2013

An Optimist's Take on the Decline of Small-Employer Health Insurance

Allison K. Hoffman
University of Pennsylvania Law School

An Optimist's Take on the Decline of Small-Employer Health Insurance

Allison K. Hoffman[*]

In their Article, *Saving Small-Employer Health Insurance*, Amy Monahan and Dan Schwarcz contend that the Patient Protection and Affordable Care Act ("ACA") could be the death of small-group health insurance by incentivizing many small employers *not* to offer coverage. This article, like other work by Monahan and Schwarcz, offers timely, insightful, and carefully written analysis of an important social issue. While their prediction that the ACA, after implemented, will destabilize the small-group insurance market may prove true, I argue why their prescription that it should be saved is flawed and why we may be better off without small group insurance.

∗ Assistant Professor, UCLA School of Law. Thank you to Michael Frakes, Mark Hall, Jill Horwitz, Russell Korobkin, Timothy Jost, Bill Sage, and Daniel Schwarcz for comments on an earlier draft of this article and to my editors at the Iowa Law Review for an invitation to write this response.

In their introduction, Monahan and Schwarcz write: "Of course, a skeptic may reasonably wonder whether small-group insurance markets ought to be saved."[1] They then "proceed[] on the assumption that the ACA will not be able to accomplish its broader goals as effectively if that market segment collapses."[2] But one does not need to be a skeptic to wonder whether small-group insurance markets ought to be saved. An *optimist* and an ACA supporter could argue that the small-group markets need not be saved for the ACA to achieve its cornerstone goal of ensuring affordable, high-quality coverage to more people. In fact, it might be better to allow small-group health insurance to decline gradually, with more employees moving over time to the ACA's new individual-market exchanges instead.[3]

The U.S. system of employer-based insurance is often described as a historical accident that developed, in part, because employers enticed employees with benefits packages when wage controls limited wage increases.[4] Employer-based health insurance then became more prevalent because labor unions advocated for health insurance as a benefit for workers.[5] Favorable tax treatment of employer-based coverage (health benefits are tax deductible for the employer and excludable from income for the employee) has entrenched this system.[6]

But there is no inherent reason to preserve the small-group insurance market (or employment-based insurance more generally, for that matter), in whole or in part, unless it is an efficient and equitable means of coverage. Three markets for health insurance exist in the U.S.: (1) large group for employers with more than 50 employees, (2) small-group for those with fewer than 50 employees, and (3) individual-market insurance, where an individual buys insurance directly from an insurer. While there are reasons why large-group insurance has worked well (albeit not as efficiently or equitably as the non-employer based systems in other countries, as noted below), the same has never been true for small-group insurance. Furthermore, if the ACA works as intended, individual-market coverage, where people will be able to buy insurance directly from the new exchanges, may be a

1. Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1941 (2013).

2. *Id.* They base this assumption on the fact that political challenges will arise if attempts to save this market fail and on a belief that the stability of small-group market is more certain than that of the individual-market exchanges because of existing tax benefits and infrastructure. *Id.*

3. I believe this vision is fully consistent with the design of the ACA, as discussed below.

4. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 309–10 (1982); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y L. & ETHICS 23, 25–26 (2001).

5. TIMOTHY STOLTZFUS JOST, HEALTH CARE AT RISK: A CRITIQUE OF THE CONSUMER-DRIVEN MOVEMENT 62–63 (2007).

6. Hyman & Hall, *supra* note 3, at 25.

just as good or a better option than small-group insurance (or than employer-based insurance more broadly) for many people.[7]

The bottom line: The primary goal of the ACA is to make high-quality insurance affordable for more Americans. If the individual market exchanges succeed, the ACA can achieve this goal even—or perhaps more so—in the absence of small-group insurance. Thus, efforts to save small-group insurance are neither necessary nor advisable, as a priority.

I. THE PROBLEM (AS MONAHAN AND SCHWARCZ DESCRIBE IT)

Monahan and Schwarcz describe three major trends that could shrink the small-group market and, in so doing, leave fewer people in the small-group exchanges, known as the "Small Business Health Options Program" or SHOP exchanges. If these exchanges are smaller—particularly if they suffer from adverse selection, or sorting of less healthy employees into them—they will not pool risk well and will struggle to offer affordable coverage.

The first two trends Monahan and Schwarcz predict result in employers directing all or some of their employees, particularly the low-income ones, onto the individual-market exchanges. First, they argue that the ACA discourages small employers with lower-income employees from offering any employee coverage.[8] Offering coverage could subject their employees to loss of eligibility for tax credits that are available to low-income purchasers on the individual-market health insurance exchanges but are not available to low-income employees insured through an employer.[9] Offering coverage might also subject employees, who would otherwise be exempt, to the individual mandate.[10] Monahan and Schwarcz also suggest employers may feel less moral obligation to offer coverage if employees can get good coverage on the individual exchanges, regardless of their health, as the ACA's individual-market exchanges intend to facilitate.[11] Furthermore, the ACA does not require employers with fewer than 50 employees to offer coverage;[12] while it offers tax credits to some small businesses who choose

7. While not the focus of this article, I discuss herein many of the disadvantages of employer-based coverage and self-funded plans, which support arguments for a longer term phase out of employer-based insurance altogether.

