DOES SMALL GROUP HEALTH INSURANCE DELIVER GROUP BENEFITS? AN ARGUMENT IN FAVOR OF ALLOWING THE SMALL GROUP MARKET TO DIE

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Abstract: The small group health insurance market is failing. Today, fewer than one-third of small firms now offer health insurance and the number of people covered by small group insurance continues to drop. These problems invite the obvious question: What should be done about the small group market? Past scholarship on the small group market has largely focused on documenting the market's problems, evaluating the effectiveness of prior reform efforts, and proposing regulatory changes to stabilize the market. This Article takes a different approach to the small group problem by asking a previously unasked question: Does the small group market deliver group insurance benefits? Group insurance, first established in the life insurance industry, came about because it offered insureds a better deal than individual coverage. Group insurance provided four core benefits: reduced adverse selection, lower administrative costs, greater access to insurance, and tax-subsidized premiums. This Article argues the small group market largely fails to deliver the core benefits of group coverage. For many, the small group market offers no better deal than the individual market. Given these findings, it is hard to justify further interventions to save the small group market. The decline and dissolution of the small group market would likely shift millions to the individual market, resulting in a substantially larger and more stable individual market.

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INTRODUCTION

The small group health insurance market,[1] covering employers with fifty or fewer employees,[2] is failing. Despite repeated legislative efforts to reform the small group market stretching back nearly three decades, including substantial changes under the Affordable Care Act (ACA),[3] the steady decline of the small group market continues. Only 29% of small employers now offer health insurance coverage to their employees,[4] down from 51% in the mid-1990s.[5] Small group enrollment

1. The large and small group health insurance markets offer fully insured coverage. This means the employer purchases a health insurance policy to cover its employees from a state-licensed insurer. In exchange for a premium payment by the employer, the insurer bears the full risk for all claims covered by the policy. *See* Russell Korobkin, *The Battle over Self-Insured Health Plans, or "One Good Loophole Deserves Another"*, 5 YALE J. HEALTH POL'Y, L. & ETHICS 89, 89–90 (2005). In contrast, self-insured (also called self-funded) employer groups do not purchase health insurance. Instead, they bear the risk, at least partially, of the health care expenses of their employees through an insurance-like employee benefit plan. *Id.*

2. Prior to the ACA, the large employer group market consisted of employers with fifty-one or more employees, and the small employer group market consisted of employers with fifty or fewer employees. The ACA amended these definitions to enlarge the small employer group market to include employers with up to 100 employees as of January 1, 2016. Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1304(a)(3)(b)(2), 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.). Congress later amended the ACA to retain the original definitions of large and small group employers. Protecting Affordable Coverage for Employees Act, Pub. L. 114-60, § 2(a)(1)–(2), 129 Stat. 543 (2015) (codified in scattered sections of 42 U.S.C.). Four states—California, Colorado, New York, and Vermont—currently extend their small group market to cover employers with up to 100 employees. Sabrina Corlette et al., *Repeal of Small-Business Provision of the ACA Creates Natural Experiment in States*, COMMONWEALTH FUND (Mar. 22, 2016), http://www.commonwealthfund.org/publications/blog/2016/mar/repeal-of-small-business-provision-of-the-aca [https://perma.cc/DE2G-5GVC].

3. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

4. *2016 Medical Expenditure Panel Survey, Insurance Component National-Level Summary Tables, Table I.A.2 Percent of Private-sector Establishments that Offer Health Insurance by Firm Size and Selected Characteristics: United States (2016)*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T HEALTH & HUM. SERVS. (2016), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2016/tia2.pdf [https://perma.cc/KR7V-8GRR] (reporting that only 28.6% of private-sector firms with less than fifty employees offered health insurance coverage).

5. *See* Michael A. Morrisey et al., *Small Employers and the Health Insurance Market*, HEALTH AFF., Jan. 1994, at 149, 150 (noting that 51% of small businesses offered health insurance in 1993).

has also declined significantly, dropping to 14.7 million people in 2015[6]—a loss of nearly 3.5 million since 2012.[7]

The small group market's history of poor performance has stimulated considerable scholarship, much of it focused on evaluating reform efforts and proposing regulatory changes to stabilize the market.[8] Scholarship and policy analysis following passage of the ACA has largely travelled down the same path, with some arguing that the small group market should be protected from further decline.[9] This Article takes a different approach to the small group market. It poses a central but previously unexplored question: Does the small group market deliver group insurance benefits? Group insurance came about for a single reason: it offered insureds a better deal than individual coverage. If small

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6. *See* PAUL R. HOUCHENS ET AL., MILLIMAN, 2015 COMMERCIAL HEALTH INSURANCE: OVERVIEW OF FINANCIAL RESULTS 6 fig.4 (2017) [hereinafter MILLIMAN 2015], http://www.milliman.com/uploadedFiles/insight/2017/2015-commercial-health-insurance.pdf [https://perma.cc/Q5WL-JBDF].

7. *See* PAUL R. HOUCHENS, MILLIMAN, 2012 COMMERCIAL HEALTH INSURANCE: OVERVIEW OF FINANCIAL RESULTS 1 fig.1 (2013) [hereinafter MILLIMAN 2012], http://us.milliman.com/uploadedFiles/insight/healthreform/ 2012-commerical-health-insurance-financial-results.pdf [https://perma.cc/RAC9-3XH7] (reporting 18.1 million covered lives in the small group market in 2012).

8. *See, e.g.*, Rick Curtis et al., *Health Insurance Reform in the Small-Group Market*, HEALTH AFF. May-June 1999, at 151 (examining the scope and development of small group health insurance rating laws in the 1990s); Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685 (1999) (evaluating how small group health insurance reform laws affected competition among insurers); Catherine G. McLaughlin & Wendy K. Zellers, *The Shortcomings of Voluntarism in the Small-Group Insurance Market*, HEALTH AFF., Summer 1992, at 28 (assessing results of health care financing projects for small businesses); Alan C. Monheit & Barbara Steinberg Schone, *How Has Small Group Market Reform Affected Employee Health Insurance Coverage?*, 88 J. PUB. ECON. 237 (2003) (evaluating effects of small group reforms in the 1990s); Olympia J. Snowe, *Small Business Health Plans: A Critical Step in Solving the Small Business Health Care Crisis*, 43 HARV. J. ON LEGIS. 231 (2006) (arguing in favor of proposed legislation that would allow small businesses to offer association-sponsored health insurance).

9. *See e.g.*, Timothy Stoltzfus Jost & Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 68 N.Y.U. ANN. SURV. AM. L. 539 (2013) (analyzing the problems self-insurance poses to the small-group market and proposing legislative solutions); Amy B. Monahan & Daniel Schwarcz, *Saving Small-Employer Health Insurance*, 98 IOWA L. REV. 1935 (2013) (proposing solutions to "save" the small group market from instability after the ACA takes effect); Matthew Buettgens & Linda J. Blumberg, *Small Firm Self-Insurance Under the Affordable Care Act*, COMMONWEALTH FUND 2 (Nov. 28, 2012), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2012_nov_1647_buettgens_small_firm_self_insurance_under_aca_ib.pdf [https://perma.cc/Q4FC-FX67] (arguing that regulation of stop-loss insurance will reduce adverse selection in the small group market). *But see* Allison K. Hoffman, *An Optimist's Take on the Decline of Small-Employer Health Insurance*, 98 IOWA L. REV. BULL. 113 (2013) (arguing that the U.S. health insurance system might be better off without the small group market after the ACA).

group health insurance does not deliver insureds a better deal than coverage available in the individual health insurance market, there is little reason to save the small group market from further decline and dissolution.[10]

In order to proceed with this inquiry, it is important to first understand what "a better deal than individual coverage" means in relation to the small group market. To do so, the benefits of group insurance that make it more desirable than individual insurance must be identified. Although modern scholars have laid out an extensive catalog of the benefits of group health insurance, no consensus exists as to the core benefits that make group health insurance a better deal than individual coverage.[11] To identify the core benefits of group coverage, this Article turns to the birthplace of group insurance—the life insurance industry just after the turn of the last century. When first offered about a century ago, the group insurance model revolutionized life insurance by providing three benefits: (1) a reduced risk of adverse selection, (2) lower administrative expenses, and (3) expanded access to coverage. A fourth benefit, a federal tax advantage, also lowered the cost of group coverage. Together, these four core benefits made group insurance a better deal

10. Throughout this Article, I refer to the dissolution or death of the small group market. This can mean one of two future states of the market. The first is a death spiral, a circular pattern in which low-risk insureds leave the market, thereby driving up prices, which prompts more low-risk to leave, driving up prices even more. This cycle continues until the risk pool collapses and no one remains covered. *See* Peter Siegelman, *Adverse Selection in Insurance Markets: An Exaggerated Threat*, 113 YALE L.J. 1223, 1224 (2004) (explaining how adverse selection can lead to a death spiral). A second possibility is that the small group market continues to decline but eventually stabilizes, albeit with low enrollment and high costs. This would leave the small group market functioning, but dwarfed by the individual and large group markets.

11. *See, e.g.*, MICHAEL A. MORRISEY, HEALTH INSURANCE 244–46 (2d ed. 2014) (identifying benefits of group coverage: healthier risk pool, tax subsidies, lower administrative costs, and employers as beneficial agents for employees); Kathryn L. Moore, *The Future of Employment-Based Health Insurance After the Patient Protection and Affordable Care Act*, 89 NEB. L. REV. 885, 893–902 (2011) (discussing how employer-based group coverage provides favorable tax treatment, lower costs, beneficial agency relationships between the employer and its employees, and labor incentives); David A. Hyman & Mark Hall, *Two Cheers for Employment-Based Health Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 30–35 (2001) (finding that group insurance offers employers as beneficial agents, solutions to bounded rationality problems, valuable administrative services, efficiencies of scale with regard to costs, a tax subsidy that binds a heterogeneous risk pool, and reduced adverse selection, among others); Uwe E. Reinhardt, *Employer-Based Health Insurance: A Balance Sheet*, HEALTH AFF., Nov.–Dec. 1999, at 124, 125–26 (discussing how employer-based group coverage effectively pools health insurance risks, provides a tax benefit, offers opportunity for innovation in the purchase of health care, and reflects consumer preferences). Group health coverage has also been subject to criticism. *See, e.g.*, Hyman & Hall, *supra*, at 27–30 (discussing "informational, preference, and incentive mismatches—between employers and employees, and between employee groups and individual employees—that play out in the cost and breadth of [group] coverage").

than individual insurance by lowering the cost of life insurance and making it available to those who would have been denied coverage in the individual market.[12]

Using these four benefits as a framework to evaluate small group health insurance, this Article draws two conclusions about the small group market. First, small employers have always been an awkward fit in the group insurance market. Due to their size and the actuarial limits of experience rating, small groups cannot be priced or administered the same way as large groups. As a result, the small group market has always been (and continues to be) exposed to adverse selection, very much like the individual insurance market.[13]

Second, the post-ACA small group market largely fails to deliver group benefits to its insureds, in part because of its adverse selection problems and in part because the ACA brought a number of improvements to the individual market. While the small group market was thought to provide worthwhile benefits over the individual market prior to the ACA (i.e., greater access to coverage, a tax subsidy not available to purchasers in the individual market, and lower administrative costs),[14] the post-ACA small group market: (1) provides no greater protection from adverse selection than the individual market, (2) fails to deliver insurance at a lower administrative cost than the individual market, and (3) does not offer any greater access to coverage than the individual market. As for the fourth benefit, the tax subsidy, the results are mixed. Insureds in the small group market with higher incomes enjoy a tax subsidy that is not available to them in the individual market. Conversely, lower- and middle-income individuals get a better tax subsidy in the individual market.[15]

As a result of these findings, there appears to be little reason to prop up the small group market. Allowing the small group market to continue its decline would likely push millions to the individual market.[16] This

12. *See infra* sections I.A–B.

