

A Prescription to Heal Small- Employer Health Insurance

*Closing loopholes that plague the Affordable Care
Act's small-group markets*

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I. INTRODUCTION

Employer-sponsored coverage developed in response to federally imposed wage controls during World War II.¹ In the wake of a scarce labor market, the federal government restricted wages to prevent wartime inflation.² However, a loophole emerged when the War Labor Board announced wage controls did not apply to fringe benefits such as health insurance.³ In an effort to attract desperately needed workers, employers began offering health care coverage.⁴

Large-group employer-sponsored coverage has dominated the private insurance market since the 1940s.⁵ However, the same cannot be said for the small-group market. Many small employers, particularly small employers that pay low wages, do not offer health insurance. A report issued by the United States Government Accountability Office (“GAO”) noted:

[A]bout 17 percent of employers with less than 10 employees who earn low wages (50 percent or more of their employees earn \$11.50 per hour or less) offered health insurance to their employees in 2010, while about 90 percent of employers with 100 to 999 employees who earn low wages did.⁶

The small-group market has been underutilized for many reasons: employers face high administrative costs, have low bargaining power, and encounter significant premium volatility.

¹ David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 N. ENG. J. MED. 82, 83 (2006); see also Quantria Strategies, *Health Insurance in the Small Business Market: Availability, Coverage, and the Effect of Tax Incentives* 9 (2011).

² *Id.* at 83.

³ *Id.*

⁴ *Id.*

⁵ In 2012, forty-eight percent of Americans received health insurance through their employer. *Health Insurance Coverage of the Total Population*, THE HENRY J. KAISER FAMILY FOUNDATION (2012), <http://kff.org/other/state-indicator/total-population/>.

⁶ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-549, SMALL EMPLOYER HEALTH TAX CREDIT: FACTORS CONTRIBUTING TO LOW USE AND COMPLEXITY 1 (2012). In Minnesota, only 6.8 percent of small-firm employees held health insurance coverage through the small-group market. Nathan Hierlmaier, *Minnesota's Small Group Market General Overview*, MINNESOTA DEPARTMENT OF HEALTH (2012), <https://www.mnsure.org/images/SEE-MDHPresentation-2012-03-21.pdf>. This figure is stark compared to the 49.6 percent of Minnesotans who had coverage through the large group market. *Id.*

The Patient Protection and Affordable Care Act (“ACA”) sought to eliminate these problems and improve the operation of the small-group market.⁷ In many respects, the ACA succeeded.

However, systematic issues continue to threaten the success of small firm health insurance.

This paper explores the ACA’s reform of small-group markets. Part II describes small-employer health insurance before and after the enactment of the ACA. Part III identifies issues that continue to plague the ACA’s small-group market. Loopholes within the ACA discourage employer participation in the small-group market. Moreover, federal delays and technological problems have made the small business exchange undesirable. Part IV offers strategies to prevent the collapse of the small-group market. For the small-group market to succeed, employers must be able to receive tax credits beyond the current 2016 phase-out date. In addition, premium tax credits and cost sharing subsidies must be made available to low-income employees who obtain coverage through the Small Business Health Options Program (“SHOP”) exchange. Finally, states must regulate stop-loss insurance to discourage small firms from self-insurance.

II. THE OPERATION OF SMALL-GROUP MARKETS

A. The “Old” Small-Group Market

Small businesses are the heart of the American economy. Often considered a primary economic driver, small firms account for 55 percent of jobs in the United States.⁸ The success of this vital category of firms often hinges on the ability to attract skilled workers. However, small firms historically struggled to provide a highly valued employee benefit—health care coverage.

⁷ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 130–38 (2010) (codified as amended in various sections of 42 U.S.C.).

⁸ *Small Business Trends*, THE U.S. SMALL BUS. ADMIN., <http://www.sba.gov/content/small-business-trends> (last visited Apr. 1, 2014).

Significant obstacles hindered the ability of small firms to offer health insurance. First, small firms incurred higher administrative costs than large firms. The administrative costs of providing health insurance are largely fixed.⁹ This creates higher costs for small firms who have fewer enrollees, and therefore fewer individuals to share the cost.¹⁰ A report issued by the federal government noted premiums for small firm employees contained three times more administrative cost than premiums for large-firm employees.¹¹

Second, small firms lacked bargaining power when negotiating prices with insurance companies.¹² On average, small firms paid eighteen percent more per employee than large businesses for the same health insurance policy.¹³ Third, small firms were more susceptible to premium volatility. The health care system operates under the theory that the premiums of healthy individuals will subsidize medical costs incurred by unhealthy individuals. In a perfectly balanced pool of insureds, health care premiums cover claims. Unfortunately, in a small risk pool one unhealthy individual can push health care costs beyond available premiums.¹⁴ When this happens, carriers increase premiums to cover claims. Thus, small firm employees often experienced premium increases from just one high-cost employee.¹⁵

⁹ Stacey McMorrow, et. al., *The Effects of Health Reform on Small Businesses and Their Workers*, June 2011, at 2.

¹⁰ *Id.*

¹¹ *The Affordable Care Act Increases Choice and Saving Money for Small Businesses*, THEWHITEHOUSE.GOV, http://www.whitehouse.gov/files/documents/health_reform_for_small_businesses.pdf.

¹² *Id.*

¹³ *The Economic Effects of Health care Reform on Small Businesses and their Employees*, THEWHITEHOUSE.GOV, <http://www.whitehouse.gov/administration/eop/cea/Health-Care-Reform-and-Small-Businesses>. Amy B. Monahan & Daniel Schwarcz note, “administrative expenses account for 25-27% of premiums in small-group markets, but only 5-10% in large-group markets.” Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935, 1942 (2013).

¹⁴ See Gary Cohen, *Testimony before Committee on Small Business*, CENTERS FOR MEDICARE AND MEDICAID SERVICES, <http://www.hhs.gov/asl/testify/2013/12/t20131211b.html> (last revised Dec. 19, 2013).

¹⁵ *Id.*; Monahan & Schwarcz, *supra* note 13, at 1943. Monahan & Schwarcz note this issue is intensified by the fact that federal law prohibits employers from discriminating against employees on the basis of

Finally, small businesses typically lacked the expertise and manpower to effectively navigate the health care system.¹⁶ The burden of shopping for health plans often fell on staff who were unfamiliar with the health care industry.¹⁷ Selecting insurance coverage was a time consuming, confusing, and overwhelming task. Aside from diverting an employee’s attention away from regular business operations, an employee tasked with finding an insurance plan could choose a plan inappropriate for the firm.

Due to these substantial burdens, many small employers simply declined to offer coverage.¹⁸ Others dropped coverage when premiums increased.¹⁹ Small employers that did offer coverage typically shifted the costs onto employees. Studies show “employees effectively [paid] for their employer-provided health insurance with lower wages than they would have received absent the benefits.”²⁰ As a result, small-group coverage was undesirable to both employers and employees.²¹

B. The “New” Small-Group Market

The ACA, enacted March 23, 2010, aimed to fix the problems that plagued the small-group market. In some respects, the ACA made equivalent changes to both the individual and

health status. *Id.* Thus, an employer that provides health insurance is required to offer high-risk employees coverage.

¹⁶ Monahan & Schwarcz, *supra* note 13, at 1942–43.

¹⁷ McMorrow, *supra* note 9, at 2.

¹⁸ Monahan & Schwarcz, *supra* note 13, at 1943.