8. As Monahan and Schwarcz discuss, small employers have been less likely to offer coverage historically, as compared to large employers, due to the higher per capita administrative costs of coverage, the lack of in-house human resources expertise, and the challenges of risk pooling with small groups. Monahan & Schwarcz, *supra* note 1, at 1942–43.

9. *Id.* at 1951. Tax credits are available to anyone whose household income is between 100% and 400% of the federal poverty level ("FPL"), as discussed below. *See infra* Part II.A.2.

10 Monahan & Schwarcz, *supra* note 1, at 1953–54. An individual is subject to the individual mandate only when she has access to affordable coverage and declines to purchase it. *See* Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244–47 (2010) (codified as amended at I.R.C. § 5000A (Supp. V 2011)). Coverage is "affordable" for purposes of the mandate if it is less than or equal to 8% of household income. ACA § 1501(b), I.R.C. § 5000A(e)(1).

11. Monahan & Schwarcz, *supra* note 1, at 1954.

12. ACA § 1513, I.R.C. § 4980H(c)(2).

to offer coverage, these credits are only available to some employers and only for a limited duration.[13] In light of these conditions, it may be rational for a small employer with low-income employees not to offer coverage.

Second, Monahan and Schwarcz argue that the ACA enables small employers to sort employees based on income or health so that the higher-income and healthy choose employer-based coverage and others opt out. Employers with both higher- and lower-income employees can design plans to create incentives for higher-income employees to enroll in the employer plan but lower-income employees to opt instead for coverage through the individual-market exchanges. Employers could do so by creating insurance plan options that are not "affordable" (premiums exceed 9.5% of income) or do not provide "minimum value" (actuarial value of at least 60%) for lower-income employees.[14] Either of these conditions preserves the employees' access to tax credits for coverage on the individual-market exchanges[15] and creates incentives for lower-income employees to buy individual coverage to take advantage of these tax credits.[16] In contrast, higher-income employees, who are not eligible for tax credits on the exchange and who would benefit relatively more from the tax exclusion of employer-based insurance, might nonetheless stick with the employer plan.[17] As Monahan and Schwarcz describe, employers who take this approach avoid subsidizing employer-based coverage for low-income employees, for whom beneficial tax treatment has little value, and can use any dollars that would have funded health benefits to increase wages instead.[18] But the employer will still enjoy tax deductions for high-income employees who stick with the employer health plan, which provides a less expensive way to compensate these employees.[19]

In addition, if an employer sorts by offering a minimum-value plan, it subjects an employee with high health spending to considerable cost-sharing. High-risk or sick employees—whether high- or low-income—would also be more likely to decline employer coverage and buy more comprehensive coverage on the individual exchanges.[20] In this case, employers would also reduce the number of high-risk, expensive employees in their risk pools.

Finally, Monahan and Schwarcz predict—and others have examined in more detail[21]—that the ACA is likely to cause more small employers to "self-insure," or

13. Monahan & Schwarcz, *supra* note 1, at 1954–55; *see* ACA § 1421, I.R.C. § 45R.

14. Monahan & Schwarcz, *supra* note 1, at 1958–59.

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

16. *Id.*

17. Monahan & Schwarcz, *supra* note 1, at 1958–61.

18. *See id.* at 1960.

19. *See id.*

20. *See id.* at 1959–60.

21. *See generally* CHRISTINE EIBNER ET AL., RAND HEALTH, EMPLOYER SELF-INSURANCE DECISIONS AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA) (2011), *available at* http://www.rand.org/pubs/technical_reports/TR971.html; Timothy Stoltzfus Jost & Mark A. Hall, *Self Insurance for Small Employers Under the Affordable Care Act: Federal and State*

retain liability for claims rather than transfer risk to an insurer.[22] They highlight several concerns with self-insurance, including that it enables employers to design coverage that is not affordable or minimum value, which will exacerbate the aforementioned sorting.[23] In addition, employers with healthier, lower-cost employee groups are more likely to self-insure, leaving less healthy groups in the SHOP exchanges and making them more unstable.[24] Finally, employers who self-insure can avoid substantive health insurance regulations, including many of the important consumer protection regulations of the ACA.[25] While this last issue poses reason for concern—and is a problem separate from and pre-dating the ACA—I'll argue that the other two consequences of self-insurance are not necessarily problematic.

In short, Monahan and Schwarcz are concerned that some small employers will send lower-income or less-healthy employees into the individual market and that other small employers with healthy employee groups will self-insure, extracting healthy employees from the SHOP exchanges. Both trends could destabilize SHOP exchanges. I argue, however, that the first concern might be a boon and the second is easily remedied within the parameters already set out in the ACA.

II. WHY THESE TRENDS ARE LARGELY NOT A PROBLEM

Rather than lamenting the likely decline of small-group coverage, I argue that its decline might be preferable in the long run, especially for lower-income or higher-risk individuals.

