Post–Affordable Care Act Trends in Health Coverage for Small Businesses: Views From the Market

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Robert Wood Johnson Foundation
With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010 (ACA). The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally.

INTRODUCTION

Small employers often pay up to 18 percent more than large employers to provide health insurance, in part because large employers have the economy of scale to negotiate lower premiums, provider reimbursement rates, administrative costs and often have better, more stable risk profiles. And though large employers often offer their employees a choice of health plans, small employers (defined as businesses with fewer than 50 employees) usually offer only one health plan. Small employers account for a substantial share of the workforce, as nearly one-quarter (24.6 percent) of full-time employees and over one-third (35.1 percent) of part-time employees worked for small employers in 2014. Health plans offered by small employers also tend to have less-generous benefits and higher deductibles than those offered by large employers. And if a health plan is offered to them, employees at small businesses are much less likely to take up health benefits than those at large businesses. Accordingly, small-group coverage has been on the decline. Between 2000 and 2010, the share of small-business workers covered by employer-based health insurance fell from 43 to 33 percent. In contrast, coverage for workers in firms with 1,000 or more employees fell from 87 to 82 percent in the same decade.

The Affordable Care Act (ACA) sought to address some of the limitations in the small-group market by making offering and enrolling in adequate coverage easier and more affordable. However, growing opportunities to purchase coverage outside of the ACA-compliant, fully insured small-group market have led to uncertainty about whether the law’s small-group market reform provisions are fulfilling their purpose. This paper explores trends in the market for small-business health insurance, including the effects of new incentives created by the ACA. In particular, we examine the continued existence of grandfathered or grandmothered (transitional) plans, the migration of employees to individual policies offered through the new health insurance marketplaces, and other coverage options available to small employers, such as self-funding arrangements (Table 1). Grandfathered and grandfathered policies, also known as non-ACA-compliant plans and described in further detail below, are health plans exempted from many of the ACA’s small-group market reform provisions.
**Table 1. Defining Coverage Options for Small Employers**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Typical Access Point For Small Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-ACA-compliant plan</td>
<td>Plan exempt from most of the ACA market reforms.</td>
<td>Broker or Insurer, renewal of existing plans only</td>
</tr>
<tr>
<td>• Grandfathered plan</td>
<td>Health plan in existence before the ACA was enacted in March 2010; allowed to exist indefinitely, provided that its benefits and cost-sharing structure do not change significantly.</td>
<td></td>
</tr>
<tr>
<td>• Grandmothered plan</td>
<td>Health plan that employer had and renewed in 2013 before the ACA’s primary benefit and rating reforms became effective; often referred to as transitional policies because states are allowing these plans to exist until 2017.</td>
<td></td>
</tr>
<tr>
<td>Fully insured health plan</td>
<td>A plan for which the plan sponsor (e.g., employer) purchases health insurance coverage from an insurer who takes on the financial risk of paying claims for covered benefits. In most states, these plans can be purchased through the Small Business Health Options Program (SHOP) or outside the SHOP. Vermont and the District of Columbia require all fully insured small-group plans to be purchased through the SHOP.</td>
<td>Broker, Insurer or SHOP</td>
</tr>
<tr>
<td>Self-funded health plan</td>
<td>A plan for which the plan sponsor (e.g., employer) takes on the financial risk of paying claims for covered benefits.</td>
<td>Broker, Insurer, or Third Party Administrator</td>
</tr>
<tr>
<td>Self-funding arrangement</td>
<td>A bundled package that combines stop-loss insurance with other services required to properly administer a self-funded health plan, such as access to a provider network and claims processing. Stop-loss insurance is an insurance policy that operates like reinsurance to reimburse sponsors of self-funded plans for claims above a specified level.</td>
<td>Broker, Insurer or Third Party Administrator</td>
</tr>
<tr>
<td>Group-purchasing arrangement</td>
<td>An arrangement that bands together employers to provide health coverage or health coverage-related products and other services.</td>
<td>Group Purchasing Entity, sometimes referred to by Broker or Insurer</td>
</tr>
<tr>
<td>• Association health plan</td>
<td>An arrangement in which health coverage is sold to employer members of an association, such as a professional or trade association.</td>
<td></td>
</tr>
<tr>
<td>• Multiple employer welfare arrangement</td>
<td>An arrangement of two or more employers or self-employed individuals established to offer health coverage.</td>
<td></td>
</tr>
<tr>
<td>• Professional employer organization</td>
<td>An organization that provides various employer functions, in some cases taking on the administrative role of acquiring and obtaining health insurance for a group of employers.</td>
<td></td>
</tr>
<tr>
<td>• Group captive</td>
<td>An arrangement under which multiple employers form an insurance company, or captive, to allow the member employers to underwrite their own insurance rather than buy it from a separate insurer.</td>
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</table>
About This Study

This study focuses on trends in the health insurance market for businesses with 50 or fewer workers in five states: Arkansas, Montana, New Mexico, Pennsylvania and Vermont. We chose these states, in part, because insurers’ self-reported data provided in annual filings to the National Association of Insurance Commissioners’ Supplemental Health Care Exhibit (SHCE) suggest a decrease in small-group enrollment in these states since the ACA’s enactment. In addition, data collected through national surveys, released after this study was underway, confirm that offer rates in these five states appear to be declining faster than the national average. Among small firms, offers of health insurance decreased between 2.5 and 8.8 percent per year on average between 2011 and 2014 across the five states, according to data from the Medical Expenditure Panel Survey Insurance Component Tables (Table 2).