13. *See infra* section II.B.

14. *See, e.g.*, Monahan & Schwarcz, *supra* note 9, at 1944 (noting that prior to the ACA, "the individual market for health insurance . . . has historically been even less attractive than the small-group market" due to the lack of a tax benefit and significant adverse selection).

15. *See infra* Part III.

16. Although the individual market is the natural landing spot for many leaving the small group market, it is unlikely that everyone shifting out of that market will transition to the individual market. Some small employers currently in the small group market will self-insure as the small group market declines. Member of some households will shift to a large group plan through a spouse or other family member. Other may avail themselves of other types of coverage, such as short-term coverage. *See infra* note 183 and accompanying text. Some will remain uninsured.

would help reduce the fragmentation that has long beset our private health insurance markets. It would also make the individual health insurance market larger and more stable. Of course, not everyone would win if the small group market were allowed to die off. The biggest losers would be the high earners in the small group market who will lose their premium tax subsidy. But it makes little sense to maintain an entire insurance market to retain a tax benefit for only some insureds.[17] If Congress wanted to maintain this tax break after the collapse of the small group market, it could, for example, allow small employers to reimburse their high-income employees for premiums paid in the individual market with pre-tax wages. Indeed, prior to the ACA, small employers could reimburse their employees with pre-tax dollars for premiums they paid for individual market coverage and can still do so to a limited extent.[18]

This Article proceeds as follows. Part I briefly describes the origins of group coverage in the life insurance market, explains the advantages of group coverage over individual insurance, and sets out the framework that is used in Part III to evaluate the benefits of the small group market. Part I also describes three aspects of the group insurance model that have negatively affected the functionality of the small group market: experience rating, group size limits, and market competition. Next, Part II shifts to the development of group health insurance, its expansion into small group coverage, and the detrimental effect of experience rating and market competition on the small group market. Part III, the heart of this Article, applies the core benefits identified in Part I to the post-ACA small group market. Drawing on the analysis in Part II and recent data, this Article demonstrates that the post-ACA small group market offers no advantages over the individual market with respect to adverse selection, access to coverage, or administrative costs. For those with low or moderate incomes, below 400% of the federal poverty level (FPL), the individual market offers a better tax subsidy. For those above 400% FPL, the small group market offers a better subsidy. Finally, Part IV considers some additional questions about the small group market. Does small group coverage provide consumer or employer

17. To be sure, the tax inequities of our health insurance system are longstanding and they have long favored the wealthy. *See* STAN DORN, URBAN INST., CAPPING THE TAX EXCLUSION OF EMPLOYER-SPONSORED HEALTH INSURANCE: IS EQUITY FEASIBLE? 1 (2009), http://www.urban.org/uploadedpdf/411894_cappingthetaxexclusion.pdf [https://perma.cc/LL9B-ZHMR] (noting that the group insurance tax exclusion provides the most benefit "to the affluent, who pay the highest marginal tax rates and who tend to receive the most generous health benefits").

18. *See infra* notes 302–303, and accompanying text.

benefits that weigh in favor of preserving the market? Fixes have been suggested for the small group market. If these fixes are implemented, will the small group market deliver group benefits? Finally, who will be the winners and losers if the small group market dies?

I. LIFE INSURANCE AND THE ORIGINS OF GROUP COVERAGE

This Part describes the development of group insurance as it first emerged in the life insurance industry, thereby laying the foundation for the analysis of the small group health insurance market in Part III. Section I.A describes the individual insurance market just prior to the advent of group life insurance. Adverse selection and high administrative costs were core problems in the individual life insurance market. These problems paved the way for group coverage. Next, section I.B describes the advent of group insurance and identifies the four core benefits that made group insurance an attractive alternative to individual insurance. Section I.C closes by explaining the legacy of three aspects of the group model for small group coverage: experience rating, group size, and competition.

A. Individual Life Insurance, Adverse Selection, and High Administrative Costs

Individual life insurance had been available for more than one hundred years before the group insurance model emerged.[19] Although largely scorned by the public for decades,[20] life insurance had developed into a desirable commodity by the mid-1800s.[21] No longer viewed as gambling for "dirty money" or the immoral pricing of human life,[22] life

19. *See* Viviana A. Zelizer, *Human Values and the Market: The Case of Life Insurance and Death in 19th-Century America*, 84 AM. J. SOC. 591, 595 (1978) (noting that life insurance was first sold in the U.S. in the late eighteenth century).

20. *See* VIVIANA A. ROTMAN ZELIZER, MORALS AND MARKETS: THE DEVELOPMENT OF LIFE INSURANCE IN THE UNITED STATES 1 (2017) [hereinafter ZELIZER, MORALS] (noting that early on, life insurance had been considered "'detrimental' to the interests of the country").

21. Shifts in economic conditions and cultural values in the nineteenth century made life insurance a desirable commodity. Urbanization in the nineteenth century coupled with family reliance on wage income created financial insecurity for widows and orphans. *Id.* at 12–13. In the eighteenth and early nineteenth centuries, inherited land often provided widows and orphans sufficient resources for support. *Id.* at 62. Urbanization changed this, making families almost exclusively dependent on the husband/father's wage. With little capital beyond his income and no property to pass on to the family, the premature death of an urban breadwinner "spelled economic disaster to his widow and orphans." *Id.* at 66.

22. By the mid-1800s, the growing awareness of the connection between death and economic loss

insurance was regarded as a responsible way for urban breadwinners to provide for their families after death.[23] To some, the purchase of life insurance was even viewed as a moral obligation.[24]

But life insurance was not available to everyone. Individual coverage was expensive and exclusive; many applicants could not meet the price[25] or the stringent application and medical examination requirements[26] and were excluded from coverage. These barriers were largely the result of two factors: insurer fears of adverse selection and the high costs of marketing and administering individual insurance policies. In turn, these barriers imposed financial and social costs on families unable to access coverage.

1. Barriers to Individual Coverage

a. Adverse Selection

Adverse selection is an information problem; it occurs when buyers of insurance know more about their own risk of making a claim than the insurance company.[27] If buyers use their own private risk information when purchasing or forgoing insurance, an insurer can lose money.[28] A simple example illustrates how adverse selection works. Imagine two

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made the public more receptive to insurers' discourse linking life insurance to a "good death." *Id.* at 50, 60–64. Life insurance was seen as a form of risk management and a moral means to economic security of the family. *Id.* at 66. *See also* SOLOMON S. HUEBNER, LIFE INSURANCE 12 (1921) ("Failure of the head of a family to insure his life . . . amounts to gambling with the greatest of all chances, and the gamble is a particularly mean one since . . . the dependent family and not the gambler must suffer the consequences.").

23. *See* ZELIZER, MORALS, *supra* note 20, at 66.

24. BURTON JESSE HENDRICK, THE STORY OF LIFE INSURANCE 262 (1907) ("He who has dependents and no income except the product of his own toil is as morally bound to carry life insurance as he is to furnish his children food and shelter.").

25. U.S. BUREAU OF LABOR STAT., U.S. DEP'T OF LABOR, BULLETIN NO. 250, WELFARE WORK FOR EMPLOYEES IN INDUSTRIAL ESTABLISHMENT IN THE UNITED STATES 110 (1919) (noting that individual life insurance was too expensive for most workers); P. H. McCormack, *Group Insurance*, 51 J. INST. ACTUARIES 313, 314 (1919) ("Ordinary life insurance . . . is of course beyond the means of the majority of wage-earners . . . .").

26. *See* Henry C. Lippincott, *The Essentials of Life Insurance Administration*, 26 ANNALS AM. ACAD. POL. SOC. SCI. 192, 200 (1905) ("In dealing with life insurance men act selfishly . . . if the medical examiner did not stand at the entrance gate, the weakest and least desirable lives would be surest and soonest to come in."); John M. Holcombe, *Life Insurance in the United States*, 150 N. AM. REV. 401, 402 (1890) ("[I]t has been found necessary . . . to admit only those who shall be found by physical examination and personal and family record to possess in the highest degree the elements of longevity.").

27. *See* Siegelman, *supra* note 10, at 1223.

28. *See id.* at 1224.

types of people, a sick person who is likely to die soon and a healthy person who is unlikely to die soon. Both are considering buying life insurance. The insurer, however, is handicapped by an information disadvantage: it does not know the health status of its applicants. If the insurer sets its premiums based on the population's average risk of death, the sick person, with a high risk of death, will find the coverage to be a good deal and will buy the insurance. On the other hand, the healthy person, with a low risk of death, will find the same policy too expensive and will not buy the insurance. If this scenario plays out on a larger scale—too many sick people buy insurance and too many healthy people forgo it—the insurer's claims costs will be higher than expected. The premium collected will not cover claims costs and the insurer will lose money.[29]

Fear of adverse selection drove life insurers to collect and evaluate personal information about their applicants. They used a process called underwriting to screen out high-risk applicants.[30] Only those who passed a selective application process and medical examination were offered coverage.[31] In addition to screening out high-risk applicants, insurers also used sales agents to aggressively bring low-risk applicants into the insurance pool.[32] As Burton J. Hendrick noted in 1907 in *The Story of Life Insurance*, there is "a powerful actuarial justification" for hiring agents:

> Experience has demonstrated that men do not insure of their own free will. They must be clubbed into it . . . . Properly regulated, [the agent system] brings only healthy lives into the company. A man anticipating early death does not need to be persuaded; he is only too glad to obtain a policy. That is the class which voluntarily seeks insurance.[33]

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29. *See id.* at 1223–24.

30. Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL'Y & L. 287, 295 (1993); *id.* at 294–95 (noting that life insurers developed underwriting as a process "to find 'the best and most desirable insureds'"); *see also* EMMETT J. VAUGHAN & THERESE M. VAUGHAN, FUNDAMENTALS OF RISK AND INSURANCE 133 (11th ed. 2014) (noting that underwriting "is an essential element in the operation of any insurance program" and that unless the insurer "selects from among its applicants" adverse selection will be "inevitable").

31. *See* Holcombe, *supra* note 26, at 402.

32. *See* ZELIZER, MORALS, *supra* note 20, at 136–43 (describing the indispensability of direct person-to-person sales by agents of the life insurance industry); *id.* at 137 (noting that by 1905 the leading life insurance companies each employed 10,000 to 15,000 agents and subagents).

