

U.S. Health Reform—Monitoring and Impact

# Small Business Health Insurance and the ACA: Views from the Market 2017

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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 health reform. 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](http://www.rwjf.org) and [www.healthpolicycenter.org](http://www.healthpolicycenter.org).

## EXECUTIVE SUMMARY

The Affordable Care Act (ACA) ushered in dramatic changes for small employers and the market where these employers purchase coverage. However, the impact of ACA provisions designed to improve coverage options and reduce administrative costs for small businesses has been lessened by the availability of non-ACA compliant plans and other benefit arrangements. This report assesses small-group market trends through a review of premium and enrollment data, federal and state policy decisions, and semi-structured interviews with insurance company executives, brokers, and representatives of small business purchasers in six states—Arkansas, Minnesota, Montana, New Mexico, Pennsylvania, and Vermont.

Our research reveals a market that has been relatively insulated from the dramatic changes in the individual market since enactment of the ACA, but is undergoing a significant evolution nonetheless. Stakeholders in our study states provided insights into small-group market trends that may characterize markets nationwide.

- *Premium trends and offer rates.* The small-group market in our study states experienced low or moderate rate increases between 2016 and 2017, generally consistent with medical trend. All study states experienced some decline in the number of small employers offering group health plans, but less than most stakeholders had expected.
- *Shifts to and from the individual market.* Many small businesses, particularly those with fewer than 10 employees, dropped their group policies and shifted employees to the individual market in 2014. However, stakeholders reported that many of those employers are migrating back to the small-group market because of rising premiums, narrow provider networks, and less generous coverage in the individual market, as well as uncertainty over the future of the ACA.
- *Expanded coverage choices for small businesses.* The ACA created an environment that expanded coverage options for many small employers, particularly those with young and healthy workers. Many small employers have remained in transitional “grandmothered” plans that are not ACA-compliant in states that continue to allow them. But enrollment is beginning to decline as sicker groups shift to the ACA-compliant market. Enrollment has steadily declined or disappeared completely in “grandfathered” plans, plans that predated the ACA and do not have to comply with many of the law’s reforms.
- *Level-funded products marketed to healthier groups.* Insurers have ramped up the marketing of level-funded products that combine self-funding, a stop-loss policy, and administrative services. These products are targeted to small employers that have relatively young and healthy workers. They are less expensive for these groups than ACA-compliant plans. But stakeholders note that as these plans gain traction, they will segment the market between high- and low-risk groups.
- *Additional purchasing arrangements for small groups.* Other group purchasing arrangements have emerged to appeal to small employers with healthy employees, such as self-funded MEWAs and group captives.
- *Health reimbursement arrangements (HRAs).* Brokers and small business representatives reported that HRAs could

be an attractive coverage option for many small employers to help employees buy individual health insurance, but they have yet to gain much of a foothold in the market.

## Discussion

The ACA improved premium rates and coverage for some small businesses, but some groups with young and healthy employees faced premium hikes. Insurers and brokers have been quick to respond to these employer groups, and government policies have permitted a greater set of coverage options than originally envisioned under the ACA.

- New coverage options can provide more affordable coverage for employers with healthy employees, but pose

a risk to the small-group market as a whole. When markets are divided between healthy and less-healthy groups, premiums will rise for those less-healthy groups and fewer insurers will be willing to offer them coverage.

- Many new products designed to cater to the young and healthy require small employers to enter into complex financial arrangements that can expose them to new legal and financial risks.
- State and federal policymakers can monitor data on changing coverage choices and their impact on premium trends, and respond with policies that support all small business purchasers.

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## INTRODUCTION

The Affordable Care Act (ACA) ushered in dramatic changes for small employers and the small-group market where these employers purchase coverage. Small employers, defined as businesses with fewer than 50 workers, account for a substantial share of the workforce, as about one in four (25 percent) full-time employees worked for small employers in 2015.<sup>1</sup>

Many small business owners see health insurance as an important benefit for their employees, yet historically they have paid more than large employers to provide that insurance; large employers have greater leverage to negotiate with insurers and obtain better rates. Small businesses also tend to see higher administrative costs, and historically they have had fewer options for self-funding their insurance coverage. In 2013, prior to the implementation of many of the ACA's market reforms, 98 percent of businesses with 100 or more workers offered health insurance to their workers, whereas only 28 percent of businesses with 2 to 9 workers provided coverage.<sup>2</sup>

Not only are small businesses less likely to offer coverage, but the insurance packages they offer historically have been less generous than those offered by large employers.<sup>3</sup> In addition, prior to the ACA, there were no federal requirements and no requirements in many states for insurance offered in the small-group market to include mental health services, substance use disorder treatments, or even a prescription drug benefit.<sup>4</sup>

The ACA sought to address some of the limitations in the small-group market by, for example, limiting the amount insurers can vary premiums based on the health status of small employer groups and setting a minimum standard for essential health benefits. The ACA also created a Small Group Health Options Program (SHOP) designed to provide small businesses a platform to purchase insurance for their employees.

Yet the impact of these provisions has been lessened by the continuation of non-ACA compliant plans and new, self-funded arrangements marketed to small business. These alternative coverage options segment the risk pool because they are more attractive to small groups with favorable risk profiles, while those with higher costs have gravitated to the ACA-compliant market.