The authors conducted 18 interviews with representatives from the study states’ departments of insurance, insurers selling health insurance plans to small employers, and brokers with experience working in the small-group market. The interviews were conducted between June and August 2015.

Table 2. Percent of Private-Sector Establishments That Offer Health Insurance, Among Firms With Less Than 50 employees, for Five States and the United States, 2011 to 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>Arkansas</th>
<th>Montana</th>
<th>New Mexico</th>
<th>Pennsylvania</th>
<th>Vermont</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>24.1%</td>
<td>30.6%</td>
<td>30.0%</td>
<td>46.7%</td>
<td>41.2%</td>
<td>35.7%</td>
</tr>
<tr>
<td>2012</td>
<td>28.4%</td>
<td>28.6%</td>
<td>28.7%</td>
<td>43.4%</td>
<td>41.8%</td>
<td>35.2%</td>
</tr>
<tr>
<td>2013</td>
<td>26.4%</td>
<td>28.4%</td>
<td>28.8%</td>
<td>37.7%</td>
<td>43.5%</td>
<td>34.8%</td>
</tr>
<tr>
<td>2014</td>
<td>21.6%</td>
<td>27.0%</td>
<td>25.0%</td>
<td>38.5%</td>
<td>29.6%</td>
<td>32.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trend Across Four Years</th>
<th>Arkansas</th>
<th>Montana</th>
<th>New Mexico</th>
<th>Pennsylvania</th>
<th>Vermont</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Change 2011 - 2014</td>
<td>-10.4%</td>
<td>-11.8%</td>
<td>-16.7%</td>
<td>-17.6%</td>
<td>-28.2%</td>
<td>-9.8%</td>
</tr>
<tr>
<td>Average Annual Percent Change 2011 - 2014</td>
<td>-2.5%</td>
<td>-4.1%</td>
<td>-5.7%</td>
<td>-6.0%</td>
<td>-8.8%</td>
<td>-3.3%</td>
</tr>
</tbody>
</table>


Note: The category “average annual percent change, 2011 to 2014” does not include the 2010 - 2011 percent change.
BACKGROUND

Though pre-existing federal law requires insurers to offer health coverage to small employers on a guaranteed issue basis, the ACA introduced market reforms focused on the adequacy and affordability of coverage offered in the small-group market. As noted, health plans offered by small employers tend to have less generous benefits and higher deductibles than their large employer peers. To address the adequacy of coverage, the ACA requires minimum essential health benefits and standardized tiers of coverage based on relative cost-sharing (i.e., the bronze, silver, gold and platinum levels). In addition, insurers must provide first-dollar coverage of approved preventive services, eliminate dollar benefit limits and exclusions based on pre-existing conditions, and cap enrollees’ annual out-of-pocket liability.

In the decade leading up to the ACA’s passage, small employers faced significant annual premium increases. Among small firms, the average single premiums, employee-plus-one premiums, and family premiums increased approximately 6 percent per year on average between 2001 and 2010 (Table 3).

Table 3. Average Total Single Premium, Employee-Plus-One Premium, and Family Premium (in dollars) per Enrolled Employee at Private-Sector Establishments That Offer Health Insurance Among Firms With Less Than 50 Employees, for US 2001 to 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Single Total Premium</th>
<th>Employee Plus One Total Premium</th>
<th>Family Total Premium</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>$3,031</td>
<td>$5,709</td>
<td>$7,704</td>
</tr>
<tr>
<td>2002</td>
<td>$3,375</td>
<td>$6,307</td>
<td>$8,502</td>
</tr>
<tr>
<td>2003</td>
<td>$3,623</td>
<td>$6,763</td>
<td>$9,321</td>
</tr>
<tr>
<td>2004</td>
<td>$3,764</td>
<td>$7,373</td>
<td>$9,898</td>
</tr>
<tr>
<td>2005</td>
<td>$4,121</td>
<td>$7,841</td>
<td>$10,632</td>
</tr>
<tr>
<td>2006</td>
<td>$4,260</td>
<td>$8,105</td>
<td>$11,095</td>
</tr>
<tr>
<td>2007</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2008</td>
<td>$4,501</td>
<td>$8,631</td>
<td>$11,679</td>
</tr>
<tr>
<td>2009</td>
<td>$4,652</td>
<td>$9,124</td>
<td>$12,041</td>
</tr>
<tr>
<td>2010</td>
<td>$4,956</td>
<td>$9,850</td>
<td>$13,170</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trend Across Four Years</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent Change, 2001 - 2010</td>
<td>63.5%</td>
<td>72.5%</td>
<td>71.0%</td>
</tr>
<tr>
<td>Average Annual Percent Change, 2001 - 2010</td>
<td>5.7%</td>
<td>6.3%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>


N/A = Data not available; MEPS-IC data was not collected in 2007.