¹⁹ Monahan & Schwarcz, *supra* note 13, at 1943.

²⁰ McMorrow, *supra* note 9, at 2.

²¹ McMorrow, *supra* note 9, at 2. McMorrow notes the barriers to small firm health insurance may result in labor market inefficiencies. McMorrow states, “In some cases, a worker may otherwise prefer a position in a small firm, but her demand for health insurance coverage will steer her toward a job in a large firm that provides coverage (or that provides coverage at a lower cost than the small firm). The barriers to small firm health insurance provision and the limited ability for many workers to obtain affordable coverage outside employment may therefore place small firms at a disadvantage in attracting desired employees.” McMorrow, *supra* note 9, at 2.

small-group markets. Policies offered in both markets must cover “essential health benefits.”²² Health insurers that offer coverage must offer coverage to every applicant.²³ Moreover, the ACA prohibits health insurers from employing lifetime or annual benefit limits,²⁴ excluding applicants because of pre-existing conditions,²⁵ and canceling or declining to renew coverage except in rare circumstances.²⁶ Premiums are based on only four factors: age, family size, geographic location, and tobacco use.²⁷ Both markets implemented risk adjustment.²⁸

In other respects the ACA specifically reformed the small-group market. The ACA defines “small employer” as “an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.”²⁹ States have the option to define “small employer” as employers with not more than fifty employees until 2016.³⁰

The ACA exempts all firms with fewer than fifty employees from the “Employer Responsibility” or “Pay or Play” requirements—small firm do not face a penalty for failing to

²² ACA § 1302.

²³ ACA § 1201 (codified as amended at 42 U.S.C. § 300gg-1).

²⁴ ACA § 1201; 42 U.S.C. § 300gg-11 (2006 & Supp. V 2011) (adding section 2711 to the Public Health Service Act).

²⁵ ACA 1201; 42 U.S.C. 300gg-3.

²⁶ ACA § 1201; 42 U.S.C. §§ 300gg-2.

²⁷ ACA § 1201; 42 USC 300gg (adding section 2701 to the Public Health Service Act) (“With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small-group market--such rate shall vary with respect to the particular plan or coverage involved only by-- (i) whether such plan or coverage covers an individual or family; (ii) rating area, as established in accordance with paragraph (2); (iii) age, except that such rate shall not vary by more than 3 to 1 for adults (consistent with section 300gg-6(c) of this title); and (iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1.”).

²⁸ Section 1343 of the ACA provides for a risk adjustment program, where funds from plans with relatively lower risk enrollees are transferred to plans with relatively higher risk enrollees.

²⁹ ACA § 1304.

³⁰ ACA § 1304(b)(3). Minnesota defines a small employer as one with 2-50 employees. Minn. Stat. 62L.02, subd. 26.

offer coverage.³¹ Instead, employers can decline to offer coverage and direct their employees to the public exchange, offer coverage through SHOP, or use a broker to buy group coverage on the private market. Rather than imposing the “Pay or Play” mandate, the ACA reformed the small-group market by incentivizing small employers to *voluntarily* offer coverage. These incentives take three primary forms: the SHOP exchange, employer tax credits, and cafeteria benefit plans.

1. The SHOP Exchange

Perhaps the most significant change to the small-group market is the creation of the Small Business Health Options Program, commonly known as “SHOP.” ACA section 1311 establishes SHOP marketplaces:

Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an “Exchange”) for the State that . . . provides for the establishment of a Small Business Health Options Program (in this title referred to as a “SHOP Exchange”) that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State³²

Section 1321 directs the Secretary of Health and Human Services to establish and operate a federally facilitated SHOP in any states unable or unwilling to establish a state-based SHOP exchange.³³ Thus, states can choose to default into the federally-facilitated SHOP marketplace.

³¹ Section 1513 of the ACA implements what is known as the “Pay or Play” or “Employer Shared Responsibility” mandate. Beginning January 1, 2015, employers with more than 100 full-time employees are required to offer health care coverage or pay a penalty. *Id.* The mandate applies to employers with more than 50 full-time employees starting in 2016. The Internal Revenue Service released the final rule implementing the “Pay or Play” provision on February 11, 2014. The final rule is available at <https://www.federalregister.gov/articles/2014/02/12/2014-03082/shared-responsibility-for-employers-regarding-health-coverage>.

³² ACA § 1311.

³³ ACA § 1321.

Currently, thirty-three states have opted into the federal exchange and seventeen states have established state-based SHOP Marketplaces.³⁴

SHOP is designed to target the weaknesses that have historically burdened the small business market. Similar to the individual market exchange, it acts as a one-stop shop for small firm employers and employees. SHOP supports small firm employers by spreading administrative costs and pooling risk across multiple firms. In theory, the online system facilitates simple enrollment and coverage management. Employers could add and drop employees from coverage, pay bills, and receive online and telephone support if issues arise. In addition, 45 C.F.R. § 155.705(b)(4) requires SHOP marketplaces to perform premium aggregation services. SHOP marketplaces must deliver a single bill to the employer that reflects the employer premium contribution for all employees and the amount withheld from each employee's paycheck.³⁵

SHOP was designed to benefit employees by improving health insurance coverage and reducing premiums.³⁶ Historically, small firms offered only a single health plan. ACA section 1312 requires SHOP exchanges to include an "employee choice" feature in which employers choose a metal tier of coverage and allow employees to select any plan from that tier.³⁷ This enables employees to select the plan that best fits their individual needs. In addition, SHOP exchanges are designed to reduce the cost of health insurance coverage. Theoretically, employee

³⁴ Sarah J. Dash, et.al., *Realizing Health Reform's Potential, Implementing the Affordable Care Act: State Action to Establish SHOP Marketplaces*, 1735 COMMONWEALTH FUND 3, March 2014.

³⁵ Center for Consumer Information and Insurance Oversight, *SHOP and the Small Group Market Policies*, CENTERS FOR MEDICARE & MEDICAID SERVICES (May 21–23, 2012), <https://www.cms.gov/CCIIO/Resources/Presentations/Downloads/hie-shop-and-the-small-group-market-policies.pdf>.

³⁶ SHOP also benefits employees by enabling them to enroll and manage their account online.

³⁷ 45 C.F.R. § 155.705(b)(2); *See* Dash, *supra* note 34, at 2.

premiums will decrease due to a greater risk pool and increased competitive pressure among insurance carriers.³⁸

SHOP marketplaces are the foundation of the ACA's small-group market. However, as will be discussed in Part III, the implementation of SHOP exchanges has been anything but perfect. Technological problems with SHOP marketplaces have hindered employer participation. In addition, two primary benefits of SHOP—employee choice and premium aggregation services—have been delayed until January 1, 2015.³⁹

2. Small Business Health Care Tax Credits

As of 2010, small firm employers that provide health insurance to employees are eligible for the small business health care tax credit. The tax credit is a critical component to a successful small-group market. It aims to resolve the disproportionately high cost of providing small-employer coverage. As stated above, small-firms paid on average eighteen percent more than large firms for health insurance due to high administrative costs. The tax credit helps small employers afford the cost of health insurance for their employees.⁴⁰ Without it, many small firms would not have the means to offer coverage. In addition, the tax credit incentivizes new employers to enter the market, which increases the risk pool and spreads costs across more employers.

³⁸ See Brandon Hemmings et. al., *The ACA and Its Effects on Small Employers*, in Issue Brief 2, 5 (2013). Risk is pooled across all groups in the insurer's small group market plans; Center for Consumer Information and Insurance Oversight, *supra* note 35, at 2.