In a previous report on the small-group market, we examined the state of play in five states (Arkansas, Montana, New Mexico, Pennsylvania, and Vermont) as of mid-year 2015 through a series of stakeholder interviews with insurance regulators, insurers, and brokers. At that time in these states, we found that many small employers had maintained their non-ACA compliant policies, such as grandfathered or grandmothered policies. Our report found no sign that the ACA reforms for the small-group market were being fully realized.

In that report, we heard about some migration by employees of small businesses to the individual market. Some employers, especially those with fewer than 10 employees (called "microgroups"), dropped coverage at least in part because affordable individual coverage had become available in the marketplaces. In addition, we found no large shift by small employers away from the fully insured market toward self-funding arrangements. In 2015, when interviews were conducted for that report, some respondents suggested that "2017 could be a pivotal year for the small-group market as employers shift off of [pre-ACA] policies."

Of course, that report did not anticipate that the 2016 election would bring a new President united with a majority in Congress in a desire to "repeal and replace" the ACA. The changing environment makes this an opportune time to revisit our 2015 report and reexamine the small-group market.

# ABOUT THIS REPORT

This report focuses on trends in the health insurance market for businesses with fewer than 50 workers in six states: Arkansas, Minnesota, Montana, New Mexico, Pennsylvania, and Vermont—the same states as in the 2015 report, with the addition of Minnesota. We selected states in 2015 based on data showing that they were experiencing a relatively larger decrease in small-group enrollment than the national average since the ACA's enactment. We also sought states from different regions of the country that reflected a range of regulatory approaches to the small-group market.<sup>5</sup>

For this report, we reviewed federal and state policy decisions affecting the small-group market and national and state-level data on small employer health plan offer and enrollment rates as well as premiums. We also conducted 22 structured

interviews with stakeholders from the six study states and one additional interview with an expert who had formerly served as a state regulator. Overall, we interviewed seven insurers, eight brokers, and seven representatives of small businesses (either associations representing small business or actual business owners). We conducted at least one interview with each type of stakeholder in each of the six states. Interviews were conducted between March and May 2017. Because economic and regulatory environments differ across states, we cannot generalize with certainty from findings in our six states to the nation. However, our findings highlight key trends that may characterize the small-group market in other states. They suggest issues and challenges for this market that should be considered by policymakers concerned with its future.

## BACKGROUND

### Offer and enrollment rates: national trends

Nationally, the share of small employers that offer health insurance dropped from approximately 36 percent to less than 30 percent between 2011 and 2015.<sup>6</sup> However, enrollment rates—the percent of small business employees taking up their employer's offer of insurance—dropped by a more modest 3 percent in that time frame. See Table 1.

### Premiums: national trends

Premiums for individual or family coverage for insurance offered by small employers have risen more slowly since the passage of the ACA than they did prior to 2010.<sup>7</sup> Average premiums rose about 3.1 percent per year between the first year after passage of the ACA (2011) and the most recent year available (2015). By contrast, premiums went up at a higher

**Table 1. National Trends in Offer and Enrollment Rates among Private Sector Establishments with <50 Employees, 2011–2015**

Year	Percent that Offer Health Insurance	Percent of Employees Enrolled in Health Insurance
2011	35.7	58.6
2012	35.2	57.7
2013	34.8	57.1
2014	32.2	56.8
2015	29.4	57.0
Trend across five years		
Percent change, 2011–2015	-17.6	-2.7
Average annual percent change, 2011–2015	-4.7	-0.7

Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality. *2011–2015 Medical Expenditure Panel Survey - Insurance Component*. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Available at [https://meps.ahrq.gov/mepsweb/data\\_stats/quick\\_tables\\_search.jsp?component=2&subcomponent=2](https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2) (accessed June 2017).

**Table 2. National Trends in Premiums among Private Sector Establishments with <50 Employees, 2011–2015**

Year	Single total premium	Family total premium
2011	\$5,258	\$14,086
2012	\$5,460	\$14,496
2013	\$5,628	\$14,787
2014	\$5,886	\$15,575
2015	\$5,947	\$15,919
Trend across five years		
Percent change, 2011–2015	13.1	13.0
Average annual percent change, 2011–2015	3.1	3.1

Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality. *2011–2015 Medical Expenditure Panel Survey - Insurance Component*. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Available at [https://meps.ahrq.gov/mepsweb/data\\_stats/quick\\_tables\\_search.jsp?component=2&subcomponent=2](https://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2) (accessed June 2017).

rate between 2005 and 2010 or about 4.4 percent for single coverage and 5.6 percent for family coverage.<sup>8</sup> See Table 2. To a large extent, the rate of increase in the small-group market has tracked the growth in health expenditures nationally, including the large-group market and Medicare.<sup>9</sup>

### The ACA and the small-group market: key reforms

While the ACA's insurance reforms were primarily focused on a dysfunctional individual market, policymakers also sought to address some of the shortcomings of the small-group market, including a lack of insurance choices and high and often volatile premiums for many small businesses due to year-to-year variability in an employer group's health status.

#### Insurance reforms

Although many states had previously set consumer protection standards for premiums and benefits in the small-group market, the ACA established a set of comprehensive standards at the federal level that apply to both the small-group and individual markets. Reforms included:

- New rating rules, prohibiting insurers from using health status to set premium rates and setting a limit on the amount charged based on the age of employees;
- A minimum set of essential health benefits, based on what is offered by a "typical" employer-based plan, and a requirement to cover preventive services without cost-sharing for enrollees;
- A prohibition on limits or exclusions from plan benefits based on pre-existing conditions;
- An annual cap on the amount employees are required to pay for out-of-pocket costs, including deductibles, co-payments and coinsurance.