Note: The category “average annual percent change, 2001 to 2010” does not include the 2000 - 2001 percent change.
Compared with larger employers, small businesses were particularly vulnerable to unpredictable annual fluctuations because of the smaller pool of employees among whom to spread costs. Before the ACA, insurers offering plans in the small-group market could base premiums on factors such as the group’s health status, medical claims history, gender and occupation. Under the ACA’s small-group market reforms, insurers can base premiums only on age, family size, geography and tobacco use. The ACA also requires insurers offering products in the small-group market to set rates using a single risk pool that includes both healthy and sick enrollees across all of their small-group plans in the state. This spreads the risk of high claims across the small-group market and can help stabilize premium cost growth for individual small employers, along with preventing any particular small employer from being singled out for increases based on health factors of their employees.

The ACA also established the Small Business Health Options Program (SHOP), a marketplace in every state through which small employers can shop, compare and buy health insurance coverage. The SHOP marketplaces were designed to respond to small-business owners’ concerns about the lack of choice among health plan options. By enrolling in the SHOP, an employer can set a contribution level and let each employee select his or her preferred option among a range of plans. Under a SHOP plan, eligible small employers can also receive a time-limited federal tax credit to help defray the cost of offering health insurance. However, dysfunctional websites, low insurer and broker interest, and the limited and complex eligibility process to receive federal tax credits have kept enrollment through the SHOP low.

Though many small businesses and their employees stand to benefit from the ACA’s rating and benefit reforms, other businesses, particularly those businesses with young and healthy workers, could face premium increases when they are placed into a single risk pool with older and sicker workers. If small-employer groups with lower risk profiles find more competitive premiums than in the small-group fully insured market, many may gravitate away from it over time. This could lead to market segmentation, adverse selection and higher premiums for those employers remaining in the fully insured small-group market.

Many alternative coverage options are currently available in most states to small employers with healthy risk profiles, although there is limited data at the federal level and in most states about the number of small employers that are enrolled in these different types of arrangements. A type of coverage option available for some employers are plans exempted from many of the ACA’s market reforms. Some are considered “grandfathered” because they were in existence before the ACA and, under the ACA, are allowed to exist indefinitely provided that the plan’s benefits and cost-sharing structure do not change significantly. Others, sometimes referred to as “grandmothered” or “transitional” plans, are those that employers renewed in 2013, before the ACA’s primary benefit and rating reforms went into effect. Most states are allowing transitional policies to continue through 2017, which further delays all small employers from entering the small-group market risk pool.

Small employers can also self-fund their coverage, meaning that they take on the risk of paying employees’ medical claims themselves rather than paying an insurance company to take on that risk. Doing so exempts them from most of the ACA’s market reforms, including the requirement to join the single risk pool, and to pay the health insurer fee. Historically, self-funding was primarily an option for large employers; among small firms that offered coverage in 2014, only 12.3% of covered workers enrolled in self-funded plans. Because of their size, large employers can better absorb the financial risk of paying out unpredictable medical claims. However, self-funding arrangements that incorporate stop-loss insurance allow smaller employers to mitigate the risk of large claims. Increasingly, these stop-loss policies have very low thresholds above which claims are covered. In many ways, these policies can mimic traditional health insurance, but avoid the associated state and federal regulatory requirements and consumer protections.

Depending on the state, small employers can also obtain coverage through group purchasing arrangements such as association health plans (AHPs), multiple employer welfare arrangements (MEWAs) and professional employer organizations (PEOs). In some cases, these arrangements try to lower their costs by self-insuring and by pooling administrative functions. Otherwise, they may attempt to claim large employer status under ERISA (the Employee Retirement Income Security Act) for the purpose of buying health insurance coverage, thus avoiding the small-group market reforms. In most circumstances, federal law requires health insurance sold to small employers through these types of arrangements to meet the ACA insurance standards for the small-group market. But employers sized 51 or more are considered “large employers” and are not required to meet the ACA protections that otherwise specifically apply to the small group market, such as adjusted community rating and essential health benefits package. Some state and federal regulatory approaches allow some AHPs to continue to be treated as large-group plans and be exempt from the ACA’s small group reforms.

Another type of group purchasing arrangement is the “group captive.” With a typical group captive, multiple businesses (member employers) enter into an arrangement under which
an insurance company (captive) is formed to allow the member employers to underwrite their own insurance rather than buy it from a separate insurer. The group captive approach has traditionally been used to provide other lines of insurance for businesses, such as liability insurance. Its use to cover financial risks for medical and health benefits is relatively new. Under one type of group captive, the “group medical stop-loss captive,” each employer member maintains coverage under its own self-funding arrangement, which includes a medical stop-loss policy. This arrangement provides financial protection for lower levels of risk; the captive itself maintains a reinsurance policy to cover higher levels of risk. In theory, these types of group captives allow employer members to collectively benefit from economies of scale related to the purchase of stop-loss policies, reinsurance and administrative functions required of self-funded health plans. Because each employer is maintaining a self-funded arrangement, each claims an exemption from the small-group market reforms.