³⁹ In 2014, small firms in the federally facilitated SHOP exchange can choose one plan for all eligible employees. See Hemmings, *supra* note 38. Starting 2015, employers can choose a general level of coverage and permit employees to choose a plan on the SHOP exchange within that level. Hemmings, *supra* note 38.

⁴⁰ *Employers with Fewer Than 25 Employees*, THE U.S. SMALL BUS. ADMIN., <http://www.sba.gov/content/employers-with-fewer-25-employees> (last visited Apr. 2, 2014).

To be eligible for the credit, employers must have less than twenty-five full-time equivalent employees with average annual wages of less than \$50,000.⁴¹ In addition, the employer must pay at least fifty percent of the employee's health insurance premium.⁴² Small employers achieve substantial savings through tax credits. From 2010 through 2013, eligible small employers received a tax credit of up to thirty-five percent of the employer's contribution to the employee's health insurance premium.⁴³ Tax-exempt businesses received tax credits of up to twenty-five percent of the employer's contribution.⁴⁴ Beginning in 2014, the tax credit amount increased to fifty percent of the employer-paid premiums.⁴⁵ However, the fifty percent tax credit is only available for two consecutive years.⁴⁶

A major shortcoming of the tax credit is its limited duration. The credit is available for six years overall.⁴⁷ As of 2014, the credit is only available for two consecutive years. Thus, starting in 2016, small firm employers may begin to age out of the tax credit benefit. The limited duration is problematic because few employers have claimed the credit. Government agencies and small business advocacy groups estimated anywhere from 1.4 million to 4 million small employers would be eligible for the tax credit.⁴⁸ However, the GAO found only approximately 170,300 small employers claimed the credit in 2010.⁴⁹ Most of the claims were for less than the

⁴¹ ACA § 1421; I.R.C. § 45R(d). See Monahan & Schwarcz, *supra* note 13, at 1949.

⁴² ACA § 1421; I.R.C. § 45R(c)–(d).

⁴³ ACA § 1421; I.R.C. § 45R(g). See *The Affordable Care Act Increases Choice and Saving Money for Small Businesses*, *supra* note 11, at 1.

⁴⁴ *The Affordable Care Act Increases Choice and Saving Money for Small Businesses*, *supra* note 11, at 1.

⁴⁵ ACA § 1421; I.R.C. § 45R(g). See Monahan & Schwarcz, *supra* note 13, at 1949.

⁴⁶ ACA § 1421; I.R.C. § 45R(g).

⁴⁷ The tax credit is available for “four years from 2010 through 2013, and two years beginning in 2014 and thereafter.” Monahan & Schwarcz, *supra* note 13, at 1949. See ACA § 1421; I.R.C. § 45R(g).

⁴⁸ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-549, SMALL EMPLOYER HEALTH TAX CREDIT: FACTORS CONTRIBUTING TO LOW USE AND COMPLEXITY 1 (2012).

⁴⁹ *Id.*

full credit percentage.⁵⁰ Of small employers claiming credits, 142,200 firms, or 83 percent, were ineligible for the full credit percentage.⁵¹

A few factors contribute to the low credit usage. Claiming the credit is a complicated and onerous task. The GAO report noted how a supposedly simple task turns daunting:

On its website, IRS tried to reduce the burden on taxpayers by offering “3 Simple Steps” as a screening tool to help taxpayers determine whether they might be eligible for the credit. However, to calculate the actual dollars that can be claimed, the three steps become 15 calculations, 11 of which are based on seven worksheets, some of which request multiple columns of information.⁵²

In addition, small employers do not likely view the credit as a big enough incentive. According to the GAO report, the tax credit “may not offset costs enough to justify a new outlay for health insurance premiums.” This is particularly true when employers are eligible for only partial credit. A related deterrence is the limited duration of the tax credit. The GAO noted, “the credit being available for 6 years overall and just 2 consecutive years after 2014 further detracts from any potential incentive to small employers to start offering health insurance in order to claim the credit.”⁵³

3. Cafeteria Benefit Plans

Small employers can offer cafeteria plan benefits through the SHOP exchange. Cafeteria plans, also known as premium reimbursement plans, allow employees to receive certain qualified benefits on a pre-tax basis.⁵⁴ In a typical scenario, the employee signs a salary reduction agreement where the employee agrees to contribute a portion of her salary to pay for qualified

⁵⁰ *Id.* at 10.

⁵¹ *Id.* Most employers did not qualify for the full credit because they failed to meet the average wage requirement. *Id.* Approximately 68 percent of employers “did not qualify based on wages but did meet the FTE [full-time equivalent] requirement.” *Id.*

⁵² *Id.* at 13.

⁵³ *Id.* at 12.

⁵⁴ Monahan & Schwarcz, *supra* note 13, at 1949.

benefits.⁵⁵ The employee neither actually nor constructively receives salary-reduced contributions.⁵⁶ Thus, the contributions are not considered wages under the Internal Revenue Code. As a result, the employee can pay for benefits with pre-tax dollars. Employers may elect to contribute to employee benefits in excess of the salary reduction amount.

It is important to note that employers are only permitted to offer premium reimbursement plans through SHOP.⁵⁷ I.R.C. section 125(f) prohibits employees from using a cafeteria plan to pay for coverage purchased through the individual market.⁵⁸ Notice 2013-54, issued by the Internal Revenue Service on September 13, 2013, further restricts premium reimbursement cafeteria plans to two scenarios: Premium Only Plans (POPs) and SHOP Reimbursement Plans.

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The chief benefit of cafeteria plans is flexibility. Small employers could designate one or more group plans offered on the SHOP exchange as available health insurance options.⁶⁰ Employees could choose which plan to select and pay their share of the premiums using pre-tax

⁵⁵ *FAQs for government entities regarding Cafeteria Plans*, IRS, <http://www.irs.gov/Government-Entities/Federal,-State-&-Local-Governments/FAQs-for-government-entities-regarding-Cafeteria-Plans> (last revised Jan. 28, 2014).

⁵⁶ *Id.*

⁵⁷ *See* I.R.C. § 125(f).

⁵⁸ Monahan & Schwarcz, *supra* note 13, at 1949; I.R.C. section 125(f) (requiring employers that use cafeteria plans “offer[] the employee the opportunity to enroll through such an Exchange in a qualified health plan in a group market”).

⁵⁹ *See Application of Market Reform and other Provisions of the Affordable Care Act to HRAs, Health FSAs, and Certain other Employer Healthcare Arrangements, Notice 2013-54*, IRS, <http://www.irs.gov/pub/irs-drop/n-13-54.pdf> (last visited Apr. 2, 2014); *Account-Based Health Reimbursement Plans and IRS Notice 2013-54*, WOLTERS KLUWER (Oct. 2, 2013), <http://www.ftwilliam.com/articles/AcctPlans13-54.html>. Premium Only Plans (“POP”) are defined as “a cafeteria plan that offers as its sole benefit an election between cash (for example, salary) and payment of the employee share of the employer-provided accident and health insurance premium (excludible from the employee's gross income under section 106).” Treas. Reg. § 1.125-1(a)(5). POP plans are beneficial to both employers and employees—employees save money by paying for coverage on a pretax basis, and employers save money by not paying FICA and federal unemployment taxes on those amounts. *See* Wolters Kluwer, *supra*.