A. WITH ACA SUCCESS, THERE IS NO LONGER A REASON TO PREFER SMALL-GROUP COVERAGE OVER INDIVIDUAL-MARKET COVERAGE

Employer-based coverage is not inherently superior to other forms of coverage; in fact in most countries, health care financing is not employer-based and these countries enjoy better outcomes per dollar spent.[26] However, in practice in the U.S., employer-based insurance has historically been better than individual-market coverage for three main reasons: (1) risk pooling, (2) tax benefits, and (3)

Regulatory Options, N.Y.U. ANN. SURV. AM. L. (forthcoming 2013) (manuscript at 5–10), *available at* http://ssrn.com/abstract=2070883.

22. Monahan & Schwarcz, *supra* note 1, at 1967. Because most employers who self-insure obtain stop-loss policies, in reality, they retain limited risk. *Id.* at 1970–72.

23. *Id.* at 1972–75.

24. EIBNER ET AL., *supra* note 21, at 61–63; Jost & Hall, *supra* note 21, at 8–10.

25. Self-insuring allows small employers to avoid the mandated benefit requirements (essential health benefits), medical-loss ratios, premium review, and deductible limits. Monahan & Schwarcz, *supra* note 1, at 1967.

26. OECD, OECD HEALTH DATA 2012: HOW DOES THE UNITED STATES COMPARE 1–2 (2012), *available at* http://web.archive.org/web/20130515051025/http://www.oecd.org/unitedstates/BriefingNoteUSA2012.pdf (showing the U.S. health expenditures as the highest in the world and describing some of the ways the U.S. lags on outcomes, including slower gains in life expectancy than other countries and the highest rate of obesity among OECD countries).

enhanced regulatory protections. None of these reasons is especially compelling with regard to small groups after the implementation of the ACA, assuming the individual-market reforms work reasonably well.

1. Risk Pooling

A primary argument for employer-based health insurance is that employee groups often offer perfect insurance risk pools.[27] Employees come together in a workplace for non-health related purposes, which usually leads to a diverse health makeup among members and, in turn, predictable and stable average per capita health care costs year-to-year.

While this benefit accrues to most large employee groups, it is less true for small groups, where one very sick person can lead to extremely high costs for the group. Because federal law prevents employers from excluding employees from coverage based on health status and because they are not able to charge a risky individual more for coverage,[28] having a single sick employee can have a strong effect on the composition of the risk pool and, historically, on premiums for all employees.[29] Thus, the main argument for preserving employer-based coverage never applied to small groups.

Even in light of ACA regulations that will improve risk pooling by eliminating most underwriting for small groups,[30] it is not clear that small group markets will have any significant risk-pooling advantage over the individual market.[31] The individual market exchange pools will be quite large with 22 million expected insured by 2019.[32] In addition, the "individual mandate" is intended to

27. *See, e.g.*, Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 573–74 (2008).

28. 29 U.S.C. § 1182 (2006 & Supp. V 2011).

29. *See* Monahan & Schwarcz, *supra* note 1, at 1943.

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

31. Empirically, it is difficult to predict which market will result in a better risk pool for several reasons. First, the ACA's rules for risk pooling among those insured inside and outside exchanges are complex. While an insurer participating in an exchange must treat all insured, whether inside or outside the exchange, as one risk pool, some insurers might not participate in the exchanges and grandfathered plans are not included in this requirement, thus fragmenting risk pooling in both the individual and small-group markets. *See* NAT'L ASS'N INS. COMM'RS, ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT 2 (2011).

32. CONG. BUDGET OFFICE, CBO'S FEBRUARY 2013 ESTIMATE OF THE EFFECTS OF THE AFFORDABLE CARE ACT ON HEALTH INSURANCE COVERAGE 3 (2013), *available at* http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf. The individual and small-group markets are estimated to be roughly similar in size overall. *Id.* at 2. In 2023, an estimated 28 million individuals under age 65 will have nongroup (i.e. individual) or "other" coverage outside of exchanges—a significant portion of whom with "other" coverage—which refers to Medicare. *Id.* An estimated 25 million will have individual-market exchange coverage, which means more than 30 million will have individual-market coverage. *Id.* 167 million will have employer coverage—just over 18% of whom with small-group coverage—making over 30 million small-group insured. *Id.*; THE KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2012 ANNUAL SURVEY 16 (2012) [hereinafter "KAISER & HRET SURVEY"], *available at*

combat adverse selection by encouraging healthy people to buy coverage.[33] If the mandate is successful,[34] the individual market may thus pool risk and stabilize health care premiums as well as or better than the small-group market.

2. Tax Benefits

Tax excludability is a second advantage of employment-based coverage over individual coverage. Employer-sponsored health insurance can be financed with pre-tax income,[35] whereas individual coverage can only be purchased with after-tax dollars.