The ACA also increases incentives for some small employers to drop coverage entirely. The ACA does not apply the employer mandate to employers with fewer than 50 employees; there is no penalty if such small employers choose not to provide health insurance. The ACA also guarantees health insurance coverage to individuals regardless of their health status, and many low- and moderate-income people now qualify for federal tax credits to defray the cost of coverage. Simultaneously, one of the primary financial incentives for employers to offer health insurance and for employees to enroll that insurance is that employers’ payments toward health insurance are exempt from federal income and payroll taxes (often called the “tax exclusion” for employer-based coverage). Because the tax exclusion reduces taxable income, it is worth more to high-income taxpayers than to low-income taxpayers. For small employers that have historically offered health insurance, the new insurance options through the ACA’s health insurance marketplaces could be an attractive alternative coverage option, particularly if they have a large percentage of low-wage workers who qualify for federal subsidies and do not benefit as much from the tax exclusion.

The ACA’s definition of a small employer will also likely affect the small-group market. Starting in 2016, the ACA will define a small employer as a business with 1 to 100 employees. Currently, most states define a small employer as having 50 or fewer employees. Midsize small employer plans (those with 51 to 100 employees) that are regulated as a large group will thus move into the small-group pool and be required to follow the ACA market reform provisions applicable to small-group coverage if they continue to fully insure their health plan. At the same time, these midsize employers are not exempt from the ACA’s employer mandate. Beginning in 2016, they will face financial penalties if at least one of their full-time employees receives a federal subsidy for an individual policy purchased through the marketplace.

Some midsize groups with young, healthy employees could face premium increases as they become subject to the ACA’s small-group reforms, particularly the ban on health status underwriting and the limits on age-based premium surcharges. Consequently, these midsize employers may seek opportunities to self-fund, leaving the fully insured group market altogether.

**OBSERVATIONS FROM THE STATES**

The ACA’s market reforms have dramatically changed the landscape for small group health insurance. Because some reforms could initially make health insurance more expensive for small groups with young and healthy employees, these groups have incentives to seek out alternative coverage options that allow them to escape the reforms and stay outside the small-group risk pool. In most states, employers currently have several alternative options; this has caused some experts to raise concerns about the long-term viability of the traditional small-group market. Why is it still too soon to fully assess the nationwide effect of the ACA on both employers’ ability to offer insurance and employees’ enrollment. However, the early experience of brokers, insurers and regulators with changing incentives and new options created under the ACA can provide insights on how the existing fully insured small-group market is faring as well as possible future trends.

**Some states are not closely monitoring enrollment in small-group markets**

The number of small employers offering coverage, along with the overall share of employees and their dependents that are covered under a small-group plan, has steadily declined over the past decade. However, questions remain about the extent of the decline in small-group enrollment since the ACA’s enactment. Despite this, some state insurance departments appear not to be proactively collecting or analyzing data.
to track real-time enrollment in the small-group market. In addition, since states do not directly regulate self-funded plans, states often lack data regarding the number of small employers in these types of arrangements. Consequently, although their picture of the small-group market is often hazy, their picture of the self-funded small-group market is generally nonexistent.  

Although most state departments of insurance have long had clear authority to monitor enrollment in the fully insured group market, among our study states, Arkansas, New Mexico and Pennsylvania report that they have no comprehensive enrollment data relating to the small-group market (New Mexico reports that it has just begun to collect this data). Rather, state officials rely on either anecdotal evidence from insurers or available consumer complaints. In particular, New Mexico officials voiced frustration at the lack of data available to inform policy decisions about self-funding among small employers, the use of stop-loss policies, and the existence of transitional policies. In Arkansas and Pennsylvania, where the federal government operates the SHOP, state regulators have no firm data on how many small businesses have enrolled or in what plans they have enrolled.

Our other study states, Montana and Vermont, appear to be more proactive in collecting data from insurers to inform their understanding of enrollment trends in the small-group market. For example, Montana officials asked insurers in 2014 to provide small-group enrollment data. This allowed them to find, relatively accurately, a marked decrease (of approximately 10,000 covered lives) in the small-group market from the previous year. They speculate that almost half of those covered lives, approximately 10 percent of the small-group market, shifted to individual policies; the other half migrated to self-funded MEWAs. Montana officials plan to collect this type of enrollment data annually. In Vermont, state officials report that they are monthly collecting from insurers detailed enrollment data on the small-group market; this information is not yet public.

The SHOP continues to have a minimal enrollment

Respondents uniformly confirmed that small employers show minimal interest in the SHOP, and that few have enrolled. One broker noted, “There is not much of an appetite for SHOP.” Though most respondents could not provide specific, current enrollment data, Montana’s data collection efforts have shown that as of April 2015, approximately 835 people were covered under SHOP plans out of an estimated 44,735 people in the small-group market. In New Mexico, as of July 2015, officials estimated that only 850 people were covered through SHOP plans.

Most respondents shared a perception that the SHOP does not add value to the coverage already available to small employers. Respondents pointed to several factors preventing the SHOP from being an attractive option, such as the complexity of employee choice and the federal tax credit. Regarding the federal tax credit for the SHOP, most respondents noted that the federal program is “so complicated and so hard to actually qualify for” that the modest tax credit employers received was not worth the effort to apply. Also, because the tax credit itself only applies to employers with fewer than 25 employees with average salaries of less than $50,000 per year, respondents noted its limited applicability.