33. *See* HENDRICK, *supra* note 24, at 262–63.

b. Administrative Costs

Efforts to reduce adverse selection, however, came at considerable expense. The costs of individual underwriting (screening every applicant and engaging physicians to conduct medical examinations) and paying thousands of agents to sell individual coverage were significant. When added to the costs of managing thousands of individual life insurance policies, an insurer's administrative costs could consume a sizable percentage of the premium, in some cases as high as 80% of the first year's premium.[34]

2. The Social and Financial Costs of Underwriting

Certainly, underwriting benefitted the insurance companies and the applicants who bought insurance. Insurers covered a less risky and more predictable pool of insureds. This reduced insurers' financial risk, allowing them to charge lower premiums, and made them more competitive. For insurer and insured, this was a win-win situation. But there was also a tradeoff. Those denied coverage lacked the financial protection of insurance. As Tom Baker has argued, such denials imposed social and financial consequences. Insurance not only preserves social status through risk sharing but also assigns status when limiting access through underwriting:

> [T]he children of a parent refused life . . . insurance maintain[ed] a more tenuous grasp on their [social] position as a result of the insurers having classified their parent as a high risk. Should the parent die . . . there [would] be no insurance payment to offset the loss of the parent's income.[35]

Group insurance provided at least a partial solution to this tradeoff. The group insurance model not only lowered costs and reduced adverse selection, it also increased access to the financial protections of life insurance.

B. Group Life Insurance

The first group life insurance policy, sold in 1911 by the Equitable Life Assurance Society of New York (Equitable), covered 121

34. *See* HUEBNER, *supra* note 22, at 209–12 (describing the administrative charges of individual life insurance); *id.* at 210 (noting that one actuary's review of life insurance company records found that administrative expenses took up 80% of the first year's premium).

35. Tom Baker, *Containing the Promise of Insurance: Adverse Selection and Risk Classification*, 9 CONN. INS. L.J. 371, 377 (2003).

employees of the Pantasote Leather Co.[36] In the months following the Pantasote contract, Equitable issued several more group polices, including a large policy providing nearly $6 million in coverage for nearly three thousand employees of the retailer Montgomery Ward and Co.[37] Other insurers quickly recognized group life insurance as "a tremendous business opportunity"[38] and energetically entered the group insurance market.[39] By the end of 1930—less than two decades after the Pantasote policy was issued—life insurers provided nearly $10 billion of group life insurance on 6.5 million employees.[40] Today, employer-based group life insurance covers nearly three quarters of full-time employees in the United States.[41]

Group insurance made its mark with a simple change to insurance practice: it shifted the focus of underwriting from the individual to the group.[42] This change produced three advantages over individual insurance: (1) reduced risk of adverse selection, (2) lowered administrative expenses, and (3) greater access to coverage.[43] Additionally, federal tax laws produced a fourth benefit: employer expenditures for group life insurance were deductible expenses for the employer and were not considered taxable income of employees.

1. Reduced Risk of Adverse Selection

Group insurance minimized the risk of adverse selection two ways. First, the risk pool—the group of insured individuals—was formed independent of a demand for insurance. In the individual life insurance

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36. *See* Michael Bucci, *Growth of Employer-Sponsored Group Life Insurance*, MONTHLY LAB. REV., Oct. 1991, at 25, 25.

37. Montgomery Ward approached Equitable as early as 1910 seeking a group policy, the policy was not issued until 1912. *See* C. Manton Eddy, *Development and Significance of Group Life Insurance*, *in* GROUP INSURANCE HANDBOOK 45, 46 (Robert D. Eilers & Robert M. Crowe eds., 1965). The policy was issued along with a disability income contract, issued by the London Guarantee and Accident Company. *See A Large Life and Casualty Line*, 38 INDICATOR 149, 149 (1912).

38. *See* Bucci, *supra* note 36, at 27.

39. *See id.*

40. William J. Graham, *Group Insurance*, 161 ANNALS AM. ACAD. POL. & SOC. SCI. 40, 41 (1932).

41. BUREAU OF LABOR STAT., U.S. DEP'T LABOR, NATIONAL COMPENSATION SURVEY: EMPLOYEE BENEFITS IN THE UNITED STATES, MARCH 2017, Bull. No. 2787, tbl.16 (2017), https://www.bls.gov/ncs/ebs/benefits/2017/ebbl0061.pdf [https://perma.cc/SU92-GPXR] (noting 73% of full-time civilian workers participate in employer-sponsored life insurance).

42. *See* McCormack, *supra* note 25, at 314–15 ("The distinctive feature of group insurance is that the unit of insurance is not the single life but a group of lives.").

43. *See supra* section I.B.

market, applicants joined the risk pool precisely because they wanted to buy insurance. This raised the risk (and insurer fears) of adverse selection. Conversely, in employer-based group coverage, only employees entered the risk pool. Since employees came to the group for a reason other than to buy insurance (i.e., to get a job), the group was unlikely to be disproportionality populated with high-risk individuals seeking insurance.[44] While the group model reduced the risk of adverse selection, it did not eliminate it; there was still a risk of adverse selection from within the group of potential insureds. The group likely included some high-risk individuals. If only those high-risk employees sought insurance through the group, adverse selection would be a problem. Insurers controlled this adverse selection risk by imposing a minimum participation requirement. This meant that a minimum percentage of the group of employees had to participate in the life insurance plan.[45] Together, the employer-based group model and the minimum participation requirement substantially reduced the possibility of adverse selection compared to individual coverage. This eliminated the need for individual underwriting in group coverage.

2. Lower Administrative Costs

The second benefit of group insurance was lower administrative costs. Group coverage reduced the per-life cost of coverage compared to individual insurance. Marketing costs were reduced because sales efforts were directed toward a small number of large employers rather than thousands and thousands of individuals. Because rates were determined on a group basis, the costs of individual underwriting were eliminated.[46] A single contract was issued to the group, reducing the insurer's clerical

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44. *See* DUNCAN M. MACINTYRE, VOLUNTARY HEALTH INSURANCE AND RATE MAKING 4 (1962) (noting that adverse selection is reduced because employer groups are organized for a reason other than obtaining insurance); Note, *Some Economic and Legal Aspects of Group Insurance Policies*, 36 COLUM. L. REV. 89, 89–90 (1936) ("The danger that sub-standard risks will band together for the sole purpose of insurance can be avoided only by a limitation to groups organized for a *bona fide* purpose.").

45. An insurance industry standard was first proposed in 1917. The standard required 100% participation of employees if the employer paid the entire premium and a minimum participation of 75% if employees contributed to coverage. By 1917 a committee of the National Convention of Insurance Commissioners in collaboration with a committee of actuaries representing the insurance companies recommended a minimum participation rate of 75% of employees. *See* Sterling Pierson, *The Legislatures Expand the Group Insurance Field*, 15 A.B.A. J. 407, 409 (1929) (quoting PROCEEDINGS OF NATIONAL CONVENTION OF INSURANCE COMMISSIONERS 27–29 (1918)).

46. Frank W. Hanft, *Group Life Insurance: Its Legal Aspects*, 2 LAW & CONTEMP. PROBS. 70, 90 (1935) ("[T]he cheapness of group insurance is supposed to spring from economies produced by the nature of the device, such as the elimination of medical examinations . . . .").

expenses. In addition, many administrative costs were shifted to the employer, including record keeping and premium collection.[47] This meant that coverage could be written in the employment-based market at a considerably lower cost than would be the case if each member of the pool were individually insured. These savings could be passed on in the form of lower premiums.

3. Increased Access to Coverage

Group coverage made life insurance more accessible by eliminating the restrictive underwriting practices of individual insurance, which in turn expanded insurance benefits to most members of society, including many previously thought to be uninsurable.[48] This access, however, required membership in a group, typically a group of employees. Thus, while group coverage increased access to life insurance, it did so only for those who could work. Group coverage opened no new doors for those unable to work (e.g., the elderly or the very sick) or those who could not find work.

4. The Tax Advantage of Group Insurance

Favorable treatment under federal tax laws was a major advantage of group insurance. Employers could deduct group life insurance premiums as ordinary and necessary business expenses when calculating their taxable income.[49] Moreover, premiums paid by employers for group life insurance were not considered taxable employee income.[50]

C. The Legacy of the Group Insurance Model

The group insurance model was generally well-received[51] and, as described in Part II, later became the dominant method for delivering

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47. *See* EARL T. CRAWFORD & SAMUEL P. HARLAN, THE LAW OF GROUP INSURANCE 4–5 (1936); Davis W. Gregg, *Fundamental Characteristics of the Group Technique, in* GROUP INSURANCE HANDBOOK 31, 41–42 (Robert D. Eilers & Robert M. Crowe eds., 1965).

48. *See* Gregg, *supra* note 47, at 43; McCormack, *supra* note 25, at 314 (noting that one of the objects of group insurance was to enable "many grades of wage-earners, who could not otherwise be adequately insured, to obtain the benefit of substantial life insurance protection, at least during the period of their employment").

49. O. 1014, 1920-2 C.B. 88, 89–90 (1920).

50. *Id.* In 1964 the law changed, limiting employees to $50,000 in tax-exempt employer-provided life insurance coverage. *See* William W. Keefer, *Forms of Group Permanent Life Insurance, in* GROUP INSURANCE HANDBOOK 128, 134–35 (Robert D. Eilers & Robert M. Crowe eds., 1965).

51. Although the group insurance model spread rapidly, it did draw early criticism. Detractors complained that group insurance was paternalistic. *See* CRAWFORD & HARLAN, *supra* note 47, at 6.

health insurance in the United States. But there are two features of group insurance, experience rating and group size, as well as a third issue related to insurer competition in the presence of adverse selection, that are worth additional discussion. These features played a role in shaping the group insurance market and contributed to problems when group coverage was extended to small firms.

1. Experience Rating

Experience rating is the principal method for calculating premiums under the group model. Under experience rating, each group pays a premium based on its own claims costs.[52] Initially, the group insurance model did not rely on experience rating; group life policies were priced using standard actuarial tables.[53] By the 1920s, life insurers had embraced experience rating for their group business.[54]

To the insurance industry, experience rating was the hallmark of insurance equity and fairness—each group pays for its own risk.[55] But the "experience-rating-as-fairness" narrative does not fully square with the historical origins of experience rating. First used the 1890s,[56] experience rates (then called "special rates") were developed by employers' liability insurers as a means to compete in a market dominated by intense price competition.[57] But in the liability insurance

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Some complained that coverage was gratuitous gift, like a bonus or a holiday turkey, meant to bribe workers or prevent them from leaving. They also noted the possibility of impaired job mobility if the insurance coverage was particularly valuable to the employee or his family, and that coverage was linked to the interests and finances of the employer. Note, *supra* note 44, at 91–92.

52. *See* J.F. Follmann, Jr., *Experience Rating vs. Community Rating*, 29 J. INS. 403, 403 (1962) ("Experience rating is based on the traditional insurance concept of basing a premium for a group of individuals on the probability of loss among that group.").

53. Group life policies initially priced groups using standard actuarial tables, much like individual life insurance. *See Insurance Commissioners' National Convention*, 81 STANDARD 213, 219 (1917) (noting discussion by actuary H. Pierson Hammond discussing group life rates and noting that rates were initially based on standard life expectancy rates but shifted to the experience of the insured groups).

54. While it is not clear exactly when life insurers adopted experience rating, it may have appeared as early as 1919. *See* MACINTYRE, *supra* note 44, at 45–46 (noting that experience rating may have begun as early as 1919, but was authorized by statute in New York by 1926).

55. *See id.* at 28.

56. *See id.* at 39 (noting that "special rates" in employers' liability insurance date back to 1896 or earlier).

57. *See id.* at 37. At the time, price completion was a significant problem in the insurance industry. Employer liability rates were based on classification—high for firms in risky industries, low for firms in safer industries. As the market for employers' liability insurance grew, more insurers entered the market. Intense competition drove rates too low, resulting in insurer losses. In

setting, experience rating was also thought to have salutary effects as means to encourage loss prevention. An employer with a safe workplace—and fewer than average liability claims—would be rewarded with lower premiums. Thus, experience rating also became a means of loss prevention.[58] The prospect of lower premiums provided an incentive to reduce liability risks.