While employers with 50 or fewer employees are not subject to the law's penalty for not offering affordable, adequate coverage to workers (often called the employer mandate), those with 51 or more are, beginning in 2016.

### SHOP marketplaces, small business tax credits and Health Reimbursement Arrangements

The ACA created new, state-based marketplaces for small businesses, called SHOPS. The SHOP was designed to respond to concerns among small business owners about the limited availability of insurance options and their inability to provide employees with a choice of health plans. The ACA also created small business premium tax credits for very small employers with moderate-income workers that enroll through the SHOP. The credits are only available for three years.

Although there was considerable participation by insurers in the state-run SHOPS that were created in 18 states and the District of Columbia, overall SHOP enrollment has lagged considerably below expectations. In 2016, the Obama Administration released a rule to rescind an earlier requirement that major insurers participate in the federally run SHOPS. As a result, it is likely many of these insurers will decline to participate; by 2018 most SHOP marketplaces may exist in name only.<sup>11</sup>

Congress enacted another reform affecting the small-group market in a 2016 bill allowing small employers to drop their group health plans and use a health reimbursement arrangement (HRA) as a way for employees to purchase individual market coverage.<sup>12</sup> This option became available in January 2017. At this writing, Congress is considering legislation to "repeal and replace" the ACA. If it is enacted, it would make much broader changes to the way the small-group market is regulated.

# FINDINGS

Interviews with stakeholders across the six study states reveal a market that has been relatively insulated from the dramatic changes experienced by the individual market since enactment of the ACA, but is undergoing a significant evolution nonetheless. While health plan premium increases and coverage rates have generally maintained pre-ACA trends, underlying those numbers are markets in which employers are taking advantage of expanded options and responding to new incentives created by the ACA's insurance reforms. These include shifting employees to the individual market—and in some cases, back again to the small-group market—and maintaining pre-ACA plans or shifting to alternative coverage options in order to avoid the ACA's more costly insurance reforms. Individual decisions by small employers to find less costly coverage options, however, have led to increased market segmentation and the potential for future market instability.

## Small-group market rate increases generally consistent with medical trend

There has been relative consistency in small-group premium changes since 2014 in the states studied, especially taking into account the premium volatility that characterized the market before the ACA passed.<sup>13</sup> Most respondents reported low or moderate average rate increases in the small-group market between 2016 and 2017. For example, a broker from Arkansas reported that there have not been large increases in rates for the small-group market. These responses are consistent with rate increase data published by state insurance departments and other state agencies.<sup>14</sup> However, individual employers reported more varied experiences with premium growth; a small business owner from New Mexico told us “we’re getting double digit increases—we have been for several years, and it’s not sustainable.”

*Interviews with insurance stakeholders suggest that they had braced themselves for bigger post-ACA declines in the small-group market than they actually experienced.*

Insurers were in the midst of setting 2018 rates during our interviews, but two insurer respondents estimated that their 2018 rates will be higher than in 2017. One insurer from Montana said they expect the 2018 increases to be “slightly more than our trend increase... somewhere between 9 to 13%”. An insurer, from Pennsylvania, expected 2018 rate increases to be larger than in

2017. However, another insurer in the same state said “for 2018, it’s going to be modest, more like trend increases.”

Insurers attribute cost increases in the small-group market to the same factors that affect large-group and other markets. It’s “really just been pharmacy and medical trends,” said one insurer. Two broker respondents similarly referenced pharmacy costs, one particularly noting the price of specialty medications along with utilization of pharmacy benefits.

There are some state-specific factors that affected the small-group market rates in our study states. The individual and small-group markets are merged in Vermont, which means that there is one rate for both markets. An insurer respondent suggested that the small-group rates in that state are less volatile as a result. Conversely, respondents in other states noted other factors that resulted in greater rate volatility in the small-group market, including Medicaid expansion, which transitioned some covered lives out of the small-group market plans, as well as the prevalence of non-ACA compliant plans in some states, discussed below.

## Strong incentives for small employers to offer coverage remain

Between 2011 and 2015, our study states reflected mixed experiences with small employer offer rates, compared to national trends. In Arkansas, the small-group offer rate rose over that period, while Minnesota’s offer rate declined, but at a slower rate than the national average (12 percent compared to 18 percent). In the remaining four states, the offer rate dropped by more than the national average. The largest drops from 2011 to 2015 were in Montana (30 percent) and Vermont (33 percent).<sup>15</sup>

Interviews with insurance stakeholders suggest that they had braced themselves for bigger post-ACA declines in the small-group market than they actually experienced. A broker respondent said, “one of the myths of the ACA is that it would drive small business away from health care,” but concluded that has not happened on a large scale. An insurer respondent from New Mexico said, “in January 2016, we had our largest month in the small-group [market] as far as writing new policies.”

Although not subject to the employer mandate, many small employers see a benefit in offering health insurance benefits. Respondents from all states said that small employers offer health coverage to attract and retain employees, particularly for groups with more white-collar employees, noted one broker: “If they’re not competitive [with benefits], they’re not going to be able to recruit.” A few respondents talked



specifically about small businesses believing they need to offer health insurance in a tight labor market. For example, a Minnesota broker observed that the workforce shortage in the health care industry in his state is driving small groups in that sector to start offering group coverage.

Some respondents also pointed out the special nature of small businesses, in particular that the employer knows the employees personally, and family members are often employees. One broker said employers that would like to get out of the business of offering health insurance often say something to the effect of: “we can’t [discontinue our group plan], because we have this one employee that’s been with us forever and she would be adversely affected if [we did.]”