The SHOP marketplaces also appear to suffer from a perception in some states that they offer either too much or too little choice for employers and employees. Some respondents observed that employers preferred buying outside of the SHOP because they had more choice among insurance companies, noting that “there are a minimal number of products on SHOP compared to off-SHOP.” But other respondents believe that one of the most highly touted benefits of the SHOP marketplaces, employee choice, is actually a disincentive for some employers to enroll. One broker says that “[employees] don’t want to look at the 50 [plan] options. They want two or three to compare. Choice is important, but there is a limit. When there are too many options, it confuses minds.” Though it is hard to reconcile the two perspectives, they suggest that the SHOPs have not yet demonstrated the ability to satisfy two competing employer desires: multiple options and a highly efficient, simple enrollment process.

Vermont’s small-group market is unique among our study states. There, state officials merged their SHOP with the traditional small-group market. Consequently, employers may only purchase fully insured group plans through the SHOP. However, because of ongoing technical challenges, online enrollment for the SHOP is not yet available, and employers must contact insurers directly to sign up for coverage. Employee choice is an option, but this feature still has not attracted more employers to offer coverage. On the contrary, broker respondents in Vermont found that the availability of subsidies on the individual health insurance marketplace has encouraged some small employers to transition their employees to individual market policies. Vermont brokers further noted that state officials encouraged employers to make this transition because it aligns with the state’s long-term goal of providing coverage under a single payer system.

In some states, a significant proportion of small-group employers remain in non-ACA-compliant plans

As discussed, certain small-group plans are exempt from many of the ACA market reforms, including the grandfathered and grandfathered plans (transitional plans). Among our study
states, only Vermont and New Mexico does not allow employers to stay on grandfathered plans through 2017. Respondents in our study states indicate that small-group enrollment in these types of plans varies across states and insurers. For example, stakeholders in Vermont, a state that does not allow transitional policies, reported that most of the small-group market is now in ACA-compliant plans, and only a small number remain in grandfathered plans. Montana state officials also noted that close to all of the small-group market had transitioned to ACA-compliant policies. Conversely, in Pennsylvania and New Mexico, respondents indicated that most of the state's small-group enrollment remains in transitional plans. A Pennsylvania insurer estimated that such plans constitute 60 to 80 percent of small-group enrollment in Pennsylvania, while New Mexico officials estimated transitional plan enrollment at 60 percent of their small group market. One Arkansas insurer estimated that as much as 90 percent of its small business clients continue to be enrolled in non-ACA-compliant plans, mostly grandfathered plans.

Most states left the decision of whether or not to maintain small employers in non-ACA-compliant plans entirely up to insurers. Stakeholders suggested that by continuing to allow these plans, dominant insurers were able to protect and maintain their share of the small-group market for as long as possible. For example, some brokers in Arkansas are offered higher commissions for renewing employers in grandfathered plans than for enrolling them into an ACA-compliant policy. Other stakeholders noted that certain small employers had their own financial incentives to remain in non-ACA-compliant plans, particularly those with young and healthy workers who would be adversely affected by the ACA’s rating and single risk pool requirements. In all cases, the availability of both grandfathered and grandfathered plans for small employers has currently limited the number of them interested in the SHOP. It may also have delayed employers’ willingness to explore alternative coverage options, such as self-funding arrangements.

Some small employers are dropping health coverage with an expectation that employees will shift to the individual marketplace

Under the ACA, some small employers that have traditionally offered coverage to their employees have new incentives to consider dropping their group plan and shifting employees to the nongroup health insurance marketplaces. Those with fewer than 50 employees face no penalty for doing so, and lower-wage workers could gain financially from the availability of federal premium tax credits and cost-sharing subsidies. In each of the study states, stakeholders report that some small employers, often “microgroups” (those with fewer than 10 employees), have dropped their group coverage with the expectation that their employees will shift to individual policies. It is too soon to have complete quantitative data on how many or what kinds of small employers have made this shift, but as noted above, in Montana as many as 5,000 individuals moved from small-group coverage to individual policies; many likely employed by very small “family owned” businesses. A broker in Montana also opined about his firm’s microgroup customers, saying that while “most are continuing to offer coverage; about a third are no longer offering coverage.” In Pennsylvania and Vermont, insurers also pointed out that microgroups, particularly sole proprietors (businesses with just one employee, or small family businesses), made up much of the migration from small-group coverage to individual policies. Finally, an insurer representative in Arkansas noted that although the insurer observed no measurable decrease in its small-group business overall, most of the small employers that discontinued coverage in the past year had between 2 and 15 employees, and approximately 25 percent of those shifted to individual market policies. “That group [family business] in particular is ripe for moving to the individual market;” stated one regulator, noting too that these groups tended to be less attractive for insurers because of the uncertainty of their risk. Many were only able to obtain coverage before the ACA because of state laws, such as in Vermont, requiring guaranteed availability of group health insurance for family businesses.