But tax excludability is not necessarily a good thing. In fact, leading into the ACA debates, economists of all political persuasions were in large agreement that the tax treatment of employer-sponsored insurance is a problem and should be limited or eliminated.[36] The exclusion of health benefits is regressive; higher-income employees benefit more when income is excluded from taxes because they are being taxed at higher rates. Exclusion is also inefficient because it causes too much investment into health benefits instead of wages, by making the former relatively cheaper.[37] By one estimate, for the typical worker, health benefits cost 65% of wages or other goods purchased; in essence a dollar of health benefits costs only 65 cents.[38] In turn, comprehensive insurance coverage might prompt people to

---

http://kaiserfamilyfoundation.

files.wordpress.com/2013/03/8345-employer-health-benefits-annual-survey-full-report-0912.pdf (estimating that 18.3% of covered workers are in small groups with 49 or fewer employees, which would mean 30.5 million workers with small-group coverage—18.3% of 167 million—in 2023 if this percentage remains constant). While the individual market pools may be small enough in some states that risk-pooling may be imperfect, the potential SHOP exchange pool will be even smaller in those states. CBO estimates about one-fifth as many people will have employer-based coverage on exchanges as will have individually purchased coverage on exchanges. *See* CONG. BUDGET OFFICE, *supra*.

33. ACA, Pub. L. No. 111-148, § 1501, 124 Stat. 119, 242–44 (2010) (codified as amended at 42 U.S.C. § 18091 (Supp. V 2011)).

34. Some believe individual mandate penalties are not high enough to provoke young, healthy people to get coverage, which would undermine individual-market risk pooling. However, evidence from Massachusetts' 2006 reform, which also had relatively low penalties for non-compliance, showed high rates of participation. Amitabh Chandra et al., *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293, 295 (2011).

35. I.R.C. §§ 106, 125 (2006 & Supp. V 2011). The ACA explicitly allows employees to buy coverage on the SHOP exchanges with pre-tax dollars as a cafeteria plan benefit. ACA § 1421, I.R.C. § 45R (Supp. V 2011). But individual coverage still must be purchased with post-tax dollars.

36. *E.g.*, CATO INST., CATO HANDBOOK FOR POLICYMAKERS 141 (2009), *available at* http://www.cato.org/cato-handbook-policymakers/cato-handbook-policymakers-7th-edition-2009; Paul N. Van de Water, *Limiting the Tax Exclusion for Employer-Sponsored Insurance Can Help Pay for Health Reform*, CTR. ON BUDGET & POLICY PRIORITIES 1 (June 4, 2009), http://www.cbpp.org/files/6-2-09health.pdf.

37. *See, e.g.*, Martin S. Feldstein, *The Welfare Loss of Excess Health Insurance*, 81 J. POL. ECON. 251, 255 (1973) (explaining how tax subsidies of employer-based insurance create overinsurance); Gruber, *supra* note 27, at 574, 580.

38. Gruber, *supra* note 27, at 574. In addition, employees can receive tax subsidies for money spent on health insurance purchased with money in a "cafeteria plan," as defined under section 125 of the Internal Revenue Code.

overuse care if they bear little or no cost sharing (deductibles, co-payments, or co-insurance) for items or services at the time of consumption, a problem known as moral hazard.[39]

In contrast, subsidies of health care benefits available on the individual-market exchanges are a more equitable use of tax dollars. The tax credits are set on a sliding scale with the amount of subsidy decreasing as income increases. Any individual with household income between 100% and 400% of the federal poverty level ("FPL") will pay no more than a predetermined percentage of income on insurance premiums for an exchange plan, ranging from 2% of income for someone earning 100% of the FPL to 9.5% of income for someone earning 300% to 400% of the FPL.[40] The amount of a tax credit is calculated based on the premium for the second most expensive "silver-level" plan in a state minus the predetermined contribution.[41] In addition, the ACA provides cost-sharing subsidies that limit how much an individual earning up to 400% of the FPL, who buys silver-level coverage on an exchange, spends out-of-pocket when using medical care.[42]

These tax policies have the exact opposite effect as the current tax exclusion: rather than offering greater benefit for higher-income earners, for whom excludability is more valuable, they offer greater benefit the less an individual earns. The new status quo is not perfectly progressive. Some small-group employees will either lose or opt out of employer coverage and yet qualify for little, or no, exchange subsidies if they earn close to or over 400% of the FPL. These employees will be worse off than similarly-situated individuals with employer-sponsored health insurance, who benefit from the tax exclusion. Their circumstance, however, is less a critique of the ACA's tax policies and more grounds for additional critique of the inequities created by allowing purchase of health benefits with pre-tax dollars for employer-sponsored insurance. In addition, while inequitable, most of these individuals are arguably in a reasonable position to finance their own health insurance coverage, even without the benefit of tax subsidies.

In addition to being more equitable, the tax credits are more efficient because they are less likely than the status quo tax exclusion to create moral hazard—although they might still to a lesser degree. Because the tax credits are calculated based on the premium for a silver-level plan, it is unlikely an individual with income low enough to qualify for the tax credits would buy any higher than a silver level plan (i.e. "gold" or "platinum" coverage). They might, in fact, use their subsidy to buy a less expensive "bronze" plan. Individuals with silver or bronze plans incur cost-sharing when they use medical care, which could reduce such use

39. *See generally* Mark V. Pauly, *The Economics of Moral Hazard: Comment*, 58 AM. ECON. REV. 531 (1968). Cost sharing, including copayments and deductibles, decreases moral hazard. *See* GRUBER, *infra* note 40 at 5.