### **A shift to the individual market—and then a shift back**

As documented in our 2015 report, respondents confirmed that some small employers dropped health insurance and shifted to the individual market in 2014, following the start of the health insurance marketplaces and the guaranteed issue requirement in the individual market. Multiple respondents in Minnesota and New Mexico pointed to lower premium rates in the individual market, as compared to the small-group market, as driving the shift away from group coverage in 2014. A broker in Minnesota called it a “huge disruption,” noting that thousands of small businesses gave up their employer-based coverage and relied on the individual market to cover their employees. A broker from Arkansas said “many small employers saw the opportunity to get out of that business” once Medicaid was expanded and employees were able to get subsidies on the individual market. Just the existence of an individual market where employees had the option of purchasing subsidized coverage, regardless of health status, seems to have made a difference.

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*Some groups that initially shifted employees to the individual market are now migrating back to the small-group market.*

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However, the shift to the individual market was not widespread in our study states, with other insurer stakeholders calling the decline in the small-group market nominal. Further, respondents reported that much of the decline came from groups with fewer than 10 employees (known as microgroups), a market segment often less attractive to insurers than larger groups. One insurer respondent mentioned that in some ways, they perceive microgroups as more akin to individual market plans than small-group plans when calculating and pricing for risk. In

fact, one insurer noted that their small-group market risk profile improved when microgroups transitioned out of that risk pool and into the individual market.

Some groups that initially shifted employees to the individual market are now migrating back to the small-group market. Brokers and insurers attribute the return to the small-group market to four primary factors: first, rising individual market premiums relative to small-group market premiums; second, decisions by insurers to narrow the provider networks in individual market plans while broader network plans remain available in the small group market; third, increased deductibles and cost-sharing in the individual market without some of the lower cost-sharing options available to small employers; and fourth, concerns about the future of the individual market in the wake of federal ACA repeal efforts.

### **Rising premiums in the individual market**

Respondents from three states, Minnesota, Montana, and Pennsylvania, including brokers and insurers, talked about the role that increased rates on the individual market played in the migration back to the small-group market. In these states, although individual market rates were initially competitive compared to small-group rates, steady premium hikes over the past three years have now made the small-group market relatively more affordable. A broker respondent from Montana noted that “if you match up the individual plans with the closest match on the small-group, the small-group will still be less expensive.” As a result, this broker said, “I had numerous groups...who dropped their group and went with all individual plans a year ago, and now they’re back with group, because group is less expensive.”

### **Narrowing networks in the individual market**

Respondents in two states, Minnesota and New Mexico, observed employers shifting back to the small-group market when provider networks narrowed in the individual market. A Minnesota broker noted that, in one part of the state, the loss of some marquee providers from one company’s individual market plans drove several small employers back to the group market. Another insurer in the state eliminated their open access plans for individuals, but not for small groups and, as a result, “every broker in the small-group market had a windfall” as employers shifted back to the small-group market. An insurer in New Mexico found that when that firm and its competitors discontinued broad PPO-style networks in the individual market, it resulted in a migration back to the small-group market in 2016. Respondents noted that insurers do offer narrow network plans in the small-group market, but often alongside broader network options, providing greater choice than in the non-group market.

### Lower deductibles and cost-sharing in the small-group market

Two broker respondents from Minnesota mentioned that some employers are shifting back to the small-group market because of high deductibles and cost-sharing in individual market plans. Specifically, insurers in that state have discontinued low cost-sharing platinum plans in the individual market, but continue to offer them in the small-group market. As a result, group health plans are the only option for employees and owners of small businesses to get lower cost-sharing plans. Another broker respondent noted a “huge hike-up of deductibles” in the individual market; other respondents mentioned that deductibles have also been rising in small-group plans, but still tend to be lower than in most individual market plans.

### Uncertainty over future of ACA

Some small business representatives observed that uncertainty over the future of the ACA is affecting small business decision making related to health benefits. One of the respondents noted that small businesses must project five years out in relation to finances, making it difficult to manage the uncertainty of an insurance market that could change dramatically within that time frame. This same respondent noted that “employers are sort of stalled until they know what the road looks like in a year or two.” Another respondent mentioned a fear factor among small businesses because “they just don’t know what’s going to happen. There’s the fear that it’s going to get worse. If [the ACA is] repealed then there’s the fear that they won’t be able to get any insurance.”

**Table 3. Defining Coverage Options for Small Employers**

Term	Definition	Typical Access Point For Small Employer
<b>Non-ACA compliant plan</b>	Plan exempt from most of the ACA market reforms.	Broker or Insurer, renewal of existing plans only
Grandfathered plan	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.	
Grandmothered plan	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 can and are allowing these plans to exist through 2018.	
<b>Fully insured health plan</b>	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.	Broker, Insurer or SHOP
<b>Self-funded health plan</b>	A plan for which the plan sponsor (e.g., employer) takes on the financial risk of paying claims for covered benefits.	Broker, Insurer or Third Party Administrator
<b>Self-funding or “level funded” arrangement</b>	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 (called an “attachment point”).	Broker, Insurer or Third Party Administrator
<b>Group purchasing arrangement</b>	An arrangement that bands together employers to provide health coverage or health coverage-related products and other services.	Group Purchasing Entity, sometimes referred to by Broker or Insurer
Association Health Plan	An arrangement in which health coverage is sold to employer members of an association, such as a professional or trade association.	
Multiple Employer Welfare Arrangement	An arrangement of two or more employers or self-employed individuals established to offer health coverage.	
Group Captive	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.	
<b>Health Reimbursement Arrangement (HRA)</b>	Plan that allows small employers to reimburse employees for health care expenses, including premiums for individual market plans. Reimbursements are pre-tax and employers can set an annual contribution level, currently capped under federal law at \$4,950 for individuals and \$10,000 per family.	Small employers must discontinue their group health plans before they can offer a HRA.