In life and health insurance markets, however, loss prevention had only limited relevance.[59] Life and health claims costs were (and continue to be) largely tied to the identities of the employees. Employer groups with older and sicker workers will produce more claims than employer groups with younger and healthier workers, thereby raising premiums.[60] Competition was the main driver behind the use of experience rating in these markets[61] and the identities of the employer group (i.e., their health risk) were the focus of the competition.

2. Group Size

Initially, insurers in the group life market had little concern over group size. The earliest group life plans covered hundreds or thousands of workers.[62] There was, however, a need to determine an acceptable minimum group size.[63] Experience rating only works if a group's claims experience is a reliable predictor of the group's future claims. This is

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response, insurers began to set rates collectively through a rating bureau. But this only worked for a short period of time, as pricing pressures continued from insurers operating outside the rating bureau. In response, the bureau insurers were allowed to set "special" (i.e., lower) rates for some customers based on the firms' claims and payroll. *See id.* at 37. Within a few years, insurer competition and the use of "special rates" had "wrecked" bureau rates. *See id.* at 38. The term "experience rating" was first used in 1913 to describe a similar rating scenario in workmen's compensation insurance. *See id.* at 39. In his classic text on health insurance rate making, Duncan MacIntyre noted, "it could be argued that the theory of insurance equity was developed because of competition, or to rationalize inequitable practices adopted because of competition . . . ." *See id.* at 30–31 n.34.

58. *See id.* at 39. Liability insurance is still thought to function as a form of nongovernmental safety regulation. *See* Omri Ben-Shahar & Kyle D. Logue, *Outsourcing Regulation: How Insurance Reduces Moral Hazard*, 111 MICH. L. REV. 197, 199 (2012) (arguing that insurance can replace or augment government safety regulation).

59. *See* MACINTYRE, *supra* note 44, at 43.

60. *See* David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance*, *in* 1 HANDBOOK OF HEALTH ECONOMICS 563, 607 (Anthony J. Culyer & Joseph P. Newhouse eds., 2000) ("Whom one pools with in health insurance dramatically affects what one has to pay.").

61. *See* MACINTYRE, *supra* note 44, at 48–49.

62. *See supra* notes 36–37 and accompanying text.

63. *See* Gregg, *supra* note 47, at 35 ("Any theoretical exactness in determining a safe minimum number is not possible. In any case, it should be recognized that no magic number inheres in the number selected as the minimum, such as ten or twenty-five.").

due to the law of large numbers, a probability principle used in the insurance industry to predict the future claims for a given pool of insureds. The larger the pool of insureds, the more accurately future claims can be predicted.[64] For smaller groups, claims experience is much less predictive. Their claims history is simply not large enough for the law of large numbers, thus "there is no actuarially valid means of experience rating small firms."[65] Yet, there was little consensus on the minimum acceptable number of employees for group coverage. The number drifted downward from 100 to 50,[66] and later to 3 employees,[67] driven by competitive, rather than actuarial, considerations.[68] As discussed in section II.B, insurers, unable to experience rate small groups, instead pooled small firms together to create a large enough number of employees to develop sound rates. The pooling of small firms, however, created two problems for small group coverage. First, the pooling of small group risk provided an opportunity for adverse selection by small employers. Second, it opened the door for "cream-skimming" by insurers, "a kind of 'reverse adverse selection'" in which insurers "rig" a policy's incentives to attract healthy/low risk customers and discourage unhealthy/high risk customers.[69]

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64. This is due to the principle referred to as the law of large numbers. If an insurer provides coverage for a sufficiently large pool of insureds, the aggregate claims of the group will equal the expected loss of any individual insured in the pool multiplied by the number of insureds in the pool. *See* George L. Priest, *The Current Insurance Crisis and Modern Tort Law*, 96 YALE L.J. 1521, 1540 (1987) (citations omitted); VAUGHAN & VAUGHAN, *supra* note 30, at 36–40.

65. *See* Richard J. Pierce, Jr., *Small Is Not Beautiful: The Case Against Special Regulatory Treatment of Small Firms*, 50 ADMIN. L. REV. 537, 569 (1998).

66. Early legislation of group insurance required no less than 100 lives. *See* Pierson, *supra* note 45, at 408. By 1918, the National Convention of Insurance Commissioners adopted a model definition of group insurance that limited group coverage to no less than fifty employees. Hanft, *supra* note 46, at 70, 70 n.1. They believed that at least fifty lives were necessary to support sound group underwriting. *See* Graham, *supra* note 40, at 31. But there is no firm actuarial number for defining the lower limit of group size for the group model. Thus, the fifty-employee limit was not universally accepted. Michigan and some other states adopted a standard requiring only twenty-five lives in 1925. Pierson, *supra* note 45, at 409–10. By the late 1920s, only a quarter of states had defined group coverage. Most allowed, but did not legislate group coverage, thereby leaving the question of minimum group size up to each insurer. *See* Edwin E. Witte, *Group Insurance*, 27 MONTHLY LAB. REV. 108, 109 (1928).

67. *See* Donald D. Cody, *Underwriting Group Medical Expense Coverage*, *in* GROUP INSURANCE HANDBOOK 354, 368 (Robert D. Eilers & Robert M. Crowe eds., 1965).

68. *See infra* note 140 and accompanying text.

69. Siegelman, *supra* note 10, at 1253. *See also* Timothy Stoltzfus Jost, *Private or Public Approaches to Insuring the Uninsured: Lessons from International Experience with Private Insurance*, 76 N.Y.U. L. REV. 419, 458 (2001) (cream skimming involves "picking off the better risks and discouraging high-risk insureds"). Cream skimming simply shifts risks (and higher costs) "rather than providing a benefit to society." *Id.* at 481.

3. Competition and Asymmetric Information

While competition is generally thought to produce the best market outcome, including the lowest prices and the best allocation of resources,[70] this assumption does not necessarily apply in insurance markets. Asymmetric information can cause a competitive insurance market to operate inefficiently or even fail.[71] Michael Rothschild and Joseph Stiglitz illustrated this possibility in their classic analysis of asymmetric information in a competitive insurance market.[72]

The Rothschild-Stiglitz model was not intended to represent an actual insurance market.[73] Instead, it presents a model that shows how the presence of asymmetric information can undercut traditional assumptions about the value of competition in an insurance market.[74] The model contemplates two types of insurance buyers, high-risk buyers (i.e., those more likely to make a claim) and low-risk buyers (i.e., those less likely to make a claim). The model also assumes information asymmetry; each customer knows his or her own risk, but insurance companies do not know the risk of individual customers.[75]

Rothschild and Stiglitz note that only two kinds of equilibria are possible.[76] The first is a pooling equilibrium, in which high- and low-risk buyers purchase the same policy.[77] Their claims costs are pooled

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70. N. Pac. Ry. Co. v. United States, 356 U.S. 1, 4 (1958) (arguing that competition produces "the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions").

71. *See, e.g.*, Siegelman, *supra* note 10, at 1240 (noting that economists are "fascinated by adverse selection . . . because it can overturn one of the central tenets of economic theory—that perfectly competitive markets are efficient"); David M. Cutler & Sarah J. Reber, *Paying for Health Insurance: The Trade-Off Between Competition and Adverse Selection*, 113 Q.J. ECON. 433, 434–36 (1998) (noting that competition in insurance markets "is somewhat problematic" due to adverse selection problems); Cutler & Zeckhauser, *supra* note 60, at 607 (noting that health insurance "fundamentally different from other markets in ways that create harmful effects from competition").

72. Michael Rothschild & Joseph Stiglitz, *Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information*, 90 Q.J. ECON. 629 (1976). For a more detailed, but accessible explanation of the Rothschild-Stiglitz model, see Siegelman, *supra* note 10, at 1235–40.

73. Rothschild & Stiglitz, *supra* note 72, at 648.

74. *Id.* at 629 ("We are able to show that not only may a competitive equilibrium not exist, but when equilibria do exist, they may have strange properties.").

75. *Id.* at 632.

76. *Id.* at 634. Equilibrium means that when consumers choose the best policy for them (they "maximize expected utility"), insurers have no incentive to stop offering or change the policies they currently offer. *Id.* at 633 ("[N]o contract in the equilibrium set makes negative expected profits . . . [and] no contract outside the equilibrium set . . . will make a nonnegative profit.").

77. *Id.* at 634.

together, resulting in a premium based on the average cost of the high- and low-risk buyers. The second is a separating equilibrium in which the two types of buyers purchase separate policies and their claims costs are segregated in separate pools.[78] Each pool pays a premium based on its own risk; the low-risk buyers pay a lower premium and the high-risk buyers pay a higher premium.

Rothschild and Stiglitz first point out that a pooling equilibrium cannot exist in a competitive market.[79] In the pooled policy, the low-risk buyers pay a premium based on the average costs of the pool of high- and low-risk buyers. This means that the less expensive low-risk buyers subsidize the high-risk buyers. A competing insurer can exploit the low-risk buyers' private knowledge of their own risk for its own competitive advantage. It could offer the low-risk buyers a better deal and peel them away from the pooled policy. Rothschild and Stiglitz suggest this could be done by offering a policy with less coverage and lower premiums. This new policy would attract only the low-risk buyers because the high-risk buyers would prefer to stay fully insured. This would destroy a pooling equilibrium.[80]

Next, Rothschild and Stiglitz point out that insurers in a competing market could offer the high-risk buyers and low-risk buyers different policies, each of which are designed to attract only one type of customer (high-risk or low-risk).[81] The result would be either a separating equilibrium or no equilibrium.[82] Under this scenario, insurers offer two types of policies, one with full coverage and full cost and one with less coverage and a lower cost. The lower-cost policy will be attractive to the low-risk buyers because of the lower price. It will also be unattractive to the high-risk buyers because they prefer more coverage. Conversely, the high-cost policy will be attractive only to the high-risk buyers, because they desire full coverage, and unattractive to the low-risk buyers because of price. This will produce a separating equilibrium because each customer will prefer their own policy. But this does not make everyone better off. Yes, the low-risk buyers save money by paying a lower premium, but there is a trade-off. The low-risk buyers sacrifice coverage to save money. The high-risk buyers are also no better off since they remain in the full coverage pool and pay a higher premium.[83]

78. *Id.*

79. *Id.*

80. *Id.* at 635.

81. *Id.* at 635–36.

82. *Id.* at 636.

83. *Id.*

Rothschild and Stiglitz also note the possibility that a separating equilibrium will not exist at all. If the high-risk buyers are only a small part of the population, a policy can be designed so that it will attract high- and low-risk buyers.[84] The premium generated by the average claims cost of the pool will not be so high as to drive off the low-risk buyers. But this position will not last. In a competitive market, a competing insurer will offer a slightly less costly policy that will be more attractive to low-risk buyers. The pooled policy will fail as the low-risk buyers defect. If the high-risk buyers try to re-pool with the low-risk customers, the process could replay over and over again, precluding equilibrium.[85] Such a market "might oscillate wildly, or collapse entirely."[86]

D. Coda

Once introduced, the group life insurance model was quite successful because it helped solve three significant problems of the individual life insurance market: adverse selection, high costs, and limited access. Group coverage also offered a price discount that was unavailable in the individual market: a tax-subsidized premium. But the group model was not without significant limits. First, experience rating, the means of pricing group coverage, can aid loss prevention in some lines of insurance but not in life or health insurance. Instead, it could be used as a competitive tool to segregate risk. Second, the success of the group model is tied to the size of the employer. Small employers have too few employees to develop rates based on their own claims experience. The pooling of small employers for sound rates opens the door for adverse selection by insureds and cream skimming by insurers. Finally, the normal assumptions about the benefits of competition do not necessarily apply in an insurance market. Rothschild and Stiglitz demonstrate that competition in an insurance market may not be beneficial to either the insureds or the market. The next Part of this Article explores how these limits shaped the development of group health insurance and its expansion to small groups.

