such a merger would, however, be felt in both the individual and small group markets, and could affect premiums in both. As a result, states

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

178 ACA §1312(c)(3).

179 In Massachusetts, for example, where the individual market was quite small, merging the individual and small group markets brought down premiums in the individual market.
would need to carefully model such a merger in order to determine the premium and coverage effects in both the individual and small group markets before proceeding. Merging the two markets will not automatically maximize coverage while lowering premiums.

_E.A Legislative Option for the Federal Government: Modify the Small Business or Premium Tax Credits_

Recall that one of the reasons the small group market is likely to be small is because many employers will either drop or modify coverage in order to preserve the premium tax credit for their employees. And while there is a small business tax credit to encourage small firms to offer group coverage, it is both limited in size and duration, and requires employers to heavily subsidize their employees’ premiums. For many employers, the small business tax credit does not counteract the incentives associated with the premium tax credit.

There are several legislative changes that could be used to address this situation. The easiest solution may be to amend the premium tax credit so that all low-income individuals are eligible, regardless of employer coverage. Attention would need to be paid to the details, but the basic idea would be that an individual who earned between 100% and 400% FPL would be eligible for the credit whether that individual was eligible for employer coverage or not, and regardless of whether the coverage was purchased on the individual market or through the employer. In order to prevent a double benefit, an individual who received a premium tax credit and an employer contribution that together exceeded the cost of coverage would need to have the employer contribution in excess of premiums treated as taxable income. Expanding the availability of the premium tax credit in this manner would solve the problem that the individual tax credit may persuade small employers to drop group coverage, but it would also give tax-credit eligible employees a tax advantage not enjoyed by other low-income individuals, in that these individuals would receive both the premium tax credit and the ability to pay for their share of premiums with pre-tax dollars. Proceeding down this path would therefore require a policy judgment that protecting the small group market in this manner is worth the cost associated with treating employed low-income individuals better than those without access to employer coverage. Another alternative would be to make the premium tax credit available regardless of an offer of employer coverage, but to exclude any low-income employees that are receiving the premium tax credit from the ability to pay the employee share of the premium with pre-tax dollars, thereby solving the inequitable treatment just described. Of course, either approach would marginally increase the cost of the ACA’s reforms. But not only would this reform help protect the small group market from collapse, it would

See Ricky Curtis & Ed Neuschler, SMALL-EMPLOYER (SHOP) EXCHANGE ISSUES 16 (2011).
also allow competition between an employer’s group plan and the individual market, thereby creating an additional incentive for small employers to create an attractive plan.

Alternatively, the terms of the small business tax credit could be amended to make the incentive effect both stronger and more universal. Right now, the credit only benefits small employers with low average wages, and it requires that eligible employers pay at least half the cost of employee coverage, with the credit then reimbursing employers for up to half of what they contribute. It is not surprising that this structure has not proven to be a very large incentive for small employers. First, it applies only to firms with certain wage levels, and it requires a significant employer contribution. Even though the credit essentially provides federal matching funds, it still requires that small employers spend a certain amount of employee health care. Further, it is not well matched to counter the incentive to drop coverage so that low-income individuals can receive their federal premium tax credits. To be more effective, the credit could be restructured to be calculated based on an individual employee’s wage level, rather than the firm’s average wage level, and in this regard be better tailored to match the individual premium tax credit. In addition, the credit could be made available to any low-income employees of a small employer that offers group coverage, regardless of any employer contribution that is made. Unfortunately, because either of these tax credit reform options may increase the marginal cost of the ACA, they may not be politically viable.

**CONCLUSION**

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