## Growing coverage choices for small businesses

While the ACA may have given some small employers an incentive to drop their group plan and encourage employees to purchase individual policies, the law also expanded coverage options for small employers and their employees. These options (Table 3) include:

- Maintaining a “grandfathered” health plan (a plan that was purchased on or before March 23, 2010) that is exempt from most of the ACA’s insurance reforms;
- Maintaining a “grandmothered” health plan (a plan that took effect between when the ACA was enacted in 2010 and October 1, 2013), that, like a grandfathered plan, is exempt from many of the ACA’s insurance reforms;
- Switching to an ACA-compliant plan, either on- or off-SHOP;
- Self-funding a plan with a stop-loss policy to moderate the financial risk;
- Entering into other group purchasing arrangements, such as group captives or self-funded MEWAs, to bypass the ACA’s insurance reforms;
- Establishing a Health Reimbursement Account (HRA) for employees that they can use to purchase non-group coverage.

Stakeholders in our study states report that small employers are taking advantage of many of these options. Brokers report that employers who remain in the small-group market are changing insurers and plans more often than they did in the pre-ACA market. Another broker said there are employers “making [plan] changes every single year trying to mitigate the rate increases.” An insurer respondent explained that “the small-group block of business has become a less loyal block of purchasers” and that some will change coverage plans “for just a few dollars of premiums.” For many employers, however, the availability and attractiveness of different coverage options depend on state policies and the risk profile of the small employer group.

### Employers, particularly healthy groups, transitioning off grandfathered and grandmothered plans

The ACA includes a provision allowing small employers to remain in plans that were purchased on or before March 23, 2010, the date the bill was signed into law.<sup>16</sup> These grandfathered plans are not required to comply with most of the ACA’s insurance reforms, such as the mandate to cover the full range of essential health benefits or refrain from setting premiums based on the group’s health history. However, if an insurer makes significant changes to a health

plan, such as eliminating a benefit or increasing cost sharing, it may trigger a loss of grandfathered status and must come into compliance with the full panoply of ACA reforms.<sup>17</sup>

Small-group enrollment in grandfathered plans across our study states has steadily declined or disappeared completely, although an insurer in one state reports that they maintain “a pretty good chunk” of small employers in these plans. The longstanding dominant small-group carrier in its market, this insurer has used grandfathered plans to help retain its hefty market share.

For the most part, however, insurers either discontinued all their grandfathered business or have steadily shifted employers into ACA-compliant options. Insurers and brokers attributed this shift primarily to three factors: first, because insurers were prohibited from adding new customers to the grandfathered block of business (often called a “closed block” of business), the risk pool became older and sicker over time. Second, as premiums rose, insurers were required to make changes to benefits and cost-sharing, resulting in the plans losing their grandfathered status. Third, many insurers found it administratively burdensome to maintain the grandfathered block of business in addition to their other products. As a result, grandfathered plans are in decline or non-existent in most of the study states. For example, insurers interviewed in Montana and Vermont had shifted away from grandfathered plans after 2014, and believe their competitors did as well. A broker in Minnesota estimates that insurers there phased out these plans by the end of 2016. A Pennsylvania insurer estimated that grandfathered plans’ share of the market is no more than 1 or 2 percent.

So-called grandmothered or transitional plans that do not have to meet most of the ACA’s insurance rules are reportedly more prevalent than grandfathered plans in the states that permit them. See Table 4. On the eve of full implementation of the ACA’s insurance reforms, in late 2013, the Obama administration published a policy allowing individuals and small businesses to remain in their health plans for an additional year. Federal officials have extended that time period to December 31, 2018, but states can prohibit grandmothered plans or require an earlier expiration date.<sup>18</sup>

Grandmothered small-group plans continue to be allowed in three of our study states: Arkansas, Montana, and Pennsylvania. Many insurers interviewed estimate that they maintain greater small-group enrollment in these plans than in their ACA-compliant business—as much as 90 percent. However, that enrollment is beginning to decline. Insurers and brokers are actively transitioning higher-risk groups to ACA-compliant plans, while keeping healthier groups in grandmothered plans as long as possible. Insurers and brokers alike note that sicker

**Table 4. State Decisions to Allow Renewal of Grandmothered (Transitional) Policies in the Small-group Market<sup>19</sup>**

State	Allow grandmothered policies?	Date grandmothered plans required to end
Arkansas	Yes	12/31/2018
Minnesota	No	12/31/2013
Montana	Yes	12/31/2018
New Mexico	No	12/31/2015
Pennsylvania	Yes	12/31/2018
Vermont	No	12/31/2013*

\*Vermont did not adopt the transitional policy in the individual or small-group markets. Instead, individuals and small groups were presented with the option to extend their current plan for up to three months, until March 31, 2014.

groups can benefit from the ACA’s community rating, which disallows insurers from charging higher prices based on health status. As one carrier put it, each year “more high-risk groups move over to ACA plans, because they get better rates than they’re getting on the [grandmothered] products.” Conversely, another broker notes: “I am seeing...very minimal [premium] increases for healthy groups [in grandmothered plans]—the carriers want to retain these.”