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84. *Id.* at 636–37.

85. *Id.*

86. Siegelman, *supra* note 10, at 1239.

II. GROUP HEALTH INSURANCE AND THE SMALL GROUP MARKET

The rapid growth of employer-based group health insurance during World War II is often described as "a historical accident" propelled by two favorable federal policies: (1) price and wage controls that prompted employers to offer health insurance as a wage substitute to attract workers and (2) changes to the tax code that exempted employer payments for health coverage from income taxes.[87] In the decades following World War II, employer-based group insurance spread rapidly, prompted by aggressive union bargaining for health insurance and non-unionized employers offering generous health coverage in an attempt to prevent unionization.[88] By 1960, employer-based group health insurance covered over a hundred million people.[89] By 2016, over 157 million Americans were covered by employer-based group health insurance.[90]

Typically missing from the standard history of group health insurance is the development of small group coverage and the fundamental differences between coverage for large and small employers. This Part fills those gaps. Section II.A describes how rising costs of medical care drove hospitals to develop the Blue Cross model of group coverage, how the Blue Cross community-rated model was different from the experience rated group insurance model, and why group size was largely irrelevant under the Blue Cross model. Section II.A concludes by describing how commercial insurers entered the health insurance market and, using adverse selection to their advantage, brought an end to the Blue Cross model. Turning to small groups, section II.B explains how the experience rated model first excluded small groups, but later included them by pooling small groups together. While small employers realized some of the benefits of group coverage, protection from adverse selection was not one of them. The result was an unstable market that

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87. *See* Hyman & Hall, *supra* note 11, at 25; Moore, *supra* note 11, at 887–92; Melissa A. Thomasson, *The Importance of Group Coverage: How Tax Policy Shaped U.S. Health Insurance*, 93 AM. ECON. REV. 1373, 1374 (2003).

88. *See* Hyman & Hall, *supra* note 11, at 25–26.

89. Melissa A. Thomasson, *From Sickness to Health: The Twentieth-Century Development of U.S. Health Insurance*, 39 EXPLORATIONS ECON. HIST. 233, 233–34 (2002) (reporting that health insurance coverage grew from 12.3 million Americans in 1940 to 122.5 million in 1960).

90. *See Health Insurance Coverage of the Total Population*, KAISER FAMILY FOUND., https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D [https://perma.cc/4TJP-BKAA].

oscillated severely as health care costs rose in the 1980s and 1990s, requiring substantial regulation to prevent its disintegration.

A. Blue Cross and Early Group Health Insurance

1. The Need to Finance Medical Care

Unlike life insurance, health insurance had no meaningful presence prior to the twentieth century.[91] Simply put, there was no individual health insurance market because there was little need for insurance to cover medical expenses. Prior to the 1920s, medical care was both ineffective and inexpensive. Medical technology was relatively simple, the ill were usually treated at home, and hospitals were viewed as "places of death."[92] Loss of income due to illness was a far more significant problem for workers and their families than the cost of medical care.[93] Improvements in medical technology, anti-infection techniques, and more demanding education and licensure standards for physicians improved the quality of and demand for medical care.[94] As the quality of medical care improved in the early twentieth century, however, its costs increased.[95] As hospitals grew in both size and technical capability, their costs likewise increased—pricing many middle-class Americans out of the market for hospital care. By the 1920s, the cost of medical care exceeded lost earnings due to sickness for poor and middle-class families.[96] This created financial problems for both the sick and the hospitals that served them: the sick could not pay the hospitals, and the hospitals were struggling for cash. The Great Depression only intensified the financial problems of hospitals. Wealthy philanthropists, who had long provided financial support to hospitals,

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91. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 294 (1982) ("Before the 1930s, the only extensive private health plans offered direct services, usually to employees in an industry.").

92. *See* Thomasson, *supra* note 89, at 235 (noting that "the public had little confidence in the efficacy of medical care").

93. *See* JACOB S. HACKER, THE DIVIDED WELFARE STATE 191–92 (2005). Workers could obtain some financial protection from the cost of sickness by participating in industrial or fraternal sickness funds, which provided sick pay to incapacitated workers. *See* JOHN E. MURRAY, ORIGINS OF AMERICAN HEALTH INSURANCE: A HISTORY OF INDUSTRIAL SICKNESS FUNDS 3–15 (2007); Thomasson, *supra* note 89, at 235 ("[I]nstead of health insurance, 'sickness' insurance policies designed to protect the insured against loss of income developed, while actual health insurance remained relatively unknown.").

94. *See* Thomasson, *supra* note 89, at 235–36.

95. *See* STARR, *supra* note 91, at 259–60.

96. *See id.* at 258–59.

substantially reduced their support as their own financial status declined.[97] Full-paying patients were becoming less common while non-paying patients were proportionately increasing.[98] As a result, more than 100 hospitals failed in the first years of the Depression,[99] and those that remained had only about a 50% occupancy rate.[100] In absence of publicly financed health insurance,[101] conditions were ripe for a form of medical care financing that appealed to both hospitals and the middle class. Yet commercial insurance companies did not offer coverage for medical expenses. They feared adverse selection, abusive billing, and the high cost of agent commissions.[102]

In 1929, the Baylor University Hospital in Dallas, Texas, like many other hospitals, was struggling to make ends meet.[103] Looking to increase its revenues, Baylor came up with a plan: it began to offer local employers a prepaid hospitalization plan.[104] Baylor had no plans to start an insurance plan or generate a national movement; it simply wanted to control its bad debt by generating a steady income from potential patients.[105] The plan was an immediate success.

2. The Blue Cross Group Model

The Baylor plan was the first step in what would later become Blue Cross and Blue Shield.[106] First offered to Dallas public school teachers, the Baylor plan guaranteed three weeks of prepaid hospital care in

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97. *See* Fredric R. Hedinger, *The Social Role of Blue Cross: Progress and Problems*, INQUIRY, June 1968, at 4.

98. *See id.*

99. *See* Laura A. Scofea, *The Development and Growth of Employer-Provided Health Insurance*, MONTHLY LAB. REV. Mar. 1994, at 5.

100. *Id.*

101. For an overview of failed efforts by Progressive reformers to institute a social health insurance program in the United States in the early 1900s, see STARR, *supra* note 91, at 240–70.

102. *Id.* at 294.

103. ROBERT CUNNINGHAM III & ROBERT M. CUNNINGHAM JR., THE BLUES: A HISTORY OF THE BLUE CROSS AND BLUE SHIELD SYSTEM 4 (1997) (explaining that the hospital was behind on its bills, overdue by $1.5 million on bond payments, and "just 30 days ahead of the sheriff").

104. *See id.* at 5.

105. *See id.* at viii. In the late 1920s and 1930s, hospitals experienced financial troubles due to the rising costs of medical care and the economic downturn caused by the Great Depression. *See* STARR, *supra* note 91, at 295–96.

106. *See* MACINTYRE, *supra* note 44, at 116 ("[T]he Baylor plan was the forerunner of Blue Cross."). Blue Cross and Blue Shield were initially separate organizations, but formally merged in 1982. Blue Cross covered hospital care and Blue Shield covered physician care. *See generally* CUNNINGHAM & CUNNINGHAM, *supra* note 103 (providing a comprehensive history of the development of the Blue Cross and Blue Shield plans).

exchange for a monthly payment of fifty cents.[107] As Baylor extended this arrangement to various employer groups,[108] other Dallas hospitals adopted similar plans.[109] Hospitals throughout the country soon followed suit.[110] While each of these initial plans focused on a single hospital, hospitals began to band together to form community plans.[111] Eventually these plans became known as Blue Cross.[112]

The Blue Cross model was similar to the group life insurance model in some ways. Blue Cross initially channeled coverage primarily through large employer groups.[113] This meant lower marketing and administrative costs just like the group insurance model.[114] And, selling the plan to employer groups reduced adverse selection.[115] But the Blue Cross model was also very different from the group insurance model in three critical ways.[116] First, Blue Cross was not sold on the basis of a group's specific risk—there was no experience rating. Blue Cross had a communitarian orientation,[117] and its coverage was community rated.[118] This meant that their rates were based on the average claims cost of everyone covered by a Blue Cross plan. In other words, there was a single risk pool with a single community rate.[119] Second, Blue Cross plans did not compete with other Blue Cross plans. Each plan was a

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107. *See* ROBERT D. EILERS, REGULATION OF BLUE CROSS AND BLUE SHIELD PLANS 10 (1963).

108. *See id.*

109. *See* STARR, *supra* note 91, at 295.

110. *See* EILERS, *supra* note 107, at 11.

111. *See id.* (observing that hospital prepayment plans began to include local hospitals willing to participate in the plan); STARR, *supra* note 91, at 296 (noting that by 1932, multi-hospital prepayment plans were emerging across the country).

112. The Blue Cross symbol was developed in 1934 by E. A. van Steenwyk, a founder of Minnesota's Blue Cross plan. CUNNINGHAM & CUNNINGHAM, *supra* note 103, at 24. The symbol "perpetuated itself as unifying force" among the newly emerging hospitalization plans. *Id.* at 33.

113. *See id.* at 23; MACINTYRE, *supra* note 44, at 126.

114. *See* MACINTYRE, *supra* note 44, at 126 ("[T]he plans were able to secure the economies of group enrollment—no physical examinations, lower acquisition costs, [and] employment-centered collections.").

115. *See id.*

116. *See id.* at 4 n.8 (noting that although it shared many of the characteristics of an insurer, Blue Cross was not an insurance company in the legal or technical sense).

117. *See* Hedinger, *supra* note 97, at 6–7 (describing the social philosophy of Blue Cross).

118. *See* MACINTYRE, *supra* note 44, at 11–12. The term "community rating" was originally devised by advocates for Blue Cross "to function as a philosophical defense and rallying position for their rating practices." Hedinger, *supra* note 97, at 7.

119. *See* MACINTYRE, *supra* note 44, at 11–12. It should be noted that nearly all insured groups are, to some extent, grouped and priced by the risk of increased costs. Even community rated plans like Blue Cross differentiated rates based on whether the coverage was for a single subscriber, a married couple, or a family with dependents. *See* Hedinger, *supra* note 97, at 7.

local monopoly, covering a distinct geographic area.[120] The noncompetitive model meant there was no inter-plan competition for groups. Thus, there was no cream skimming. In other words, plans had no incentive to cut rates to gain a competitive advantage or poach low-cost groups from other plans. Third, the community rate and noncompetitive model made employer group size largely irrelevant. Unlike the group insurance model, group size was not significant for pricing coverage. Thus, Blue Cross could offer coverage to small groups.[121]

Although its business was overwhelmingly group-based, Blue Cross did offer individual coverage.[122] But Blue Cross individual coverage was subject to the same adverse selection problems typical of individual insurance. As a result, Blue Cross plans adopted standard insurance industry practices with respect to their individual coverage: medical screening,[123] risk-based pricing,[124] limited benefits,[125] and exclusions[126] based on risk. Adverse selection and high administrative costs led to higher premiums for individual insurance than group coverage.[127]

3. The End of the Blue Cross Group Model

The success of Blue Cross convinced commercial insurers that health insurance was a viable line. Commercial insurers offered individual

120. *See* STARR, *supra* note 91, at 297–98.