⁶⁰ Monahan & Schwarcz, *supra* note 13, at 1949. An employer that wishes to provide more generous benefits could offer additional financial contributions to the employee’s plans.

dollars. Because most small employers historically offered only a single plan, the ability to choose from potentially unlimited plans is a substantial benefit for affected employees.

III. FLAWS IN THE ACA'S SMALL-GROUP MARKET

While health care reform sought to improve the operation of the small-group market, issues remain. Certain provisions of the ACA make the small-group market undesirable and unworkable. As the provisions have gone into effect, additional problems have developed. This section explores the issues that plague the ACA's small-group market. Part A of this section discusses three loopholes in the ACA's structure of the small-group market. Part B explores additional problems that have arisen since implementation.

A. Structural problems with the ACA's small-group market

The ACA was designed to incentivize small employers to voluntarily offer coverage. However, certain provisions encourage employers to decline to offer coverage or self-insure, keeping those employers out of the small-group market altogether. The ACA's structure of the small-group market creates three unintended consequences: (1) small firm employers with predominantly low-income employees are incentivized to decline to offer coverage; (2) small employers with both low-income and high-income employees are incentivized to offer group coverage that is either unaffordable or fails to provide minimum value; and (3) small employers with low-risk employees are incentivized to self-insure.⁶¹ All three scenarios undermine the stability of the small-group market.

⁶¹ For a thorough discussion of these three structural problems, see Monahan & Schwarcz, *supra* note 13.

1. Small firm employers with predominantly low-income employees are incentivized to decline to offer coverage

Individuals that purchase coverage on the individual exchange may qualify for premium tax credits and cost sharing subsidies.⁶² Premium tax credits are advanceable, refundable tax credits that help reduce the cost of monthly premiums.⁶³ Cost sharing subsidies help pay for out-of-pocket expenses such as deductibles and copays.⁶⁴ These benefits provide substantial savings to low-income individuals. However, as of January 1, 2014, individuals are ineligible for premium tax credits when they are offered affordable, employer-sponsored coverage that provides minimum value.⁶⁵ Section 1401 of the ACA states, “in the case of an *applicable taxpayer*, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.”⁶⁶ Applicable taxpayers are entitled to premium assistance credits for all “coverage months” during the taxable year.⁶⁷ The definition of “coverage month” specifically excludes any month in which the taxpayer was eligible for “minimum essential coverage.”⁶⁸ Minimum

⁶² ACA §§ 1401, 1402.

⁶³ See ACA § 1401.

⁶⁴ See ACA § 1402; John Reichard, *A Closer Look at Those Cost-Sharing Subsidies in the Health Care Law*, THE COMMONWEALTH FUND (Aug. 9, 2013), <http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2013/Aug/August-12-2013/A-Closer-Look-at-Those-Cost-Sharing-Subsidies.aspx>.

⁶⁵ See I.R.C. §§ 36B(c)(1)(A), 36B(c)(2)(A), 36(c)(2)(B).

⁶⁶ ACA § 1401(a) (*emphasis added*); I.R.C. § 36B(c)(1). “Applicable taxpayer” is defined as, “taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.” I.R.C. § 36B(c)(1).

⁶⁷ ACA § 1401(a).

⁶⁸ I.R.C. § 36B(c)(2)(B) (“The term ‘coverage month’ shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market”).

essential coverage includes “coverage under an eligible employer-sponsored plan,” so long as the plan is affordable and provides minimum value.⁶⁹

Considering these provisions together, an individual is ineligible for premium tax credits if their employer offers affordable coverage that provides minimum essential value. Ironically, an employer may harm an employee by offering coverage. Employees miss out on valuable premium tax credits and become ineligible for cost sharing subsidies—two benefits that may be more valuable than the tax benefits associated with employer-sponsored coverage.⁷⁰ This consequence may cause employers to decline to offer coverage to allow low-income employees to take advantage of the benefits through the individual exchange.⁷¹ This outcome is problematic because it would decrease employee participation and lower the number of individuals in the small-group risk pool, making other employers more susceptible to premium volatility. It amplifies the very problems the ACA tried to fix.

2. Small employers with both low-income and high-income employees are incentivized to offer group coverage that is either unaffordable or fails to provide minimum value

Employers with mixed-income employees face an unusual dilemma.⁷² Employers have an incentive to offer coverage to middle or high-income employees, as these employees will benefit from employer-sponsored insurance.⁷³ However, there remains a disincentive to offer coverage to low-income employees. Employers may resolve this dilemma by offering

⁶⁹ I.R.C. §§ 5000A(f)(1)(B), 36B(c)(2)(C). “Eligible employer-sponsored plan” means “a group health plan or group health insurance coverage offered by an employer to the employee which is-- (A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or (B) any other plan or coverage offered in the small or large group market within a State.” I.R.C. § 5000A(f)(2).

⁷⁰ Monahan & Schwarcz, *supra* note 13, at 1939.

⁷¹ Monahan & Schwarcz, *supra* note 13, at 1939.

⁷² See Monahan & Schwarcz, *supra* note 13, at 1953.

⁷³ See Monahan & Schwarcz, *supra* note 13, at 1953.

unaffordable group coverage or coverage that fails to provide minimum value for low-income employees.⁷⁴

This strategy appears to be a win-win for everyone: low-income employees remain eligible for premium tax credits and cost-sharing subsidies through the individual market, and middle/high-income employees can obtain employer-sponsored coverage and use pre-tax dollars to pay for premiums.⁷⁵ However, the long-term effects are very problematic. Low-income employees are kept out of the small-group market. This *reduces* the size of the risk pool and the bargaining power of employers, which in turn *increases* premiums. Employees are left with higher cost plans that provide fewer benefits.

3. Small employers with low-risk employees may self-insure

A self-insured group health plan is a plan in which the employer assumes the financial liability for health services.⁷⁶ In practical terms, self-insured employers pay for each claim out-of-pocket rather than paying a fixed premium to an insurance carrier.⁷⁷ Employers typically hire “Third Party Administrators” to manage the administrative aspects of the insurance coverage (e.g. processing claims) and purchase stop-loss insurance to protect against unusually high claims.⁷⁸ Stop loss insurance establishes a maximum threshold of liability. If claims exceed the

⁷⁴ See Monahan & Schwarcz, *supra* note 13, at 1953.

⁷⁵ See Monahan & Schwarcz, *supra* note 13, at 1953. Monahan and Schwarcz point out that this coverage would still appeal to middle/high-income employees: “Group coverage that is “unaffordable” for low-income employees or does not provide “minimum value” would not necessarily be unattractive to high-income employees. An employer has many options for structuring its group plan in ways that technically meet one of these conditions, but that would, as a practical matter, provide affordable, desirable health insurance coverage for high-income employees.” Monahan & Schwarcz, *supra* note 13, at 1939.

⁷⁶ Monahan & Schwarcz, *supra* note 13, at 1965.

⁷⁷ See *Self-Insured Group Health Plans*, SELF-INSURANCE INSTITUTE OF AMERICA, INC., <http://www.siaa.org/i4a/pages/Index.cfm?pageID=4546> (Last visited Apr. 2, 2014).