Brokers did note, however, that some employers are reluctant to move to ACA-compliant policies, even when it would reduce premium rates. Some are risk-averse about making changes given the uncertainty surrounding the ACA. Another major factor is the way in which the employer receives his or her premium bill from the insurer. Before 2014, employers generally received a composite rate bill from their insurance company. In other words, after determining a single premium based on the size, age, and risk status of the group, the insurer would calculate and provide the employer with an average (composite) rate that applied to every person in the group. For an ACA-compliant plan, however, most insurers provide employers with a list bill that includes a separate premium for each employee and dependent. As a result, employers can see how much more an older employee costs in premiums relative to a younger employee. While age rating is not an invention of the ACA, for the first time it is transparent to employers, opening them up to the risk of age discrimination. For example, a broker in Pennsylvania reports that employers are now realizing that if they hire new employees over a certain age threshold, they will face a premium increase. A New Mexico broker observed: “Employers hate this age-by-age rating. It’s leading to discrimination discussions in the workplace” this broker had not witnessed before.

**A “fast-growing” trend: More insurers offering self-funding plus stop-loss to attract healthy employer groups**

Self-funding options existed for small employers prior to the ACA, but few insurers marketed these products to groups with fewer than 50 workers, in part to avoid segmenting a historically profitable fully insured small-group market. In addition, they recognized that most small employers were ill suited for the considerable, and unpredictable, financial and legal risks that accompanied self-funding.<sup>20</sup> Since enactment of the ACA, however, stakeholders in our study states report that major insurers, including Aetna, United HealthCare, Cigna, and Blue Cross Blue Shield affiliates, have developed level funded products that are designed for small employers. Level funded products generally combine a self-funding arrangement, in which the employer assumes the risks of paying claims, with a stop-loss insurance policy and administrative services (e.g., claims processing and network management). For small employers, the stop-loss policy often has a low attachment point or “retention level” that protects them against unexpectedly high claims costs. Once the employer’s claims costs in a year exceed the attachment point, the stop-loss policy will fully cover their costs. See Exhibit 1.

Stakeholders across several study states report a significant rise in the marketing of these products to small employers with healthy risk profiles. Since the small employer that buys a level funded product is legally self-funding, these plans are exempt from many of the ACA’s insurance reforms, such as the essential health benefits standard and the prohibition on health status underwriting. The popularity of level funding among insurers and brokers is likely what prompted three study states, Minnesota, New Mexico, and Vermont, to enact policies in 2017 that make it easier for small employers to obtain stop-loss coverage.<sup>22</sup> At the same time, there is a lack of data on enrollment in level-funded or similar plans, and few state departments of insurance have conducted regulatory oversight of these products.<sup>23</sup>

## Exhibit 1. Level Funded Plans for Small Businesses: Benefits and Risks

The bundling of self-funding, stop-loss insurance and administrative services lowers three major barriers to self-funding for small employers by:

- Minimizing the burden of separately contracting and paying for the administrative services of traditional insurance, such as a provider network, claims processing and disease management services.
- Minimizing 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.
- Enabling employers to spread claims costs out more predictably over the course of the year.

Several risky financial and legal features may remain in self-funding arrangements, such as:

- Cost hikes at renewal. Self-funded employers may face re-underwriting (a review of employees' health status and claims history) and may face significant cost increases due to changes in their employees' health status. The stop-loss insurer can also refuse to renew the stop-loss policy.
- Continued financial exposure. A small business may be responsible for the claims run out (the full cost of any claims incurred while covered by a stop-loss policy but not processed until after the policy has expired).
- Fiduciary responsibility and potential liabilities. Under federal law, the small employer is the plan fiduciary and is legally responsible for compliance with insurance laws.<sup>23</sup>

Across our study states, stakeholders have observed a rising interest in level-funding and similar arrangements among many small-group insurers and brokers. A New Mexico broker asserted: "[Level funding] is the next best thing since I don't know what in health care." Similarly, brokers in Minnesota report that "level funding has become a big trend." An Arkansas broker called it one of the fastest-growing product lines in his industry. Some industry experts consider level funding as a good bridge product for small employers between a fully insured, ACA-compliant plan and full self-funding.

Small employer associations and owners similarly report increased interest in self-funding options. However, many are cautious about these new arrangements, even when they come at a lower price. Small employers are at first scared by the term self-insured, one business association representative told us, but brokers are making headway educating them about stop-loss coverage. Others observed that small business owners are risk averse and like to stick with what they know. Small employers are not proactively asking for self-funded options, one broker observed: "It's all broker-driven."

*The availability and attractiveness of level funding to a small employer depends primarily on their risk profile.*

Insurer stakeholders appear of mixed minds about the growth of this market, although most recognize that they need to offer level-funded or similar products in order to maintain their small-group market share. "We've felt the need to offer self-insured products just to keep pace.... It's a defensive strategy.... We'd much prefer to have a fully functioning insured market," said one carrier. For another insurer, the only product they are offering in one state's small-group market is a level-funded plan.

Insurers and brokers differ on how large a group needs to be before it is appropriate for a level-funded plan, with some saying they would never sell one to a group smaller than 25 employees. However, the floor below which self-funding is inappropriate seems to be getting lower. "Originally it was 25 and up, and now [insurers are] looking to going down as low as 10 people," one broker informed us. Another broker has seen self-funding in groups as small as 5 employees.