121. *See* O.D. DICKERSON, HEALTH INSURANCE 161–62 (1963) (Blue Cross offered coverage to firms as small as two employees); MACINTYRE, *supra* note 44, at 135 (coverage offered to firms as small as four or five employees). Early on, some Blue Cross plans did suffer adverse selection problems due to sales of plans to small employer groups and individuals. *See* CUNNINGHAM & CUNNINGHAM, *supra* note 103, at 23 (describing financial troubles experienced by a New York Blue Cross plan in the 1930s). Those difficulties, however, were largely attributable to lax enrollment standards. *Id.* Plan administrators simply did not anticipate that open enrollment and community rating with lax enrollment oversight would encourage initial enrollment by subscribers in need of immediate medical care. *See id.* at 22–23 (noting that "the Plan's amateur underwriters had not realized that the first people to sign up for hospitalization would probably either know or suspect that they had medical problems").

122. In the mid-1930s a few Blue Cross plans offered individual coverage. By 1959 nearly all Blue Cross plans sold individual coverage. *See* MACINTYRE, *supra* note 44, at 132–33.

123. *See* EILERS, *supra* note 107, at 33 (noting that most Blue Cross plans required a medical history before coverage was issued).

124. *See* MACINTYRE, *supra* note 44, at 133.

125. *See* DICKERSON, *supra* note 121, at 161; MACINTYRE, *supra* note 44, at 134.

126. Many Blue Cross plans prohibited enrollment past age sixty or sixty-five. MACINTYRE, *supra* note 44, at 136.

127. *See* EILERS, *supra* note 107, at 308–09.

coverage,[128] which, like other types of individual insurance, was expensive due to adverse selection and high administrative costs.[129] They also entered the group hospitalization market.[130] But insurance companies did not adopt the Blue Cross, community-rated model. Instead, they turned to the life insurance group model,[131] a move that was disastrous for Blue Cross. Consistent with Rothschild-Stiglitz, insurers used the group insurance model to carve-up Blue Cross's pooled equilibrium. Using experience rating, competing insurers were able to strip heathy employer groups out of the Blue Cross pool by offering them their own rate that was lower than the Blue Cross community average.[132] As less costly groups defected from Blue Cross plans, its community rates—based on the average claims cost of all Blue Cross subscribers—went up, allowing commercial insurers to attract even more groups on an experience rated basis[133] thereby beginning a death spiral by adverse selection.[134] By 1951, the tide had turned. Whereas Blue Cross had dominated the group market since its inception, commercial insurers surpassed Blue Cross in coverage and never looked

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128. *See* J. F. Follmann, Jr., *Development and Significance of Group Health Insurance*, *in* GROUP INSURANCE HANDBOOK 57, 64 tbl.5-2 (Robert D. Eilers & Robert M. Crowe eds., 1965) (setting out the percentage of hospitalization coverage written by commercial insurers on an individual and group basis from 1940–1963).

129. *See* MACINTYRE, *supra* note 44, at 55–56 (noting loss ratio for individual accident and health insurance "sometimes averaging 45–55% or premium or less").

130. *See id.* at 48 (noting that commercial insurers first sold group hospitalization coverage in 1934).

131. *See id.* at 37–49 (detailing the development of experience rating and its application in the employers' liability and group life lines).

132. This is also referred to as cream skimming. *See supra* note 69 and accompanying text.

133. *See* MACINTYRE, *supra* note 44, at 15.

134. A death spiral occurs when "good risks begin to exit [coverage], the average quality of those insureds remaining falls and prices rise in a vicious circle, ending . . . [when] no one is covered." Siegelman, *supra* note 10, at 1224. A death spiral by adverse selection is the general accepted view for the collapse of the Blue Cross model of community rating. *See, e.g.*, MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 40 (1994) [hereinafter HALL, REFORMING PRIVATE HEALTH INSURANCE] ("Adverse selection forced Blue Cross to abandon community rating in favor of experience rating for groups . . . ."). *But see* Melissa A. Thomasson, *Did Blue Cross and Blue Shield Suffer from Adverse Selection? Evidence from the 1950s* (Nat'l Bureau of Econ. Research, Working Paper No. 9167, 2002), http://papers.nber.org/papers/w9167.pdf [https://perma.cc/9U5X-RR26] (questioning the adverse selection narrative based on a finding that Blue Cross subscribers did not have higher medical costs than enrollees in the experience rated plans of commercial insurers). Thomasson's conclusion, while interesting, is not entirely convincing. Her findings were based on a single year of data (1957), collected long after many Blue Cross plans had switched to experience rating for some or most of their group business. Thomasson's data does not disaggregate claims data from Blue Cross's experience rated business and community rated group plans. Thus, it is impossible to tell from Thomasson's analysis of the group market whether adverse selection financially disadvantaged Blue Cross group plans that relied on community rating.

back.[135] Ultimately, Blue Cross was forced to shift its group business to competitive experience rating in order to survive.[136]

B. Small Group Health Coverage Emerges

1. Experience Rating and Small Groups

The dominance of the group insurance model not only ended Blue Cross's community rating, but also prevented some small firms from obtaining group coverage.[137] The insurance laws in some states set a minimum group size that excluded small groups, and many insurers would not offer group business to small employers.[138] Experience rating relies on groups large enough to produce their own stable claims history. Because smaller groups cannot produce that kind of steady claims experience, they are ill-suited for experience rating.[139] But this barrier did not last for long. Driven by "competitive considerations and the desire to extend group insurance techniques to a larger share of the market,"[140] insurers expanded group coverage to smaller employers. This was desirable for smaller employers, who could offer group coverage and its benefits—no individual underwriting, lower costs, and a tax subsidy—to their employees.

But the expansion of the group model to small groups posed a problem: how to accurately establish rates for groups unfit for experience rating. Ironically, insurers adopted an approach that resembled the Blue Cross system: community rating.[141] Insurers pooled the claims experience of small employers to develop a basic rate and then applied group-specific adjustments based on factors such as age.[142]

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135. *See* Hedinger, *supra* note 97, at 5.

136. *See* MACINTYRE, *supra* note 44, at 14.

137. J. F. Follmann, Jr., *The Growth of Group Health Insurance*, 32 J. RISK & INS. 105, 110 (1965).

138. *Id.*

139. *See supra* notes 36–37, 63–65 and accompanying text.

140. *See* Robert R. Neal, *Health Insurance and the Practicing Lawyer*, 1962 A.B.A. SEC. INS. NEGL. & COMP. L. PROC. 251, 258 (1962); *see also* Follmann, *supra* note 137, at 110 (noting that statutory restrictions were lowered allowing insurers to offer coverage to smaller groups, some as small as two).

141. *See* MACINTYRE, *supra* note 44, at 106–07 (reporting that as the group insurance market expanded to include smaller groups, insurers pooled small groups for rating purposes); Follmann, *supra* note 52, at 413 (noting that small groups were pooled into a community and charged a community rate).

142. *See* Mark A. Hall, *The Political Economics of Health Insurance Market Reform*, HEALTH AFF. Summer 1992, at 111 [hereinafter Hall, *Political Economics of Health Insurance Market Reform*].

In a sense, the experience rating system was extended to small employers but only to a pool of small firms, rather than a pool of employees of one firm, as was the case for large firms. There was, however, a significant problem with this approach. Unlike employees who entered the large employer's risk pool because they sought employment rather than insurance, small groups entered the new small group risk pool precisely because they sought insurance. This opened the door for adverse selection. As a result, small group coverage lacked the adverse selection protection enjoyed by large group coverage.

2. Small Groups, Cream Skimming, and Blue Cross Redux

The small group system worked well for a while. But by the 1980s and early 1990s, the market for small employer coverage began to disintegrate.[143] A sharp escalation in the underlying cost of medical care drove some insurers to look for a competitive edge as healthier groups sought cheaper coverage.[144] Insurers engaged in cream skimming, in which they structured their policies to attract healthier/lower risk customers and discourage less healthy/higher risk customers[145]—the same behavior that contributed to the demise of the community-rated Blue Cross group model. This move intensified competition among all insurers, leading the industry to abandon its community rating methods in favor of greater risk selection. Under this new rating regime, insurers either applied experience rating techniques to small groups, which were wholly unsuitable and resulted in "highly unstable rating practices,"[146] or they applied "destructive medical underwriting techniques"[147] that treated small groups more like applicants in the individual insurance market—a market insurers historically approached with trepidation due to fears of adverse selection.

As a result of insurers' desire to weed out groups with potentially costly members, some small groups were turned down while others were priced out. Insurers also engaged in other risk selection techniques, such as imposing lengthy exclusions for preexisting conditions, applying broad coverage exclusions,[148] and engaging in post-claims

143. *See* Mark A. Hall, *The Competitive Impact of Small Group Health Insurance Reform Laws*, 32 U. MICH. J.L. REFORM 685, 687–89 (1999).

144. *See* Mark A. Hall, *Reforming the Health Insurance Market for Small Businesses*, 326 NEW ENG. J. MED. 565, 565 (1992) [hereinafter Hall, *Reforming the Health Insurance Market*].

145. *See supra* note 69 and accompanying text.

146. *See* Hall, *Political Economics of Health Insurance Market Reform*, *supra* note 142.

147. *See id.*

148. HALL, REFORMING PRIVATE HEALTH INSURANCE, *supra* note 134, at 18.

underwriting.[149] Some insurers also engaged in "churning," a practice whereby an insurer initially offered a significant discount to a new small group based on the group's initial good health profile.[150] At renewal time, however, the insurer imposed huge price increases or refused to renew altogether, forcing the group to seek coverage from another insurer.[151] These practices resulted in a highly volatile and disintegrating health insurance market for smaller employers.[152] This very much appeared to be the competitive, no equilibrium market envisioned by Rothschild and Stiglitz—a market that oscillated and seemed to be on the verge of collapse.

3. Small Group Health Insurance Is Reformed

As coverage rates for smaller employers began to plummet, the states and the federal government, urged on by the insurance industry itself,[153] stepped in to stabilize coverage for small employers. By 1997, forty-seven states had enacted small group reform legislation.[154] In 1996, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA).[155] These laws established a formal small group market with a dividing line between large and small groups drawn at fifty employees.[156] The reform laws also included components aimed at reducing risk selection by small group insurers.[157] For example, small group insurers were required to offer coverage on a guaranteed issue and

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149. Post claims underwriting, a process by which an insurance company waits until a claim has been filed to make underwriting decisions (which should have been made when the application was made) to deny coverage, is a particularly pernicious practice, but one that accomplished the twin goals of allowing insurers to conduct less stringent (and less costly) upfront evaluations of applicants while maintaining the ability to exclude, albeit retrospectively, costly individuals once they submitted their claims. *Id.* at 19.

150. *Id.*

151. *See* HALL, REFORMING PRIVATE HEALTH INSURANCE, *supra* note 134, at 20.