⁷⁸ Monahan & Schwarcz, *supra* note 13, at 1965–66.

threshold amount, the employer transfers liability to an insurer. This limits the amount of risk an employer assumes through self-insurance.⁷⁹

Under the Employee Retirement Income Security Act (“ERISA”), self-insured plans are exempt from state insurance regulation. This means employers can ignore state laws requiring specific benefits.⁸⁰ Unlike other insurers, beginning in 2014 employers who self-insure are *not* required to offer coverage that provides essential health benefits, participate in risk-adjustment programs, comply with medical loss ratios, review premium increases, or limit individual deductibles to \$2,000 and family deductibles to \$4,000.⁸¹ Another big attraction is the ability to avoid cross-subsiding high-risk employees from other firms.⁸²

Experts fear small-employers with low-risk employees may choose to self-insure.⁸³ M3, a Wisconsin-based insurance brokerage firm, reported clients have “independently inquired about [self-insurance] and sought out legal counsel on the question.”⁸⁴ Deborah Chollet from the New York Times reported health plan advisers are recommending firms self-insure.⁸⁵ In fact, some advisers are recommending self-insured employers offer a low-benefit health plan.⁸⁶ This sends sick employees into the individual market, keeping the employer’s costs low. Firms may

⁷⁹ Monahan and Schwarcz note, “The heightened availability of stop-loss coverage has increased the likelihood that many small employers that offer group coverage post-2014 will elect to offer self-insured plans.” Monahan & Schwarcz, *supra* note 13, at 1940.

⁸⁰ 29 U.S.C. § 1144(b)(2)(B).

⁸¹ Monahan & Schwarcz, *supra* note 13, at 1967.

⁸² See *Self Insurance Complaints*, MINNESOTA DEPARTMENT OF COMMERCE, <http://mn.gov/commerce/insurance/consumers/tools/complaints/self-insurance-health-plan-complaints.jsp> (last visited Apr. 2, 2014); Monahan & Schwarcz, *supra* note 13, at 1967.

⁸³ See Monahan & Schwarcz, *supra* note 13.

⁸⁴ Meghan Foley, *Self-Insurance: Business Savior or Obamacare Nightmare?*, WALL ST. CHEATSHEET, Jan. 7, 2014, <http://wallstcheatsheet.com/stocks/self-insurance-business-savior-or-obamacare-nightmare.html?a=viewall>.

⁸⁵ Deborah Chollet, *One Complication That Could Create Problems*, N. Y. TIMES, May 29, 2013, <http://www.nytimes.com/roomfordebate/2013/05/29/is-obamacare-too-complicated-to-succeed/self-insurance-could-create-problems-for-obamacare>.

⁸⁶ *Id.*

even try to pay high-cost employees to move to the individual market.⁸⁷ While it is illegal for an employer to discriminate between workers in offering health benefits, it is not illegal for the employer and employee to reach a mutual agreement in which the employee voluntarily declines coverage in return for money.⁸⁸

The promotion of self-insurance is cause for concern. Self-insurance damages the small-group market and threatens to undermine the success of the exchange system. First, if employers with low-risk employees pull out of the exchange, only high-risk individuals remain in the risk pool. Amy Monahan and Daniel Schwarcz succinctly summarize the problem:

If self-insurance becomes widespread among small employers, small-group markets could face substantial adverse selection: as comparatively healthy small groups exit the market, premiums must increase to reflect the decreasing health of the remaining small groups, which may further cause low-risk small groups to exit the market.⁸⁹

Second, the ease in which an employer can opt in or out of self-insurance leads to an unstable small-group market.⁹⁰ For example, a small firm that self-insures may discover its employees are too expensive. The firm can easily abandon self-insurance and opt back into the SHOP exchange—adding high-risk employees to the risk-pool.⁹¹ The converse is also true: if a small firm in SHOP discovers its employees are generally low-risk, the firm can pull out of SHOP and self-insure.⁹² SHOP becomes a back-up plan or an assessment tool for employers rather than a comprehensive marketplace for small firm employees.

⁸⁷ Foley, *supra* note 84.

⁸⁸ Foley, *supra* note 84.

⁸⁹ Monahan & Schwarcz, *supra* note 13, at 1940.

⁹⁰ Monahan & Schwarcz, *supra* note 13, at 1972–73.

⁹¹ See Monahan & Schwarcz, *supra* note 13, at 1972–73.

⁹² See Monahan & Schwarcz, *supra* note 13, at 1972–73.

B. Problems with the small-group market intensified during the rollout of the ACA

Problems with the ACA's small-group market amplified during the rollout of the ACA. First, the federal government delayed the employee choice and premium aggregation provisions, postponing what many consider to be the most attractive features of the reformed small-group market. Second, employers and insurers alike are resisting the SHOP exchange, resulting in lowered projected competition. Finally, technological problems prevented implementation of both state and federal SHOP marketplaces.

1. Delay of the employee choice and premium aggregation benefits in the federally-facilitated SHOP

Within the past year, the Department of Health and Human Services ("HHS") delayed the employee choice benefit in the federally-facilitated SHOP ("FF-SHOP") and granted states the option to employ this delay in state-based SHOP exchanges. HHS issued a proposed rule on March 11, 2013:

[T]his proposed rule would require SHOPS to provide qualified employers the option to offer qualified employees a choice of any QHP at a single metal level starting with plan years beginning on or after January 1, 2015, instead of January 1, 2014. For plan years beginning in calendar year 2014, qualified employers would offer qualified employees coverage under a single QHP in FF-SHOPs; State-based SHOPS would have the flexibility to offer either employer or employee choice in 2014.⁹³

⁹³ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 47, 15556 (proposed March 11, 2013) (to be codified at 45 C.F.R. pt. 155).

HHS finalized this provision on June 4, 2013.⁹⁴ For the first year of operation, employers in the FF-SHOP can only offer their employees a single plan.⁹⁵ With a reformed marketplace premised on employee choice and competition, this is a substantial blow to employees. The delay of employee choice in turn triggered a delay in premium aggregation services.⁹⁶ Premium aggregation is the process of collecting all monthly premium payments from employees and providing a single bill to employers. SHOP was originally required to perform premium aggregation services beginning Jan. 1, 2014. However, HHS determined premium aggregation services are unnecessary when there is no employee choice model.⁹⁷ Thus, the premium aggregation function was delayed until 2015 in FF-SHOPs.⁹⁸

States have the option to delay employee choice and premium aggregation services.⁹⁹ Some states have experienced challenges with the employee choice provision. In an open letter to the Obama administration, health insurer Aetna stated, “Experience with Massachusetts has demonstrated that employee choice models are extremely cumbersome to establish and operate.”¹⁰⁰ To implement an employee choice model, insurers must complete complex operational changes to make the insurer’s system compatible with SHOP and premium

⁹⁴ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 107, 33239 (June 4, 2013) (to be codified at 45 C.F.R. pt. 155).

⁹⁵ *See Id.*

⁹⁶ *Id.* at 33235.

⁹⁷ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 47, 15555 (proposed March 11, 2013) (to be codified at 45 C.F.R. pt. 155).

⁹⁸ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 107, 33239 (June 4, 2013) (to be codified at 45 C.F.R. pt. 155).

⁹⁹ *New Report: 17 States and Washington, D.C., Implementing ‘SHOP’ Health Insurance Marketplaces for Small Businesses; Most Offer Employees Competitive Choice of Plans and Insurers*, THE COMMONWEALTH FUND (March 14, 2014), <http://www.commonwealthfund.org/News/News-Releases/2014/Mar/SHOP-Health-Insurance-Marketplaces-for-Small-Businesses.aspx>.