Other respondents noted that small employers with lower-income employees were more likely to consider transitioning to the nongroup marketplace. “Not sure if size matters, but [it's] the nature of the business and what they do. I don’t think you’ll see law firms dropping coverage,” stated one broker. Another observed that employers of white-collar professionals see health benefits as necessary to recruit and retain highly skilled employees. Ultimately, respondents felt that employers would make their decision based on the costs associated with providing coverage. If a small employer is struggling financially, that organization will be more likely to stop offering health insurance. This decision is made easier because they now know their employees can purchase coverage, potentially with a subsidy, on the individual market. In addition, some respondents predict that the individual market might become an increasingly attractive alternative for employers if premiums in the small-group market increase relative to the individual market. One broker has observed that “the trend of a declining small-group market is in direct correlation with guaranteed coverage in the individual market and the availability of subsidies. One Pennsylvania broker noted that some employees will be better off in the state’s individual market because premiums there are lower than in the small-group market.

Given the incentives, when asked why more small employers did not transition employees to the nongroup marketplaces, respondents cited three main reasons. First, 2014 small-group
premiums generally remained stable; most employers did not experience high price increases. One broker noted that “[Small-business owners] were concerned about rates, but they weren’t looking to bail out of their plans.” Second, the rocky rollout of the individual marketplaces, information technology problems and overall uncertainty about the individual market made some employers reluctant to drop their coverage. And last, for some employers and employees, offering employer-sponsored insurance continues to be an expectation as part of the business culture or necessary to compete for talent. Many respondents noted that “the top-notch employers will go down the street to get better benefits,” and employers are afraid of losing them. Consequently, some small employers will hold on to their group coverage as long as they can afford it.

More self-funded arrangements are available, although uptake among small employers is relatively limited for now

Before the ACA, very few health insurers marketed self-funding arrangements to small employers, largely because of the uncertain financial gain. Small employers generally do not have the financial cushion to cover large medical claims or the size to spread their costs across healthy and sick employees. But stakeholders report that more health insurers, including national carriers such as United Health Care and CIGNA, as well as a number of Blue Cross Blue Shield affiliates, are now either marketing or contemplating the marketing of a self-funded product for small employers. One insurer in Vermont noted their reservations about doing so, but pointed out that “when others are doing it, we kind of have to keep pace.”

According to stakeholders, these are relatively new product offerings designed for smaller employers. They are often called “level-funded” or “bundled” self-funding arrangements. Insurers market these arrangements as offering significant financial protection through low attachment points, or the thresholds at which the stop-loss insurer takes on the risk of paying claims. They resemble traditional health insurance because the insurer offers a provider network, claims processing, and other administrative services through a single administrative services contract. This bundling of services may be particularly appealing to small employers because it lowers two major barriers to self-funding for small employers. First, these packages minimize the administrative burden of separately contracting and paying for administrative services, such as a pharmacy benefits manager, a provider network, and disease management services, by bundling them under one contract. Second, these self-funding arrangements aim to minimize small employers’ exposure to unexpected, large medical claims, which can disrupt monthly cash flow. Specifically, rather than holding reimbursement for claims that go above the small employers’ specific attachment point until the end of the plan year, such arrangements provide immediate reimbursement. In addition, these self-funding arrangements limit a small employer’s aggregate exposure monthly rather than annually. These features, in addition to plan documents sometimes mirroring those of fully insured products, allow small employers, as one insurer noted, to feel like they are getting the “same [fully insured] plan that they have had for years.” One former broker in New Mexico noted that insurers and producers are telling small employers that they “have nothing to lose and everything to gain” in buying this type of product.

Still, most insurers and brokers with whom we spoke said they are focused on marketing these products primarily to groups with 50 or more employees, although some are marketing these plans to smaller groups. A Pennsylvania broker observed that businesses with 51 to 100 employees were the target market for many carriers, and said that in his state “[insurers] won’t go below [a group of] 20 [employees].” In New Mexico, state officials and other stakeholders, including an insurer and former broker, reported that insurers are marketing self-funding arrangements to small employers with as few as 9 or 10 employees, although they did not have data to determine how many such groups are buying such plans. In general, brokers across the study states report that employers are interested in these new options, but they have not seen a wholesale shift away from the fully insured market. For example, one insurer in Pennsylvania noted that “we’re getting a lot of questions asked and [requests for] quotes, but not a lot of movement.”

State officials continue to express concerns about small employers, especially those under 50 employees, pursuing self-funding arrangements. They note that self-funding arrangements, including the newer “level-funded” products, could expose small businesses to considerable and unpredictable financial and legal risks. For example, in prior research, insurers and brokers in New Mexico, indicated that small employers could still get “bitten in the end” and be liable for large claims at the end of the contract year, as is sometimes the case with employers that self-fund using a traditional stop loss policy. One insurer in New Mexico commented, “A typical small employer is wheeling and dealing each day, and doing their company’s finances in their head. I see all kinds of risk for them to unintentionally break some rule under ERISA.” A regulator in Vermont expressed a common view among department of insurance staff: “[The] self-funding option is probably not a good option for small employers.” In an attempt to ensure that small employers are protected, New Mexico regulators issued guidance requiring stop-loss insurers to comply with the ACA’s market reforms. But brokers and insurance companies, particularly those marketing stop-loss coverage, mounted a campaign against the guidance, prompting the state department of insurance to withdraw it. Still, the guidance has led at least one large insurer in New
Mexico to hold back its marketing of self-funding arrangements to small employers for now.