152. *See* Hall, *Reforming the Health Insurance Market*, *supra* note 144, at 565.

153. *See id.* (noting that insurance industry trade groups proposed extensive regulations to stabilize coverage for small groups).

154. *See* M. Susan Marquis & Stephen H. Long, *Effect of "Second Generation" Small Group Health Insurance Market Reforms, 1993 to 1997*, 38 INQUIRY 365, 365 (2001).

155. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (codified in scattered sections of 18 U.S.C., 26 U.S.C., and 42 U.S.C.).

156. The number fifty was thought best for avoiding defection of employers to the self-insured market, where they would be free from state regulation. *See* HALL, REFORMING PRIVATE HEALTH INSURANCE, *supra* note 134, at 54.

157. *See* Mark A. Hall, *The Geography of Health Insurance Regulation: A Guide to Identifying, Exploiting, and Policing Market Boundaries*, HEALTH AFF., Mar.-Apr. 2000, at 173, 179 [hereinafter Hall, *Geography*].

guaranteed renewal basis. This meant that insurers could not reject a small employer that applied for or tried to renew coverage if the employer was willing (and able) to pay the premium.[158] Most states also imposed restrictions on small group rates. The most commonly used was rating bands,[159] which limited variations in premiums attributable to health status and other factors.[160] A few states used more restrictive adjusted community rating[161] and pure community rating requirements.[162] These regulatory controls constrained the range of premiums small firms faced when purchasing group coverage and eliminated abusive rating practices by insurers. But the reforms did not increase take up in the small group market[163] and did not control the high prices of coverage that discouraged many small firms from purchasing group insurance.[164]

More importantly, small group reforms did not eliminate the threat of adverse selection. Small group rates were still tied to pools of small employers.[165] Since small employers could choose whether to buy insurance, employers with lower risk and less costly employees could avoid the high costs of the small group market by electing to self-insure their employees or by opting out of small group coverage altogether.

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158. These requirements were put in place to stop insurers from denying coverage to potentially costly groups. *See id.* at 179.

159. *See* NAT'L ASS'N OF INS. COMM'RS & CTR. FOR INS. POLICY & RESEARCH, HEALTH INSURANCE RATE REGULATION 3 (2011), https://www.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf [https://perma.cc/7BTJ-M3D3] (noting that rating bands are "the most prevalent form" of small group rate regulation).

160. *See id.* at 1.

161. Adjusted community rating bars the use of health status or claims experience in the calculation of premiums but allows other factors, such as age and geography, to be used. *See id.*

162. Pure community rating prohibits any factors besides geography to be used when setting premiums. *See id.*

163. *See* Gail A. Jensen & Michael A. Morrisey, *Small Group Reform and Insurance Provision by Small Firms*, *1989–1995*, 36 INQUIRY 176, 184 (1999) (reporting that small group reforms adopted between 1989 and 1995 did not expand coverage among small firms); Marquis & Long, *supra* note 154, at 377 (finding little evidence that small group reforms lead to any expansion of coverage among small firms in nine states).

164. *See* Jensen & Morrisey, *supra* note 163, at 184 (reporting that nearly all (90%) small firms surveyed that did not offer their employees group health insurance stated that the high cost was the most important reason for not offering coverage).

165. Some states required some form of community rates. In states that did not require community rates, insurers still pooled small groups by classes or blocks. *See* NAT'L ASS'N OF INS. COMM'RS & CTR. FOR INS. POLICY & RESEARCH, *supra* note 159, at 2–3.

C. Coda

The group insurance model has been an awkward fit for small employers, generating problems not typically faced by large groups: adverse selection, cream skimming, rating difficulties, and market volatility. Legislative reforms stabilized the market, but the core problem of adverse selection remained. Prior to the ACA, small employers that bought small group coverage did benefit from the group model. They enjoyed the same tax subsidy as large groups, avoided individual underwriting, and appeared to pay lower administrative costs. The next Part of this Article examines whether the post-ACA small group market provides a better deal than individual coverage.

III. SMALL GROUP HEALTH INSURANCE TODAY: DOES IT DELIVER CORE GROUP BENEFITS?

The ACA changed the way individual and small group health insurance is pooled, priced, structured, and delivered.[166] Although these changes were substantial and are worthy of extended discussion, the inquiry in this Article focuses on a specific question: Does the post-ACA small group market deliver the four core benefits of the group insurance model? This Part answers this question. Section III.A examines whether the small group market reduces the risk of adverse selection relative to the individual market. Next, section III.B surveys cost data to determine whether the small group market delivers coverage at a lower administrative expense than the individual market. Section III.C evaluates whether the small group market provides greater access to coverage than the individual market. Finally, section III.D examines whether small group coverage provides a tax subsidy not available in the individual market.

A. Adverse Selection in the Individual and Small Group Markets

Recall that adverse selection occurs when insurance purchasers know more than the insurer about their own risks and use that information when they buy insurance. In the individual life insurance market, insurers used individual underwriting to combat adverse selection. But this came at a cost: high administrative charges and limited access to insurance. The group model provided an answer to adverse selection by

166. For an overview of the ACA changes to the individual and small group markets, see John G. Day, *The Patient Protection and Affordable Care Act: What Does It Really Do?*, 22 CONN. INS. L.J. 121, 135–47 (2016).

creating a risk pool for reasons independent of the demand for insurance. Prior to the ACA, adverse selection was a problem for both the small group and individual markets. After the ACA, adverse selection remains a problem for both.

1. Pre-ACA Adverse Selection

Prior to the ACA, the individual market was considered a residual market,[167] where individuals lacking employer-based coverage or who were not eligible for public insurance programs sought insurance.[168] Individuals purchased insurance voluntarily, consequently some individuals churned in and out of the market as they needed coverage, while others kept individual coverage long-term.[169] Because individuals had an incentive to purchase insurance only when they thought they might need medical services, adverse selection was a problem.[170] Indeed, applicants for coverage were more likely to be high-risk than low-risk.[171] This led insurers to use underwriting and risk-based pricing to control risk. Insurers denied coverage to high-risk applicants and priced enrollees based on their risk.[172]

As noted in Part II, adverse selection was also a problem in the small group market before the ACA. Because small group employers entered the small group market for the purpose of buying insurance, the adverse selection problem in that market was similar to the adverse selection problem in the individual health insurance market. Since small employers could use their own risk information when deciding to buy

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167. *See* Melinda Beeuwkes Buntin et al., *The Role of the Individual Health Insurance Market and Prospects for Change*, HEALTH AFF., Nov.-Dec. 2004, at 79, 79–80 (noting that "only a small share of the nonelderly population purchases individual insurance").

168. *See* Gary Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, HENRY J. KAISER FAMILY FOUND. 2 (Dec. 12 2016), http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA [https://perma.cc/2QC5-WW94]. Public insurance programs include Medicare and Medicaid.

169. *See id.*

170. *See* Mark V. Pauly & Len M. Nichols, *The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes*, HEALTH AFF. W325, W326 (Oct. 23, 2002), https://pdfs.semanticscholar.org/452d/a53571e394a98f2d71ddc4a753d604962638.pdf [https://perma.cc/NR8J-EKUE] (arguing that insurers' fear of adverse selection results in underwriting and pricing practices).

171. Mark J. Browne, *Evidence of Adverse Selection in the Individual Health Insurance Market*, 59 J. RISK & INS. 13 (1992).

172. *See* Buntin et al., *supra* note 167, at 81 (noting that "those who buy coverage tend to be healthier than those who remain uninsured, even though we expect demand for insurance to be greatest among the sick").

coverage, this gave them the option of buying coverage in the small group market, self-insuring, or skipping coverage all together.[173]

2. Post-ACA Adverse Selection

Part of the ACA's individual market reforms included making individual insurance more accessible. Once the ACA market reforms took effect in 2014, insurers in the individual market were no longer allowed to deny coverage or charge higher premiums based on an applicant's health status or medical history.[174] Insurers could only determine premiums on a community rated basis, with limited adjustments for age, tobacco use, and geographic location.[175] This raised the risk of adverse selection by barring insurers from using their main tools to combat adverse selection. However, the ACA also included provisions to reduce adverse selection. The ACA imposed an individual mandate that required most Americans to maintain a minimum level of health insurance coverage or pay a tax penalty.[176] The ACA also provided subsidies for low- and moderate-income individuals and households to help them purchase insurance.[177] Moreover, the ACA also made it harder for people to delay purchasing insurance until they were sick by limiting open enrollment periods.[178]

Nevertheless, adverse selection remains a concern in the individual market. For example, the individual market has attracted more older than younger adults.[179] In addition, Congress and the Trump administration have taken actions that could increase adverse selection in the individual market. Specifically, Congress repealed the individual mandate, effective December 31, 2018.[180] The Congressional Budget Office has estimated that the repeal of the individual mandate will cause fewer

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173. Indeed, low risk group declined in coverage following the 1990s reforms, consistent with adverse selection. *See* Kosali Ilayperuma Simon, *Adverse Selection in Health Insurance Markets? Evidence from State Small-Group Health Insurance Reforms*, 89 J. PUB. ECON. 1865, 1872 (2005) (noting that coverage rates declined for low risk workers after reforms).

174. 42 U.S.C. § 300gg-1 (2012) (guaranteed availability of coverage); *id.* § 300gg-2 (guaranteed renewability of coverage); *id.* § 300gg-3 (prohibition of preexisting condition exclusion); *id.* § 300gg-4 (prohibition of discrimination based on health status).

175. *Id.* § 300gg.

176. Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 539 (2012) (citing 26 U.S.C. § 5000A (2012)).

177. *See infra* section III.D.

178. 42 U.S.C. § 300gg-1(b).

179. John A. Graves & Sayeh S. Nikpay, *The Changing Dynamics of US Health Insurance and Implications for the Future of the Affordable Care Act*, 36 HEALTH AFF. 297, 303 (2017).

180. Tax Cuts and Jobs Act, Pub. L. No. 115-97, 131 Stat. 2054, 2092 (2017).

healthy people to buy insurance, reducing individual market coverage by 13 million people by 2027.[181] The repeal is also expected to cause premiums to rise about 10% per year for the next decade.[182] In addition, the Trump Administration has promulgated regulations that allow the sale of low cost, low coverage "short-term" insurance.[183] Insurers offering this coverage could siphon (or, cream skim) low-risk insureds from the individual market and drive up individual market premiums.[184]

The small group market also remains subject to adverse selection problems. Post-ACA, insurers in the small group market are also barred from charging higher premiums based on the health status, medical history, or other risk factors of the employees of a small employer. Small group coverage is also community rated, subject to limited adjustments based on age, smoking, and geography.[185] All of this increases the risk of adverse selection. Finally, unlike the large group market, there remains no rule that requires small employers to either provide health coverage to their employees or pay a penalty.[186] Small groups can still opt out of coverage if they find it too expensive, or they can self-insure. Indeed, the number of small employers self-insuring has risen from 13.2% in 2013,[187] the year before the ACA insurance market reforms took effect, to 17.4% in 2016.[188] Moreover, the Trump Administration has

181. CONG. BUDGET OFF., REPEALING THE INDIVIDUAL HEALTH INSURANCE MANDATE: AN UPDATED ESTIMATE 3 (2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf [https://perma.cc/72F9-PNDG].