¹⁰⁰ Robert Pear, *Small Firms’ Offer of Plan Choices Under Health Law Delayed*, N. Y. TIMES, Apr. 1, 2013, http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html?_r=0.

aggregation systems. Given this weighty task, many insurers expressed concern about meeting the 2014 deadline.¹⁰¹

A more deep-rooted issue is the challenge of constructing an employee choice model that does not violate the Age Discrimination in Employment Act (“ADEA”).¹⁰² Under ADEA, employers are prohibited from discriminating against employees based on age.¹⁰³ However, the ACA permits health insurers to charge higher premiums to older individuals.¹⁰⁴ Reconciling these provisions is complex. Employer contributions must be set before an employee selects a health plan so that the employee is aware of out-of-pocket costs he/she faces with each option.¹⁰⁵ However, when more than one plan is available, the employer does not know the total cost of coverage.¹⁰⁶ Because ADEA prohibits employers from requiring older employees to pay a higher percentage of premiums than younger employees for the same health care coverage, setting the employer’s premium contribution level is challenging.¹⁰⁷

Despite the implementation challenges, many states plan to offer employee choice in their SHOP marketplaces.¹⁰⁸ Data from the Commonwealth Fund study revealed the following:

16 [of 17] states and the District of Columbia are planning to offer employee choice in their SHOP marketplaces in 2014. All states except California opted to provide small employers with a range of employee choice models beyond the federally required option in which employees select a plan from a metal tier chosen by the employer (Exhibit 5). Seven states—Hawaii, Minnesota, New

¹⁰¹ Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program, 78 Fed. Reg. 107, 33234 (June 4, 2013) (to be codified at 45 C.F.R. pt. 155).

¹⁰² Linda Blumberg & Shanna Rifkin, *Implementation of Small Business Exchanges in Six States*, ROBERT WOOD JOHNSON FOUND. 6 (2013).

¹⁰³ *Id.*

¹⁰⁴ ACA § 1201; Blumberg & Rifkin, *supra* note 102.

¹⁰⁵ Blumberg & Rifkin, *supra* note 102.

¹⁰⁶ Blumberg & Rifkin, *supra* note 102.

¹⁰⁷ *See* Blumberg & Rifkin, *supra* note 102.

¹⁰⁸ Interesting, Massachusetts is planning to offer employee choice. *See* Dash, *supra* note 34, at 6.

York, Oregon, Rhode Island, Utah, and Vermont—opted to allow employers to give employees the choice of any plan on the SHOP marketplace.¹⁰⁹

It appears employees in the seventeen states operating their own SHOP marketplace will continue to receive the employee choice benefit. However, employees in the federal exchange will be without a primary feature of ACA small-group coverage until 2015.

2. Both employers and insurers are declining to participate in SHOP exchanges

The small-group market reform was largely based on a single principle: to achieve a successful and stable market, competition must increase. The Centers for Medicare and Medicaid Services (“CMS”) stated developing a successful SHOP requires “Promot[ing] robust competition,” which entails “incentivizing key issue participation, minimizing barriers for [Qualified Health Plans] to participate, [and] creating meaningful choices for consumers.”¹¹⁰ Unfortunately, insurers are reluctant to participate in the SHOP exchange. Only one insurer in Washington offers policies through the SHOP exchange.¹¹¹ Hawaii, Nevada, and Vermont only have two participating insurers.¹¹² The reasons for limited insurer participation vary. Some insurers stated they were forced to devote all financial and temporal resources to either the individual or small-group markets.¹¹³ Reforming one market alone is a monumental undertaking—insurers concluded there is simply not enough time to do both. When faced with this dilemma, most insurers chose to prioritize the individual market. Other insurers determined

¹⁰⁹ Dash, *supra* note 34, at 4.

¹¹⁰ Center for Consumer Information and Insurance Oversight, *supra* note 35, at 7.

¹¹¹ *New Report: 17 States and Washington, D.C., Implementing ‘SHOP’ Health Insurance Marketplaces for Small Businesses; Most Offer Employees Competitive Choice of Plans and Insurers*, *supra* note 99.

¹¹² Dash, *supra* note 34, at 6.

¹¹³ Robb Mandelbaum, *Small Businesses Showing Little Interest in State SHOP Exchange*, N.Y. TIMES (Dec. 23, 2013), <http://boss.blogs.nytimes.com/2013/12/23/small-businesses-showing-little-interest-in-state-shop-exchanges/>.

the small-group market was currently unstable and unprofitable.¹¹⁴ Given historical trends and employer hesitation, insurers concluded entering the market would be a risky business decision.¹¹⁵

Fortunately, insurer participation seems to be on the rise. A recent study conducted by the Commonwealth Fund found “nearly all state-based SHOP marketplaces attracted enough competition to offer small employers and employees a choice of insurers and plans.”¹¹⁶ In New York and Massachusetts, ten insurers participate in the state SHOP exchange.¹¹⁷ In Minnesota, three insurers participate: Medica, Preferred One, and BlueCross BlueShield of Minnesota. In addition, “in all but four states—Minnesota, Nevada, New York, and Washington—the SHOP had participation from more than one insurer in every county.”¹¹⁸

While insurer participation is on the rise, employer participation remains low. No data is available for small firm enrollment in the FF-SHOP exchange. According to Jonathan Easley, a CMS official stated CMS does not anticipate having FF-SHOP enrollment data until later this year.¹¹⁹ This is largely due to the delay of the online portal. Without electronic data, CMS will have to gather the data directly from insurers.¹²⁰ Although federal data is unavailable some states have released enrollment data for their state-based SHOP marketplaces. In Colorado there

¹¹⁴ Eric Smith, *State Health Exchange Launches on Time, but not Everything is Smooth—Small Business Owners May Drop Coverage*, WASHINGTON STATE WIRE (Sept. 30, 2013), <http://washingtonstatewire.com/blog/state-launches-health-exchange-tuesday-but-not-everything-is-smooth-small-business-complains-it-is-left-with-few-options/>.

¹¹⁵ *See id.*

¹¹⁶ Dash, *supra* note 34, at 4.

¹¹⁷ *New Report: 17 States and Washington, D.C., Implementing ‘SHOP’ Health Insurance Marketplaces for Small Businesses; Most Offer Employees Competitive Choice of Plans and Insurers*, *supra* note 99.

¹¹⁸ Dash, *supra* note 34, at 4.

¹¹⁹ Johnathan Easley, *Small-business enrollment in Obamacare will be ‘modest,’ administration says*, THE HILL (Jan. 30, 2014), <http://thehill.com/blogs/healthwatch/health-reform-implementation/196922-cms-expects-only-modest-small-business>.

¹²⁰ *See id.*

is anywhere between 111,000 to 120,000 small firms eligible for SHOP coverage.¹²¹ As of April 14, 2014, only 304 firms opened accounts on the SHOP exchange and only 220 firms enrolled in coverage.¹²² In Kentucky, 1,599 small firms started applications for employee coverage.¹²³ Only 627 of those firms completed applications and are eligible to offer coverage to employees.¹²⁴ Low employer participation is consistent across states. On February 6, 2014, Bloomberg Businessweek reported only 289 firms in California and 106 firms in Connecticut enrolled on SHOP exchanges.¹²⁵ These figures show the small-group market has yet to reach desired levels of employer participation. This could be because technological challenges have hindered enrollment or because small employers are choosing to opt out of the market. Whatever the cause, low employer participation continues to threaten the stability of the small-group market. For the small-group market to truly succeed, employer participation must increase.