**In some states, small employers appear to be shifting away from association health plans, however other types of group purchasing arrangements may be gaining a foothold for future growth**

Before the ACA’s enactment, some state regulatory approaches created powerful incentives for health insurers to sell coverage through associations to small employers, largely because they were exempt from key state consumer protections and requirements that would otherwise apply to health insurance sold in the small-group market. With the ACA’s passage, in general, AHPs must meet the same standards as insurance sold in the small-group market. The ACA rules attempted to create a level playing field by eliminating the incentive for insurers to market and sell health plans through associations. However, associations in some states are claiming single large-group health plan status under ERISA, thereby sidestepping the ACA’s requirements for the small-group market.32

In three of our study states, Arkansas, New Mexico and Pennsylvania, there had been very little or no association market for small-group coverage before the ACA’s enactment, and stakeholders in those states reported little or no activity in that market after the ACA’s enactment. To the extent the market did exist, respondents assert that the associations have disbanded. For example, an Arkansas official noted, “[AHPs] have gone with the ACA.”

Only two of the study states, Montana and Vermont, reported a large percentage of the small-group market in AHPs before the ACA’s enactment. With the passage of the ACA, however, Vermont’s AHP market mostly migrated to the fully insured individual or small-group market, depending on the size of the employer. Before the ACA, AHPs were the source of coverage for many sole proprietors in Vermont. However, federal rules implementing the ACA require sole proprietors to buy their insurance through the individual market; they are no longer eligible for group coverage. State officials in Vermont note that sole proprietors consequently shifted from AHPs to the new health insurance marketplaces. One insurer noted that “there is no longer an AHP market” in Vermont.

In Montana, before full implementation of the ACA, approximately 66 percent of the state’s small-group market received coverage through associations.33 Today, many of these associations have migrated to MEWAs, in which the entity bands together small employers and offers health coverage under a self-insured arrangement. One state official noted that “for many years, [Montana] had only three [self-funded] MEWAS. Now we [have]…more than 10.” Although states have the authority to regulate self-funded MEWAs, Montana exempts these arrangements from many of the regulatory standards and consumer protections that would otherwise apply to health insurers in the state and is still waiting for federal guidance to clarify whether or not the ACA’s small-group market rules apply to these types of MEWAs. One stakeholder reported that instead of applying the rating rules required under the ACA for the small-group market, these arrangements use tier rating, which allows insurers to charge higher rates based on the health status of each group. One respondent noted that this often results in healthier groups moving to the MEWA market and the less healthy small groups staying in the community rated market where they have greater protection from rating on the basis of health status.

In addition to self-funded MEWAs, we asked stakeholders about other group-purchasing arrangements in the small-group market, such as PEOs and group captives. Stakeholders in the study states suggested that PEOs were not a prevalent vehicle for marketing health insurance coverage to small employers, and respondents had mixed views about group captives. An official in Vermont, a state with a long history of promoting and regulating captives in other insurance industries, noted that insurers have had increased interest in using the “group medical stop-loss captive” model to offer a multi-tiered self-funding arrangement to small-employer groups, although typically to those with more than 50 employees. “If you’re talking smaller employers, like less than 50, this is much riskier [financially] for the group captive,” stated the official, noting that the primary barrier for the arrangement is the inability to build sufficient capital while meeting the immediate and ongoing need to pay medical claims. A Vermont broker, however, predicted that more employers would gravitate to the group-captive model, noting “[I would be] surprised if this doesn’t take off,” particularly when the grandfathered policies come to an end. He stated that small employers with better risk profiles will look toward self-funding by using “level-funded [self-funding arrangements] or [group] captives.” Conversely, a broker in Arkansas has found that the complexity of the group-captive model makes it challenging to sell them to small employers.

**The year 2017 will be critical for the future of the small-group market**

The year 2017 may be the moment to assess the true effect of the ACA on the fully insured small-group market. It marks the end of the Obama administration’s transitional policy, which will require insurers to discontinue all grandfathered policies. That same year in most states, employers with 51 to 100 employees will need to choose between joining the fully insured small-group market and shifting to an alternative coverage option.34
The end of grandfathered or transitional policies will essentially end the underwriting practices that have kept premiums low for small employers with healthier employees. One insurer in Pennsylvania explained that before the Obama administration’s decision to allow for transitional policies, they had expected much of their small-group business to migrate to the individual market or move toward self-funding arrangements. These alternatives “will be options in 2017 when grandfathered policies expire,” said one respondent.

As the definition of the small-group market expands to include businesses with 51 to 100 employees, stakeholders predict

CONCLUSION

Although most states do not appear to closely monitor small-group market enrollment data, respondents generally agree that there has not yet been a dramatic shift of small employers away from the fully insured market since the ACA’s implementation. At least in some states, encouraged by insurers and brokers, many small employers have simply kept the status quo by maintaining non-ACA-compliant policies, such as grandfathered or grandmothered policies. In so doing, a number of the ACA’s reforms and provisions, including the SHOP marketplaces, have not yet been fully realized.

States are seeing some migration to the individual market as small employers, particularly microgroups, drop coverage because their employees can secure coverage through the marketplace, often with financial assistance. However it appears that small employers are generally not currently shifting, in any significant level, to self-funding arrangements. That could change rapidly, however, as more health insurers and brokers market level-funded self-insured arrangements to small employers, including those with fewer than 50 employees. In addition, although the ACA appears to have caused a shift away from AHPs in some states, other types of group-purchasing arrangements, such as self-funding MEWAs and group medical stop-loss captives, may be gaining a foothold for future growth.