40. ACA, Pub. L. No. 111-148, § 1401(a), 124 Stat. 119, 213–19 (2010) (codified as amended at I.R.C. § 36B(b) (Supp. V 2011)).

41. *See id.*

42. ACA § 1402(b)–(c), 42 U.S.C. § 18071 (Supp. V 2011).

overall[43] (it might, however, deter poor insured from seeking necessary care[44]). Admittedly, the cost-sharing subsidies could counterbalance this effect, rendering even individuals with silver plans less sensitive to health care spending at the point of use; but these subsidies only lessen and do not eliminate cost-sharing.

Thus, shifting away from small-group and toward individual-market coverage is more equitable and efficient from a tax policy perspective.[45]

3. Regulatory Protections

Another former advantage of employer-based coverage over individual-market coverage that the ACA equalizes is consumer protections. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibited employers from discriminating against employees based on health status,[46] limited exclusion of coverage for preexisting conditions,[47] and required insurers to issue coverage to any applicant (i.e. "guaranteed issuance").[48] These regulations meant that every employer could get access to coverage for its employees, regardless of the group's health status—albeit, sometimes at a high price—and every employee had access to the employer's plan at a community-rated price that included all benefits offered under the employer's plan.

Before the ACA, these regulations applied only to group coverage, for the most part, resulting in an individual market that was notorious for excluding high-risk applicants. By one estimate, in 2005, nearly three in five adults who applied for coverage in the individual market "found it very difficult or impossible" to find a plan that they could afford because they were denied coverage, charged higher prices, or had a health problem excluded from coverage.[49]

---

43. JONATHAN GRUBER, KAISER FAMILY FOUND., THE ROLE OF CONSUMER COPAYMENTS FOR HEALTH CARE: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT AND BEYOND 9 (2006), *available at* http://www.kff.org/insurance/upload/7566.pdf (discussing various studies revealing information about elasticity of demand for various medical treatments).

44. *Id.* at 5 (describing the results from the RAND health experiment showing that with cost sharing some individuals will forgo care, even when this forbearance is not in their best interests).

45. This line of thinking equally argues for unraveling large-group coverage as well over time, or at least for eliminating the preferential tax treatment of such coverage.

46. 29 U.S.C. § 1182 (2006) ("[p]rohibiting discrimination against individual participants and beneficiaries based on health status"). While the terms might be facially neutral, however, employers could still exclude whole categories of treatment in a way that might have a disparate impact on employees. *See, e.g.*, McGann v. H & H Music Co., 946 F.2d 401, 403, 408 (5th Cir. 1991) (holding that an employer who reduced the medical benefits for employees with AIDS did not discriminate illegally).

47. 29 U.S.C. § 1181.

48. 42 U.S.C. § 300gg-1 (2006). This provision existed in a different form prior to the passage of the ACA and was modified by the ACA to apply to both group and individual coverage.

49. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 4 (2006), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Sep/Squeezed%20%20Why%20Rising%20Exposure%20to%20Health%20Care%20Costs%20Threatens%20the%20Health%20and%20Financial%20Well%20Being%20of/Collins_squeezedrisinghltcarecosts_953%20pdf.pdf.

The ACA, however, evens the playing field by extending the protections historically in the group markets to the individual market as well. The ACA requires insurers to guarantee coverage to all applicants,[50] prohibits the exclusion of pre-existing conditions,[51] and prohibits "risk-rating" or charging people more based on health status.[52] In fact, there are only four factors for which an insurer may charge an individual more for a policy: geography, family size, age, and tobacco-use status.[53] Furthermore, the ACA requires insurers offering policies on the individual-market exchanges to include a comprehensive set of "essential health benefits."[54]

The ACA regulations intend that an individual—even if in poor health—will be able to get quality coverage on the individual-market exchanges, with comprehensive benefits, including for any pre-existing conditions, at modified community-rated prices. The effect is that high-risk individuals might be just as well or better off with individual-market coverage than with group coverage.

4. Lingering Downsides of Employer-Based Coverage

Employer-based coverage has historically also had many disadvantages, which will remain after the ACA.[55] In light of these lingering downsides, if the individual market is successful, it might be preferable to transition all employer-based coverage (both small- and large-group) to individual-market coverage over time.

For example, getting health care benefits from an employer introduces personal health matters into the workplace, where employers might have access to sensitive and private health data. While this access does offer the potential for employers to put initiatives in place to improve employee health, it has significant risks. Because having sick employees will increase the costs of an employer plan and of doing business, employers have an incentive to avoid and discriminate against sicker job applicants. Even though laws have attempted to prevent discrimination based on an individual's health,[56] they are largely considered ineffective because an employer can typically offer other nondiscriminatory reasons for not hiring an individual who might pose a risk of health care spending.[57]

50. ACA, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 156 (2010) (codified as amended at 42 U.S.C. § 300gg-1 (2006 & Supp. V 2011)) (adding § 2702 to the PHSA).