The availability and attractiveness of level funding to a small employer depends primarily on their risk profile. This self-funding option can be considerably more affordable than a fully insured plan for a healthy small group because the stop-loss policy can be medically underwritten, the plan does not have to comply with most of the ACA's insurance reforms, and it is exempt from the law's health insurer tax.

Brokers and insurers alike were quite candid about which groups they talk to about the option. "Let's be honest: Level-funding is underwriting," a carrier told us. A Minnesota broker said he targets small groups with a healthy profile "for the conversation [about self-funding]." On the other hand, groups with a riskier profile are turned away: "If I have a [business] with 9 or 10 women, I know I'll get a couple of pregnancies and the plan will be doomed." He steers those groups towards an ACA-compliant option.

However, insurers and brokers alike noted that the level-funded plans are complex and come with risks for employers. See Exhibit 1. One broker noted the significant education challenge for small businesses and that many employers do not fully understand their liability. Furthermore, although the broker community has become active in this space, many need training to get up to speed on the benefits and risks of the products. “I worry about the non-savvy brokers making a mess of this,” commented a Minnesota insurer. Another insurer said: “It’s not good to force people into less certain, more risky, more complex financial arrangements just because you’re trying to get outside of the broader pool. That’s just the sign of a public policy failure.”

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*“Segmentation is definitely going to take place.”*

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Insurers and brokers also recognize that as more healthy groups switch to level-funded plans, it could result in higher premiums for those remaining in the ACA-compliant market. “Segmentation is definitely going to take place,” a New Mexico broker predicted. “Younger groups will be jumping into the self-insured market more readily than the older, sicker groups will be.” A Minnesota insurer is already translating this adverse selection into higher 2018 premium rates for small employers remaining in fully insured, ACA-compliant plans. A Pennsylvania insurer told us that the market segmentation would eventually require them to pull their fully insured plans from the small-group market: “To be honest with you, we wouldn’t offer an ACA small-group product in the future...you’d have no way to control it. [The ACA product] is guaranteed issue, community rated, it’s too much of a risk for us even to put a product out there. So we’d basically have level funded down to 8–10 life groups, and everyone else would have to go to an individual product.”

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*“We will have two markets: a high-risk ACA market and a quasi-underwritten level funded market.”*

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Over time, industry stakeholders predict the market for level-funded products will expand. “Brokers are slowly stepping up to the plate...and getting on board,” said one insurer. Similarly, a broker said he expects this market to really take off as word spreads and more carriers demonstrate positive experiences with small groups and level funding. A Pennsylvania insurer predicted: “We will have two markets: a high-risk ACA market and a quasi-underwritten level funded market.”

### **A constantly changing market: alternative group purchasing arrangements**

In addition to level funded plans, healthy small groups seeking lower premium rates and exemptions from the ACA’s insurance mandates have additional purchasing options, sometimes through group purchasing arrangements, but these may vary by state. See Table 3.

Before the ACA, 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 insurance in the small-group market.<sup>24</sup> Under ACA rules, association health plans (AHPs) must meet the same standards as insurance sold in the small-group market. As a result, stakeholders in our study states deemed AHPs, often cited as a replacement option for the ACA’s small-group reforms, as non-viable. While they were common before the ACA, they are less so now. An insurer found the fascination with AHPs among policymakers “kind of baffling,” in part because they tend to “blow up” over time. These arrangements “look nice on the surface,” said a Pennsylvania insurer, but because carriers can’t control the entry and exit of small employer groups, they are much less attractive from a risk perspective than the emerging level funded and captive products.

However, state policy approaches to AHPs can affect whether they are an attractive coverage option for small employers and the associations who market them. For example, self-funded MEWAs (Multiple Employer Welfare Arrangements), another type of group purchasing arrangement, are relatively common in Montana but less prevalent in other states. Before the ACA, approximately 66 percent of Montana’s small-group market received coverage through associations.<sup>25</sup> In the wake of the ACA’s rules for AHPs, many of these associations did not dissolve but migrated to self-funded MEWAs. One state official noted that the number of self-funded MEWAs jumped from three to ten after the ACA was enacted.<sup>26</sup> 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. Stakeholders assert that Montana’s MEWAs have resulted in a sicker risk pool for the fully insured small-group market. As one insurer put it, these arrangements have “not allowed Montanans to get the full benefit of having the whole small group block in the same risk pool,” further noting that rates are higher in the regulated market in the state because these MEWAs are “picking off that healthy block of business.” At the same time, one respondent observed that some MEWAs formed in the wake of the ACA have faced financial problems and ultimately closed down.



## Exhibit 2. What is a 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 insurance 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.

While AHPs and MEWAs appear to be on the decline, insurers and brokers in Arkansas and Vermont have observed the growth of captives for small employers. See Exhibit 2. “The medical captive model has been extremely attractive,” observed an Arkansas broker. In Vermont, the “national capital of captives,” one local insurer has developed a captive product to compete with a large national carrier’s level-funded plans, which are pulling healthier groups away from the ACA-compliant market.<sup>27</sup> Yet, in other study states, broker and insurer stakeholders were unfamiliar with captives and did not think many small employers, if any, were using them.