Looking ahead, respondents suggest that 2017 could be a pivotal year for the small-group market as employers shift off of grandfathered policies and midsize employers are required to join the small-group market. Many predict that larger small employers, particularly those with young and healthy employees, will have strong incentives to self-fund coverage either by buying a level-funded self-insurance arrangement directly from a health insurer or through a group-purchasing arrangement claiming large group status.

This prediction should be of great concern for state and federal policymakers that are interested in maintaining a stable and robust fully insured small group market. Experts have long raised concerns about the potential for adverse selection and increased premiums in the small-group market when different regulatory frameworks exist for the same type of health plan purchaser, especially the ability to adjust premiums based on health status of the group. Inevitably, in this type of regulatory environment, small employers with younger, healthier employees will find more competitive premiums beyond the fully insured small group market. In turn, this scenario has the potential to result in significantly higher premiums for those remaining in the fully insured pool, which will ultimately cause further erosion of the small-group market, as small employers facing increased premiums drop coverage. As policymakers contemplate decisions that would influence the stability of the small-group market such as the regulation of self-funding arrangements, the applicability of small group rating rules to various group purchasing arrangements, or the definition of small employers, it is critical that they seek out policy solutions that avoid further separation of health care risks and consequent adverse selection in the fully insured market.
ENDNOTES


5. Robertson et al., Jobs Without Benefits.


7. See the April 1, 2015, filing components of National Association of Insurance Commissioners, “Annual and Quarterly Financial Statement Filing Deadlines.” http://www.naic.org/industry_filing_participation_deadlines.htm (accessed September 2015). Note that there are several limitations of the SHCE data and, most relevant to this study, the self-reported SHCE data is not necessarily consistent across insurers or from year-to-year, in part because the reporting requirements are not uniform. For these reasons, we used the SHCE data only to help select states meeting further study; we do not present and analyze the data here. Blewett L, et al., Using Insurer Filings to Monitor the Private Health Insurance Market. Minneapolis, MN: State Health Access Data Assistance Center, July 2014.


9. One study found that from 2000 to 2013, employers faced double-digit premium increases, but these varied across years. Overall, however, premium increases averaged 5.5 percent. See Blumberg L and Holahan J, “Year-to-Year Variation in Small Group Health Insurance Premiums: Double-Digit Annual Increases Have Been Common Over the Past Decade.” Washington: Urban Institute, 2014.


12. In 2014, 37 percent of percent of small firms with 3 to 199 workers offering health benefits offered at least one grandfathered health plan, a decrease from 54 percent in 2013. And 35 percent of covered employees in these small firms were enrolled in a grandfathered health plan in 2014, a decrease from 49 percent in 2013. Claxton G et al, Employer Health Benefits Annual Survey 2014: Washington, Kaiser Family Foundation, September 2014.


20. Lucia et al., Cross Cutting Issues.

21. In 2013, the New Mexico Insurance Division became the Office of the Superintendent of Insurance, an independent state agency. Prior to that, the NM Insurance Division operated under the authority of the NM Public Regulation Commission. State officials noted that since becoming an independent agency, it has begun collecting enrollment data related to specific health insurance markets, including the small group market and SHOP.


23. Blumberg and Rifkin, Early 2014 Stakeholder Experiences.

24. Lucia et al., The Extended Policy “Fix.”

25. A state official with the NM Office of the Superintendent of Insurance reported that, as of July, 2015 up to 60 percent of the small group market was enrolled in grandfathered plans, however further noted that all grandfathered plans must transition to ACA compliant policies by 2016.

26. Lucia et al., Cross Cutting Issues.

27. Typically, stop-loss insurance will begin to cover claims after a predetermined amount, referred to as an attachment point. Stop-loss contracts may include individual-level (specific) or group-level (aggregate) attachment points. Note that the description of “level funded” or “bundled” self-funding arrangements was first introduced in a prior report. See Lucia K, Monahan C and Corlette S, Cross-Cutting Issues: Factors Affecting Self-Funding by Small Employers: Views from the Market. Washington: Urban Institute, 2013.

28. State insurance regulators have identified several risky features in some self-funding arrangements, specifically stop-loss policies that “may represent a significant risk to small employers, who may not have the resources to manage the complexities of some of these policies, or the financial resources to withstand the additional risk imposed by some stop-loss policy provisions.” Examples include (1) short run out periods for covered benefits; (2) lack of standardized benefits, such as prescription drug coverage; and (3) rescission on the basis of mistake or misrepresentation, among others. See “White Paper: Stop Loss Insurance, Self Funding and the ACA,” National Association of Insurance Commissioners, http://www.naic.org/documents/committees_b_regulatory_framework_150604_stop_loss_white_paper.pdf (accessed September 2015).

29. Lucia et al., Cross Cutting Issues.

30. Lucia et al., Cross Cutting Issues.


32. Lucia et al., Federal and State Policy towards AHPS.


34. At the time of this report, Congress is considering legislation (H.R. 1624) that would repeal the ACA definition of small employer from 1-100 employees to 1-50 employees effective 2016.

About the Authors and Acknowledgements
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