51. ACA § 1201, 42 U.S.C. § 300gg-3 (adding § 2704(a) to the PHSA).

52. *Id.* § 300gg-4 (adding § 2705 to the PHSA).

53. *Id.* § 300gg (adding § 2701 to the PHSA).

54. ACA § 1302, 42 U.S.C. § 18022 (adding § 2705 to the PHSA).

55. *See, e.g.*, Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, HEALTH AFF., Nov.–Dec. 1999, at 124, 124.

56. *See, e.g.*, Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 101, 122 Stat. 881, 883–88 (2008) (codified in scattered sections of 26, 29, and 42 U.S.C.) (banning the use of genetic information when setting insurance rates for group health plans).

57. *See* Steven Greenhouse & Michael Barbaro, *Wal-Mart Memo Suggests Ways To Cut Employee Benefit Costs*, N.Y. TIMES (Oct. 26, 2005), http://www.nytimes.com/2005/10/26/

In addition, employer-based insurance is not portable. This means that when an individual leaves a job, she cannot take her insurance with her, causing disruptions in coverage and often requiring individuals to change their care providers.[58] While the law has attempted to ameliorate gaps in coverage through "COBRA" continuation coverage,[59] which allows an employee to maintain employer-sponsored coverage for 18 months after leaving employment, this option is rarely used because the employee must pay the entire cost of, typically expensive, coverage.[60]

For larger groups, administrative cost efficiency and negotiating power have been an advantage, but small groups, in particular, have a difficult time arranging for and administering health benefits. They sometimes lack an individual to manage benefits effectively in house and have experienced plan administrative costs many times higher than large-group plans.[61] While the SHOP exchanges will bolster negotiating power and might reduce some administrative costs, they will not eliminate the internal costs and challenges of managing the provision of employee benefits, which employers often claim feels like a second line of business.

In sum, if the individual-market exchanges succeed, the shift away from small-group insurance and into individual-market plans could be beneficial, considering that small-group coverage offers little or no comparative advantages over individual coverage and that there are significant disadvantages with employers as a locus for health insurance.

B. THE POST-ACA INDIVIDUAL MARKET IS BETTER, IN PARTICULAR, FOR LOWER-INCOME OR HIGHER-RISK EMPLOYEES

Monahan and Schwarcz voice concern about employers funneling lower-income or higher-risk (or less healthy) individuals, in particular, into the individual-market exchanges, but this trend might also be beneficial. The exchanges are arguably better places for these individuals to find good access to affordable health care without unduly burdening small employers.

---

business/26walmart.ready.html?pagewanted=all&_r=0 (describing the type of pretext used to screen out less healthy employees including Wal-Mart's requirement that "all jobs . . . include some physical activity (e.g., all cashiers do some cart-gathering)" (internal quotation marks omitted)).

58. It is possible that SHOP exchanges could increase portability to some degree if they have a defined-contribution model option, where employees can choose from any available plan. In this case, if an employee moves from one small employer to another, both of which have defined–benefit SHOP coverage, the employee could maintain coverage. But the chance that an employee moves to another employer with defined-benefit SHOP coverage is small and portability will still be limited if the employee moves to a large group plan or, likely also, to individual coverage.

59. Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, Title X, § 10002(a) (1986) (codified as amended at 29 U.S.C. § 1161 et seq.).

60. 29 U.S.C. § 1162(3) (2006).

61. STACEY MCMORROW ET AL., URBAN INST., THE EFFECTS OF HEALTH REFORM ON SMALL BUSINESSES AND THEIR WORKERS: TIMELY ANALYSIS OF IMMEDIATE HEALTH POLICY ISSUES 2 (2011), *available at* http://www.urban.org/uploadedpdf/412349-Effects-of-Health-Reform-on-Small-Businesses.pdf.

As Monahan and Schwarcz themselves describe, with tax credits and cost-sharing subsidies, a low-income individual will be better off getting coverage through the individual-market exchange than through an employer.[62] The individual will in most cases pay less out-of-pocket for individual-market coverage than he would if he were to try to get the same plan through his employer.[63] The example that Monahan and Schwarcz provide is that someone who earns 200% of the FPL, might pay only $704 for a bronze health plan on the exchange or $1386 for silver-level coverage (based on a premium of $4780 for silver level coverage and $3394 tax credit). Most individuals pay more than that amount for the employee share of premiums for a small-group employer plan; the average employee contribution in the U.S. in 2012 for small-group family coverage was $5134 and for single coverage was $848.[64] Furthermore, for these employees, the employer is paying part of the cost of benefits. As noted above, this spending substitutes wage spending, which means the total cost to the employee is greater than just this premium contribution.[65] Even though employees cannot pay for premiums with pre-tax dollars on an individual-market exchange, the exchange tax credit and the cost-sharing subsidies along with any wage benefit would outweigh the low value of the tax exclusion for someone with little taxable wages.[66]

Monahan and Schwarcz lament the expense of additional people taking advantage of individual-market tax credits.[67] However, this additional spending is squarely, progressively, and efficiently focused on helping the ACA achieve its goals. In the exchanges, the cost of subsidizing poor and sick people is shared and spread more broadly among all taxpayers and ACA revenue sources, rather than resting on the shoulders of small employers, who might bend under the weight. Allowing these small employers to send employees to the individual-market exchanges meets the dual goals of ensuring employees high-quality, affordable coverage and preserving employment and wages for lower-income workers. Someone will have to subsidize these employees' coverage, and it is not clear that we should place this burden on small employers or their employees, rather than on the public fisc, even if politically easier.