3. Technological challenges have impaired operation of both FF-SHOP and state-based exchanges

Technological problems with SHOP exchanges have kept employers and employees out of the small-group market. The FF-Shop exchange opened on October 1, 2013. However, within the first few hours technical problems rendered the exchange inoperable.¹²⁶ HHS delayed

¹²¹ Mandelbaum, *supra* note 113.

¹²² CONNECT FOR HEALTH COLORADO, *By the Numbers: The First Open Enrollment of Connect for Health Colorado*, available at <http://connectforhealthco.com/wp-content/uploads/2014/04/FINAL-data-open-enrollment-report-4-14-14.pdf> (Apr. 14, 2014).

¹²³ Office of Kentucky Governor Steve Beshear, *A Healthier Kentucky, Health Insurance Coverage for Every Kentuckian*, (Apr. 14, 2014, 6:57 PM), <http://governor.ky.gov/healthierky/Pages/default.aspx>.

¹²⁴ *Id.*

¹²⁵ Alex Wayne, *At Obamacare Small Business Exchanges, Sign-Ups Are Off to Slow Start*, BLOOMBERG BUSINESSWEEK (Feb. 6, 2014), <http://www.businessweek.com/articles/2014-02-06/at-obamacare-small-business-exchanges-sign-ups-off-to-slow-start>.

¹²⁶ Peter Thomas, et. al., *October 1, 2013: Health Insurance Exchanges Open*, <http://www.ppsv.com/assets/attachments/190.PDF>.

the online enrollment option and instead suggested employers submit paper applications.¹²⁷

HHS advised online enrollment would be available later in the fall.¹²⁸ However, on November 27, 2013, HHS announced online enrollment in FF-SHOP would be unavailable until November 2014.¹²⁹ Employers were told to enroll their employees in coverage using the “direct enrollment” process.¹³⁰ In direct enrollment employers enroll in coverage through an agent, broker, or insurer.¹³¹ In other words, employers are back to using the pre-ACA enrollment system. The administrative burdens that plagued the pre-ACA small-group market returned as quickly as they left.¹³²

State-based SHOP exchanges experienced similar technological setbacks. California and Maryland delayed online enrollment and directed employers to purchase plans directly from insurers or through agents and brokers.¹³³ Minnesota’s state-based exchange, MNsure, delayed the online payment option. MNsure currently requires all payments be made by check.¹³⁴ In addition, MNsure requires employee enrollment be completed using a paper application.¹³⁵

The technological problems in the small-group market undoubtedly occurred because of the magnitude and complexity of creating an online exchange system. However, the government’s inattention to the small-group market likely intensified the problems. State and

¹²⁷ *Id.*; Timothy Jost, *Implementing Health Reform: The Delay of SHOP Exchange Online Enrollment*, HEALTH AFFAIRS BLOG, Nov. 28, 2013, <http://healthaffairs.org/blog/2013/11/28/implementing-health-reform-the-delay-of-shop-exchange-online-enrollment/>.

¹²⁸ Jost, *supra* note 127.

¹²⁹ *A Direct New Path to SHOP Marketplace Coverage*, U.S. DEP’T OF HEALTH & HUMAN SERV. (Nov. 27, 2013), <http://www.hhs.gov/healthcare/facts/blog/2013/11/direct-new-path-to-shop-marketplace.html>.

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² Brokers could also be biased toward a specific insurer, creating additional challenges for employers who wish to effectively compare health plans.

¹³³ *New Report: 17 States and Washington, D.C., Implementing ‘SHOP’ Health Insurance Marketplaces for Small Businesses; Most Offer Employees Competitive Choice of Plans and Insurers*, *supra* note 99.

¹³⁴ MNsure, *Small business billing*, available at <https://www.mnsure.org/employer-employees/small-business-billing.jsp> (last visited Apr. 2, 2014).

¹³⁵ MNsure, *Small business employees*, available at <https://www.mnsure.org/employer-employees/employees.jsp> (last visited Apr. 2, 2014).

federal governments focused on fixing glitches on the individual market exchange, putting the small-group market on the back burner.¹³⁶ As individual exchanges improve, resources may shift to the small-group market. Until then, technological problems will continue to deter employer participation.

IV. SOLUTION

Although the ACA made great strides in the small-group market, structural loopholes and implementation problems threaten the stability of the market. Given the seemingly endless problems surrounding the small-group insurance, scholars and health care professionals debate whether the market should exist at all. Professor Allison K. Hoffman maintains there is no reason to preserve the small-group market.¹³⁷ Hoffman argues:

[T]he 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.¹³⁸

While the law permits states to merge the individual and small-group markets, a merger would result in undesirable consequences.¹³⁹ Merging the markets would likely result in lower premiums for individuals but higher premiums for small firm employees. This is because participants in the individual market tend to be less healthy, on average, than individuals in the

¹³⁶ The prioritization of the individual market is likely due to the individual mandate deadline. Enrollees in the individual market had a limited window to purchase coverage for the upcoming year. Individuals that failed to obtain health insurance by March 31, 2014, may be subject to a tax penalty and have to wait until the exchange opens again on November 15, 2014. Conversely, employers can apply for coverage through SHOP at any time, and small firm employers are not penalized if their employees do not have coverage.

¹³⁷ Allison K. Hoffman, *An Optimist's Take on the Decline of Small-Employer Health Insurance*, 98 IOWA L. REV. 113, 113 (2013).

¹³⁸ *Id.*

¹³⁹ *See* ACA § 1312(c)(3).

small-group market.¹⁴⁰ The rise in premiums may lead some small-groups to self-insure and others to drop health care coverage.¹⁴¹ The reduction in coverage may be substantial. The North Carolina Health Benefit Exchange Study projected merging the North Carolina markets “would prompt small group subscribers to drop coverage, ultimately reducing the number of insured in the merged market by 130,676, or 9% in 2016.”¹⁴² Thus, to achieve the ACA’s purpose of increasing the number of insured Americans, the small-group market must exist—and it must succeed.

To ensure the success of the small-group market, three strategies must be employed. First, employer tax credits should be extended to further encourage firm participation. Second, premium tax credits and cost sharing subsidies should be made available to low-income employees who obtain coverage through the SHOP exchange. Finally, self-insurance should be disincentivized through increased regulation of stop-loss insurance.

A. The small business tax credit should be extended beyond the 2016 phase-out date

The small business tax credit is vital to the ACA’s reformed small-group market. In a market premised on voluntary participation, drawing employers into the market is essential. Small business tax credits are the best mechanism to encourage participation. Tax credits help small employers afford the cost of health insurance for their employees. Without it, many small

¹⁴⁰ Market Reform Technical Advisory Group, *Selected Small Group Market Issues and Recommendations*, available at <http://www.ncdoi.com/lh/Documents/HealthCareReform/ACA/Issue%20Brief%201%20-%20Small%20Group%20Issues.pdf> (2012); see Charlie Baker, *A Costly Wrinkle in the Merged Market*, THE HEALTH CARE BLOG (June 26, 2009), <http://thehealthcareblog.com/blog/2009/06/26/a-costly-wrinkle-in-the-merged-market/>.

¹⁴¹ See Adverse Selection Work Group, *Advantages and Disadvantages Associated with Options for Five Key Issues Summary*, MNsure, available at <https://www.mnsure.org/images/ADV-MtgSum-2011-11-30.pdf>.