*“The medical captive model has been extremely attractive.”*

### **Health Reimbursement Arrangements: Attractive in concept, little market penetration yet**

Health Reimbursement Arrangements (HRAs) are plans that allow employers to reimburse employees for health care expenses. Unlike Health Savings Accounts (HSAs),

employees can use HRA funds to pay the premiums for an individual health insurance policy, in addition to cost-sharing expenses. Before 2017, the Internal Revenue Service (IRS) defined HRAs as a group health plan and thus required to comply with federal group health plan standards, such as the requirement to cover preventive services without cost-sharing and to cap enrollees’ annual out-of-pocket costs.<sup>28</sup> However, Congress enacted legislation in late 2016 reversing the IRS ruling for small employers, thereby making it easier to offer small business employees an HRA as an alternative to a traditional group health plan.<sup>29</sup> Reimbursements from HRAs are pre-tax, and they allow employers to set an annual—and predictable—contribution level. The federal legislation limits employer contributions to HRAs to \$4,950 for individuals and \$10,000 per family, but employers can contribute any amount they choose up to that cap.

Insurers, brokers and small business representatives we interviewed generally agreed that HRAs could be an appealing coverage alternative for small business owners. A Minnesota broker predicted: “I could certainly see some small employers wanting to get out of the business and [set up] an HRA...they’re not going to be subject to the whims of medical trend, and sponsoring a plan.” However, the use of HRAs in this market remains rare, which stakeholders attributed to several factors.

First, the HRA legislation went into effect only recently, on January 1, 2017. Brokers and insurers noted that this was late in the game because many employers make plan renewal decisions in the fall. An insurer predicted that any traction on HRAs would not occur until the fall of 2017. Second, many small business stakeholders we interviewed were unaware of HRAs as a new coverage option. A state small business association told us: “That’s the kind of thing that, if we knew about it, we would do an educational workshop...with our members.”

Third, stakeholders noted that brokers typically get a better commission from selling group health plans than individual policies, reducing their incentive to inform business owners about the new HRA option. Similarly, insurers prefer to market to employer groups than to individuals. “It’s not advantageous to the [insurer] or the broker,” observed an Arkansas broker. Fourth, with a federal cap of \$4,950 and \$10,000 per family, some stakeholders did not believe that HRAs would be adequate to pay for individual health plans. Stakeholders asserted that many employers would not contribute enough to pay for a comprehensive insurance policy in many states. “It’s a way for employers to wash their hands of [offering

insurance],” said one broker, “but it’s not going to be enough for individuals to purchase their coverage.” Lastly, some stakeholders pointed to concerns about the stability of the individual market, suggesting that employers might hesitate to discontinue group plans and send employees to the

## DISCUSSION

Sellers in any market try to deliver what their customers want, and the small-group market is no different. Small employers have long sought more affordable and predictable premiums together with a greater choice of coverage options. The ACA attempted to address these concerns, particularly for employers who suffered from high and rising premiums due to poor claims experience. But the ACA’s insurance reforms, while improving premium rates and the comprehensiveness of coverage for some, resulted in premium hikes for small groups with younger and healthier employees. Companies catering to this market, primarily insurers and brokers, have been quick to respond to those employer groups. Federal and state policies have also permitted a greater set of insurance options for small employers than originally envisioned by the ACA’s drafters.

Our interviews with stakeholders in six study states provide a window into the small-group market and some of the key trends that have emerged recently. Although the regulatory and market environment of each state is unique, the trends observed in these states are likely to be similar to key trends across the country.

New and expanded coverage options for small employers include the ability to stay on pre-ACA grandfathered or grandmothered plans, drop a group plan and shift employees to the individual market, self-insure, use new level-funded products designed for small businesses, or to enter into a group purchasing arrangement, such as a group medical stop-loss captive. More coverage choices are appealing to many small businesses, particularly if they have younger and healthier employees and can benefit from the lower premiums in plans that do not have to comply with the ACA’s insurance reforms. At the same time, thanks to the ACA, microgroups or groups with sicker risk profiles can shift employees to an individual market that must now protect

individual market in the face of headlines about repeal efforts, insurer withdrawals, and premium increases. For many small employers, employees are like family (or, in many cases, are family) and coverage decisions can be far more personal than those made by large employers.

people with pre-existing conditions, and some employees can qualify for income-related subsidies.

While these expanded options can provide new and more affordable coverage for many employers, they pose a risk to the small-group market as a whole. The more a market is segmented into separate risk pools, the greater the potential for adverse selection. As younger and healthier groups shift to self-funded or similar options and avoid the ACA-compliant, fully insured market, the less healthy the fully insured small-group market becomes.<sup>30</sup> As their risk pool gets sicker, insurers in that market will need to raise premiums in response, or, as predicted by one of our insurer respondents, leave the market entirely. Similarly, to the extent that the groups dropping coverage and sending employees to the individual market have a sicker risk profile than those remaining in the group market, it results in adverse selection against the individual market, and higher premiums in that market as a result.

In addition to adverse selection concerns, some new coverage arrangements, especially level-funded plans and group captives, require small business owners to enter into complex financial products that expose them to new legal and financial risks. While many small businesses are served by brokers, many brokers admit that they are not comfortable with these increasingly complicated arrangements, and that considerable training is needed to advise their small business clients. In addition, these products are exempt from many of the consumer protections required of ACA-compliant plans, such as the requirement to cover essential health benefits.

State and federal policymakers seeking to support a vibrant and stable small-group market will need to monitor and review data on changing coverage choices and the impact on premium trends, particularly for those small businesses remaining in the traditional, fully funded small-group market.



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### **About the Authors and Acknowledgements**

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