While greater reliance on the individual market is more solidaristic in terms of broad risk-spreading, a two-tiered system might develop with the healthy and wealthy in employer plans and the sick and poor in exchange plans. On one hand, this means that the two groups are not directly pooling health risks and that those in the small-group market get away without having to subsidize less-healthy

62. Monahan & Schwarcz, *supra* note 1, at 1953.

63. *See id.*

64. KAISER & HRET SURVEY, *supra* note 32, at 72.

65. Economic theory suggests that dollars not spent on health benefits translate into additional wages. *See generally* Sherwin Rosen, *The Theory of Equalizing Differences*, *in* 1 HANDBOOK OF LABOR ECONOMICS 641 (Orley C. Ashenfelter & Richard Layard eds., 1986); Lawrence H. Summers, *Some Simple Economics of Mandated Benefits*, 79 AM. ECON. REV. 177 (1989).

66. *See* Monahan & Schwarcz, *supra* note 1, at 1952–53.

67. *Id.* at 1963–64.

coworkers' coverage.[68] On the other hand, the increased costs of coverage in the individual-market exchanges, if they suffer from adverse selection, will fall on higher-income taxpayers, not on low-income individually-insured, whose contributions are capped as a percentage of income under the ACA, as discussed above. Thus, the wealthy in employer plans do not fully escape subsidizing the costs of the poor and the sick because they will help finance increased tax credits through progressive tax mechanisms.[69] In addition, the ACA's substantive regulations bring the quality of individual-market coverage in line with employer plans. This means that even if a two-tiered system develops, those with individual coverage will not suffer from lesser or more expensive insurance than those in employer plans.

Thus, while having more low-income people in exchanges would increase the bottom-line costs of the ACA and pressures on the federal budget, this end strikes me as an especially worthwhile use of government spending. Plus, spending to ensure financial protection and access to health care for low-income Americans is less vulnerable politically; it is relatively more difficult for detractors of the ACA to attack spending on necessary health care for poor people (although certainly not unimaginable).

C. THE SUCCESS OF THE ACA DOES NOT RELY ON THE SURVIVAL OF SMALL-GROUP MARKETS OR SHOP EXCHANGES

Finally, and perhaps most importantly, even if the trends described above make it difficult for the SHOP exchanges to stand on their own, this effect would not threaten the ACA's success. Both the shifting of employees to the individual market, as discussed above, and the increase in self-insurance could threaten the survival of the small-group market by depleting small-group risk pools and, in particular, by removing healthier members into self-insured plans. Monahan and Schwarcz attempt to defend the goal of saving small-group markets by suggesting that the ACA's goal was to bolster small-group markets, based on the fact that the structure of the ACA presumes the existence of small-group market and exchanges.[70]

I think it is less clear than Monahan and Schwarcz suggest, however, that the ACA intended to save the small-group market in the long run. Employer-sponsored insurance has been slowly eroding over the past decades.[71] While ACA provisions definitely acknowledge the continuation of small groups, especially in the short

68. Of course, if those employees are buying in the SHOP exchanges, where group premiums will not vary based on health, costs will be spread among all small-group SHOP insured in a state, not just among coworkers.

69. ACA, Pub. L. No. 111-148, § 10906, 124 Stat. 119, 1020 (2010) (codified as amended at 26 U.S.C. §1401 (Supp. V 2011)).

70. *Id.* at 1941.

71. KAISER & HRET SURVEY, *supra* note 32, at 5 (showing a decline in the offer rate of health benefits from 66% of all firms in 1999 to 61% in 2012, with some variability up and down in intermediate years).

term—including the subsidization of small-group coverage in the short term and the creation of SHOP exchanges—other parts of the ACA suggest that the drafters might have foreseen or accepted shrinking small-group insurance markets in the longer-term.[72] For example, the ACA's imposition of financial penalties on employers that fail to provide employees coverage does not extend to small employers; if a key goal were to preserve this market, extending these penalties to all employers would have gone a long way. While a mandate for small employers would have been a political battle, it was one that legislators took on against large employers. Furthermore, the ACA's efforts to fix the problems with the individual market could be seen as creating a gateway to allow evolution away from employer-based insurance, especially for small employers, for whom offering insurance may not be rational. If the individual-market exchanges work, individuals will have access to high-quality, affordable, and portable coverage outside the workplace.