¹⁴² Market Reform Technical Advisory Group, *supra* note 140.

firms would not have the means to offer coverage. The tax credit also acts as a monetary incentive for business owners. It is the best tool to encouraging *voluntary* participation.

Despite the benefits, the small business tax credit has been underutilized. Employers are reluctant to spend the time and money to apply for the benefit. With the delay of online enrollment and the employee choice feature, small firms may be unable or unwilling to join the market until these features are fully operational. To make matters worse, filing for the tax credit is more complicated and time-consuming than originally anticipated.

As of January 1, 2014, small firms are only eligible for the tax credit for two consecutive years. Firms will begin to age out of the tax credit benefit in 2016. For many employers, the two-year tax credit is not substantial enough to justify the time and money necessary to join the market. The duration of the tax credit must be extended. Because federal delays and operational challenges have hindered small-group enrollment, it is only logical the tax credit phase-out date be extended. Quite simply, the tax credit benefit has not had time to achieve its full potential. To ensure small firms actually enter the small-group market—to ensure the *success* of the market—the duration of this tax benefit must be increased.

B. Enable low-income employees to obtain premium tax credits and cost-sharing subsidies in the small-group market

Small employers with low-income employees are incentivized to opt out of the small-group market. Not only do employers escape the administrative costs of providing coverage, but employees benefit by becoming eligible for coverage through the individual market. To ensure these firms participate, premium tax credits and cost sharing subsidies should be made available to low-income employees in the small-group market.

This solution boils down to a simple cost-benefit analysis. Excluding low-income employees who are offered employer-sponsored coverage from government subsidies pushes these individuals to the individual market. As a result, employers and employees are removed from the small-group market. Making employees eligible for subsidies in the small-group market would encourage employer and employee participation. The benefits are vast: employers would incur lower administrative costs, the risk pool would increase, and premiums would become more stable. Moreover, the costs are low: there will not likely be an increase in government subsidy use, as these employees would have obtained the subsidies on the individual exchange.

This strategy is still beneficial if the cost of providing subsidies increases beyond current estimates. Small firms are often at a disadvantage when it comes to attracting skilled workers. Employees value health insurance, but the current market disincentivizes small employers from offering coverage. Permitting the use of government subsidies in the small-group market will allow small businesses to better attract employees. It will place small businesses, the foundation of the U.S. economy, on a more even playing field with large corporations. In the end, this will advance the U.S. economic position.

This solution may appear to favor employees of small-firms over employees of large-firms. In fact, it does—but for good reason. Small firms require additional support to counteract the additional barriers they face to providing coverage. As noted above, health insurance coverage is more expensive for small-firm employees because employers pass on the higher administrative costs. Thus, premium tax credits will help make coverage truly affordable to low-income employees of small-firms and encourage employer participation. Employees in large-firms already enjoy the benefits of a stable risk pool. However, it should be emphasized that small-firm employees will not need premium tax credits forever. The purpose of the credit is to

stabilize the small-group market by increasing employer and employee participation. Once participation increases, health care premiums will decrease, administrative costs will reduce, and the need for the premium tax credit will diminish. Accordingly, the duration of this benefit should be limited.

C. Regulate stop-loss insurance in the same manner as primary coverage

Stop-loss insurance is a necessity for small employers that self-insure, as it limits the employer's risk.¹⁴³ To prevent an increase in self-insurance, states should regulate stop-loss insurance to make it more difficult or costly to obtain stop-loss insurance coverage. By regulating stop-loss insurance, states can reduce self-insurance and strengthen the small-group market.

Despite ERISA preemption, states have the authority to regulate stop-loss insurance.¹⁴⁴ There are a variety of regulatory methods available. Some states, including Delaware, New York, and Oregon, prohibit the sale of stop-loss coverage to small employers.¹⁴⁵ Although small firms are legally entitled to self-insure, these states reason the ability to self-insure undermines the states' ability to regulate conventional insurance.¹⁴⁶ Other states set minimum "attachment points."¹⁴⁷ Attachment points are the minimum amount a firm must pay before the stop-loss insurer covers claims. Essentially, they act as deductibles.¹⁴⁸ Mandating minimum attachment points ensure self-insured firms retain some risk, constraining the appeal of self-insurance.

¹⁴³ Monahan & Schwarcz, *supra* note 13, at 1975.

¹⁴⁴ While ERISA prevents states from regulating self-insured employers, stop-loss insurance is subject to state insurance regulation. *See* Monahan & Schwarcz, *supra* note 13, at 1975.

¹⁴⁵ Mark A. Hall, *Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers From Undermining Market Reforms Health Affairs*, 31 HEALTH AFFAIRS 316, 318 (2012).

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 317.

¹⁴⁸ *Id.* at 317.

Both of these regulatory strategies disincentivize self-insurance. However, the best method is to regulate stop-loss plans as if they were normal health insurance plans. This would require stop-loss insurance to comply with the ACA's rules governing normal small-group insurance plans, including the prohibition against risk-rating and the mandate of essential health benefit coverage. This approach preserves the employer's ability to self-insure, but ensures the choice to self-insure is not based on the employer's desire to avoid health benefit regulation or gain an unfair advantage from an unusually low group risk profile.¹⁴⁹ Importantly, the prohibition on risk-rating removes a significant incentive of self-insurance.¹⁵⁰

States face an uphill battle in passing this regulation.¹⁵¹ Employers, stop-loss insurers, and other interested entities will likely challenge this method because it subjects stop-loss insurers to the risk of adverse selection. However, as noted by Professor Mark Hall, it is the only method that will prevent employers from self-insuring to escape the ACA's essential health benefit mandate.¹⁵² While Congress could prevent self-insurers from escaping this mandate, this is politically unrealistic. A primary goal of the ACA was to ensure Americans have quality health insurance—the method adopted by States should make this goal a reality.

V. CONCLUSION

According to the National Federation of Independent Business, the primary concern for small businesses since 1986 has been access to affordable health care.¹⁵³ The ACA aimed to

¹⁴⁹ *Id.* at 318.

¹⁵⁰ *See id.*

¹⁵¹ *See* Monahan & Schwarcz, *supra* note 13, at 1976 (noting this method is unlikely to gain political traction).

¹⁵² Hall, *supra* note 145, at 321.

¹⁵³ *Affordable Care Act 101: What Health Care Law Means for Small Businesses*, THE U.S. SMALL BUS. ADMIN. (July 2013), [http://www.sba.gov/sites/default/files/files/SBA%20ACA%20101%20Deck%20-%20Updated%20July%202013%20\(Disclaimer\).pdf](http://www.sba.gov/sites/default/files/files/SBA%20ACA%20101%20Deck%20-%20Updated%20July%202013%20(Disclaimer).pdf).

relieve this concern by strengthening the small-group market. The ACA was successful in many respects. However, the small-group market remains at risk in others. Certain provisions encourage employers to decline to offer coverage or self-insure, keeping those employers out of the small-group market. In addition, technological challenges and delays in the federal SHOP have discouraged small firm employers from joining the SHOP marketplace. For the small-group market to succeed, employers must be able to receive tax credits beyond the current 2016 expiration date. In addition, premium tax credits and cost sharing subsidies must be made available to low-income employees who obtain coverage through the SHOP exchange. Finally, states must regulate stop-loss insurance to discourage small firms from self-insurance.

The small-group market has the potential to provide numerous working Americans with affordable health care. Following this prescription will heal small-employer health insurance and ensure a successful, stable, and efficient small-group market.