Finally, the law explicitly permits states to create a merged market for individual- and small-group insurance, rather than setting up a separate infrastructure for SHOP exchanges,[73] as has been done successfully in Massachusetts as part of its 2006 health reform. To the extent the small-group market is depleted in numbers, especially if part of that depletion occurs through a funneling of employees to the individual market, the balance is easily regained by merging the two markets. The fact that the law explicitly authorizes such a merger could be recognition by its drafters that in some states the small-group market would be too small to stand on its own and that the markets would function better together, rather than separately. Monahan and Schwarcz recognize this possibility but, in my opinion, fail to give it enough credit. Admittedly, this merger of markets would not neutralize adverse selection due to self-insurance, but it would ameliorate the other concerns that Monahan and Schwarcz outline.

Even if the drafters of the law did intend to save the small-group market, if it becomes apparent during implementation that the ACA's goals can be achieved as well without it, there is no reason to double down efforts on saving a dying market, while other hard work awaits. The administration may already be thinking along these lines, as evinced by its decision to abandon full implementation of the SHOP exchanges this year when it became clear that it would have to triage to meet priority ACA deadlines, including that for establishing the individual-market exchanges.[74] While detractors of the law may attempt to spin weakness of SHOP

72. Other parts, such as the "Cadillac Tax" and its gradual elimination of tax exclusion of employer-sponsored health care, can be read as discouraging employer-sponsored coverage, including large-group coverage, in the long-term. *See, e.g.*, Austin Frakt, *The Decline of Employer-Sponsored Coverage Under Health Reform: Good, Bad, or Ugly?*, KAISER HEALTH NEWS (2010), *available at* http://www.kaiserhealthnews.org/Columns/2010/May/052710Frakt.aspx.

73. ACA, Pub. L. No. 111-148, § 1312(c)(3), 124 Stat. 119, 182 (2010) (codified at 42 U.S.C. § 18032(c)(3) (Supp. V 2011)).

74. Robert Pear, *Small Firms' Offer of Plan Choices Under Health Law Delayed*, N.Y. TIMES (Apr. 1, 2013).

exchanges as an ACA failure, this risk is political (not technical) and could be managed through a successful public relations campaign, rather than by trying to bolster an unnecessary SHOP exchange just for positive publicity. Monahan and Schwarcz suggest that failed attempts to preserve the small-group markets could pose political challenges to the ACA. This is true and argues for the alternative of slowing letting them slip away and cutting losses early. Assuming those who lose access to small-group coverage have good options in the individual market, detractors would be pressed to frame this decline of small-group coverage as a significant failure

III. SELF-INSURANCE IS A PROBLEM—BEYOND THE ACA AND SMALL GROUPS

Finally, while the authors do flag some genuine concerns with small employers increasingly self-insuring, the gravest concerns with regard to self-insuring are neither products of the ACA nor are they unique to small-group markets. The authors' novel contribution in this article with regard to self insurance is the insight that it facilitates employers' ability to design plans that encourage lower-income employees to seek coverage on the individual market. As already discussed, this consequence may actually provide beneficial effects overall.

That being said, the other consequences of self-insuring that they mention briefly, and that have been examined elsewhere,[75] are genuine concerns and are relevant with regard to small- and large-group plans. These are the risks that self-insurance creates for adverse selection against fully-insured markets (small and large) with resulting harm to risk pools. More importantly, self-insured employers can avoid substantive insurance regulation because of the shield provided by the Employee Retirement Income Security Act of 1974 ("ERISA").[76] ERISA allows employers to retain control over the content of their employee health plans, unless federal regulation demands otherwise. While federal laws have mandated a few substantive coverage requirements for self-insured plans, employers who self-insure have almost complete leeway over the design of their health plans. The ACA perpetuates this self-insured group favoritism (likely for political reasons) and exempts self-insured plans from many of the ACA federal regulatory provisions that bolster substantive requirements.

Monahan and Schwarcz outline several solutions to this problem with respect to small-group markets, some of which are being adopted by states: reform of stop-loss insurance to make it more difficult for a small employer to self-insure, designing SHOP exchanges to be more attractive than self-insurance, and creating incentives for brokers to promote SHOP coverage instead of self-insuring.[77] A

75. *See, e.g.*, Jost & Hall, *supra* note 21, at 8–10; Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1370.

76. 29 U.S.C. § 1144(b)(2)(B) (2006) (stating that an employee benefits plan may not be "deemed to be an insurance company or other insurer" and thus is exempt from state insurance regulations).

77. Monahan & Schwarcz, *supra* note 1, at 1975–89.

better option would have been not to exempt self-insured plans—large and small—from substantive regulations of the ACA in the first place. If the goal of health reform is to ensure that all Americans have meaningful coverage, the increasing frequency of self-insured plans could in fact undermine its success. Yet, this problem reaches beyond small-group markets and will remain whether small-group markets do or not.

IV. CONCLUSION

In sum, saving small-employer health insurance is not necessary to ensure the ACA's success if the individual-market exchanges work as envisioned. This *if* is significant. To the extent that the exchanges falter and the individual market remains the weakest link of the U.S. health insurance system, the death of small-employer health insurance might pose real reason for concern. But the likelihood that SHOP exchanges would work and prove superior to individual-markets exchanges after the ACA is implemented is small. Thus, I'm inclined to take a wait-and-see approach, rather than sound the alarms, and to focus implementation efforts on more critical concerns.