182. *Id.*

183. Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212, 38,212 (Aug. 3, 2018) (to be codified at 29 C.F.R. pt. 54, 2590; 45 C.F.R. pts. 144, 146, 148) (effective on October 2, 2018).

184. *See* Robert Pear, *Trump Moves to Relax Rules on Cheaper Health Insurance*, N.Y. TIMES (Feb. 20, 2018), https://www.nytimes.com/2018/02/20/us/politics/trump-cheaper-health-insurance.html (last visited Aug. 25, 2018) ("Some health policy experts say that if large numbers of healthy people buy short-term coverage, it could drive up premiums for those who remain in Affordable Care Act plans.").

185. 42 U.S.C. §§ 300gg–300gg-4 (2012).

186. *See* Day, *supra* note 166, at 146.

187. *2013 Medical Expenditure Panel Survey, Insurance Component National-Level Summary Tables, Table I.A.2.a Percent of Private-sector Establishments that Offer Health Insurance that Self-Insure at Least One Plan by Firm Size and Selected Characteristics: United States (2013)*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T HEALTH & HUMAN SERVS. (2013), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2013/tia2a.pdf [https://perma.cc/C6P6-HBBY].

188. *2016 Medical Expenditure Panel Survey, Insurance Component National-Level Summary Tables, Table I.A.2.a Percent of Private-sector Establishments that Offer Health Insurance that Self-insure at Least One Plan by Firm Size and Selected Characteristics: United States (2016)*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, U.S. DEP'T HEALTH & HUMAN SERVS. (2016), https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2016/tia2a.pdf [https://perma.cc/R8L9-4TGN].

promulgated a regulation that permits small firms to offer coverage purchased through associations rather than through the small group market.[189] This regulation allows small firms to offer less expensive coverage exempt from small group market requirements.[190]

In sum, post-ACA, both the individual and small group markets are subject to adverse selection, and the small group market appears to provide no greater protection from adverse selection than the individual market.

B. Administrative Costs in the Individual and Small Group Markets

The group model lowered administrative costs by eliminating the expense of individual underwriting, spreading fixed per-contract costs across a larger pool of insureds, and by transferring some administrative duties to the employer. Prior to the ACA, available data seemed to suggest that the small group market delivered a better deal on administrative costs than the individual market. Data now available shows that the small group market offers no better deal on administrative costs. In fact, administrative costs are higher for the small group market, due to the costs of brokers and agents.

1. Pre-ACA Administrative Costs

Prior to the ACA, there was little publicly available information on how much insurers spent on administrative costs.[191] Administrative costs were typically reported as the medical loss ratio (MLR), a percentage of the premium paid for medical claims.[192] Although there was no standard formula for calculating MLRs,[193] the MLR statistic was widely used by insurers, regulators, and many others for a variety of purposes, including

189. Definition of ''Employer'' under section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912, 28,912 (June 21, 2018) (codified at 29 C.F.R. pt. 2150).

190. *See* Robert Pear, *Trump Proposes New Health Plan Options for Small Businesses*, N.Y. TIMES (Jan. 4, 2018), https://www.nytimes.com/2018/01/04/us/politics/trump-association-health-plans-obamacare.html (last visited Aug. 25, 2018).

191. Jennifer Haberkorn, *Health Policy Brief: Medical Loss Ratio*, HEALTH AFF. 1 (Nov. 24, 2010), https://www.healthaffairs.org/do/10.1377/hpb20101124.949788/full/healthpolicybrief_33.pdf [https://perma.cc/4ZBA-J6AZ].

192. James C. Robinson, *Use and Abuse of the Medical Loss Ratio to Measure Health Plan Performance*, HEALTH AFF., July-Aug. 1997, at 176, 176 ("In principle, this statistic measures the fraction of total premium revenue that health plans devote to clinical services, as distinct from administration and profit.").

193. *Id.* at 177–81, 186 (noting that MLR "is not a straightforward indicator of either medical or administrative expenditures"); *see also* Haberkorn, *supra* note 191, at 2 (noting that the meaning of MLR differed among states because they "defined what constitutes medical care differently").

as an indicator of administrative efficiency.[194] Large groups tended to have the highest MLRs ranging from the low eighties to the low nineties.[195] This meant that administrative costs and profits in the large group market varied from under 10% to nearly 20% of premiums. The individual market typically had the lowest MLRs, ranging from the low sixties to the eighties,[196] meaning that administrative costs comprised between 20% to nearly 40% of premiums. The small group market fell in-between, with MLRs ranging from the high seventies to the mid-eighties.[197] Small group administrative costs and profits ranged from 15% to the just over 20%. This seems to suggest that, while small group administrative costs were high, they were generally not as high as those in the individual market—an apparent benefit of the group model.

But use of the MLR statistic as means of comparing administrative expenses across markets can be misleading. The MLR shows administrative costs as a percentage of premium rather than in dollars spent per person. Because premiums across the three markets varied, MLR figures are not particularly useful for cross-market administrative cost comparisons. Individual market plans typically provide less coverage at a lower premium, so they have fewer premium dollars over which to spread their administrative costs.[198] This yields a higher MLR in the individual market per administrative dollar spent than in the large and small group markets.

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194. Robinson, *supra* note 192, at 177 ("Despite the difficulties in access and interpretation, the medical loss ratio has achieved in recent years a remarkable amount of publicity and even notoriety.").

195. *See, e.g.*, U.S. GEN. ACCOUNTING OFFICE, PRIVATE HEALTH INSURANCE: SMALL EMPLOYERS CONTINUE TO FACE CHALLENGES IN PROVIDING COVERAGE 14 (2001) [hereinafter GAO SMALL EMPLOYERS], https://www.gao.gov/assets/240/232978.pdf [https://perma.cc/L26R-3FEP] (reporting large group administrative costs at "about 10 percent of large employers' premiums," an MLR of 90%); Haberkorn, *supra* note 191, at 2 (noting that the nation's largest health insurers reported 2009 MLRs for the large group market ranging from 83%–88%); Hall, *supra* note 157, at 174 (reporting that large group MLRs "typically run in the high 80s or low 90s").

196. *See, e.g.*, Hall, *Geography*, *supra* note 157, at 175 (reporting individual market MLRs in the "60s to mid-70s"); Haberkorn, *supra* note 191, at 2 (reporting 2009 MLRs for the individual market ranging from 68%–88%).

197. *See, e.g.*, GAO SMALL EMPLOYERS, *supra* note 195 (reporting small employer administrative costs at "about 20 percent to 25 percent," an MLR of 75–80%); Haberkorn, *supra* note 191, at 2 (noting that the nation's largest health insurers reported 2009 MLRs for the large group market ranging from 83%–88%); Hall, *Geography*, *supra* note 157, at 175 (reporting small group market MLRs in the "high 70s to mid-80s").

198. CONG. BUDGET OFFICE, PRIVATE HEALTH INSURANCE PREMIUMS AND FEDERAL POLICY 35 (2016), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf [https://perma.cc/NU4L-5866] (Appendix: Insurers' Administrative Costs and Profits).

2. Post-ACA Administrative Costs

The ACA now requires all insurers to file detailed financial reports annually.[199] The data from these reports allows more precise calculations of administrative costs. Now, administrative costs can be measured in dollars spent per each enrollee, rather than just as a percentage of premium. The new data show the small group market has higher administrative costs than the individual market.

Using 2010 to 2012 data, the Congressional Budget Office (CBO) analyzed administrative costs for the large group, small group, and individual markets.[200] The CBO found that, as a share of premiums, administrative costs in the individual market were higher than those in the small group market, 20% versus 16%. This finding was consistent with the prior MLR approach. But when administrative costs were measured in average dollars paid by each enrollee, the small group market's administrative costs were 25% higher than those in the individual market. As seen in Table 1, per enrollee administrative charges—the average number of dollars spent by each enrollee to cover administration costs—were higher in the small group market. Annual administrative costs in the small group market averaged $687 in 2010-2012. In the individual market, administrative costs averaged $548 per year.

199. 42 U.S.C. § 300gg-18 (2012).

200. CONG. BUDGET OFFICE, *supra* note 198, at 36 tbl.A-1.

Table 1:
Insurers' Average Annual Administrative Costs per Enrollee, 2010–2012[201]

Administrative Costs	Small Group Market	Individual Market
Claims Processing and Adjustment	$103	$96
Taxes and Fees	$159	$74
Sales, Marketing, and Brokers' Fees	$226	$157
Other Administrative Costs	$200	$221
Total Administrative Costs	**$687**	**$548**

For the two markets, the CBO found that cost of claims processing was roughly similar ($103 and $96 per enrollee) as were "other" administrative costs ($200 and $221 per enrollee). The two biggest differences were in taxes ($159 and $74 per enrollee) and sales, marketing, and brokers' fees ($226 and $157 per enrollee). The tax difference resulted from higher profits in the small group market, which translated into higher tax costs passed on through premium.[202] The most significant difference was the cost of sales, marketing, and brokers' fee, which were 44% higher in the small group market ($226 and $157 per enrollee).[203]

An analysis by the actuarial firm Milliman produced similar results for the years 2010 and 2012 to 2015. Table 2 shows average per member per month administrative expenses for the small group and individual markets. Again, based on the Milliman analysis, the small group market was more expensive every year but 2014, when the costs were roughly the same ($48.49 versus $48.55).[204]

201. *Id.* CBO analyzed administrative data derived from two sources: insurers' 2010 filings of the Supplemental Health Care Exhibit with the National Association of Insurance Commissioners, and insurers' 2011 and 2012 filings of the Medical Loss Ratio Annual Reporting Form with Centers for Medicare & Medicaid Services (CMS). *Id.* at 35.

202. *Id.*

203. *Id.*

204. The Milliman figures do not include taxes and fees.

Table 2:
Administrative Costs per Member per Month, 2010, 2012–2015

Year	Small Group Market	Individual Market
2010[205]	$43.83	$40.31
2012[206]	$44.38	$38.30
2013[207]	$46.37	$43.09
2014[208]	$48.49	$48.55
2015[209]	$51.94	$48.19

Milliman also noted that the biggest difference between the two markets were the broker and agent fees, which were substantially higher in the small group market.[210]

The group model lowers costs, in part, by transferring some administrative functions from the insurer to the firm. Small firms, lacking the resources to hire a staff, rely on insurance agents and brokers to perform many of the functions of a human resources staff.[211] Most

205. JILL S. HERBOLD, MILLIMAN, ADMINISTRATIVE EXPENSES: 2010 COMMERCIAL HEALTH INSURANCE 5 fig.1, 8 (2012) [hereinafter MILLIMAN 2010], http://www.milliman.com/uploadedFiles/insight/health-published/commercial-health-insurance-admin-2010.pdf [https://perma.cc/D7NV-NTUK].

206. MILLIMAN 2012, *supra* note 7, at 1 fig.1.

207. *See* PAUL R. HOUCHENS ET AL., MILLIMAN, 2013 COMMERCIAL HEALTH INSURANCE: OVERVIEW OF FINANCIAL RESULTS 1 fig.1 (2014), http://www.milliman.com/uploadedFiles/insight/2014/2013-commercial-health-insurance.pdf [https://perma.cc/H687-V29J].

208. *See* PAUL R. HOUCHENS ET AL., MILLIMAN, 2014 COMMERCIAL HEALTH INSURANCE: OVERVIEW OF FINANCIAL RESULTS 5 fig.3 (2016), http://us.milliman.com/uploadedFiles/insight/2016/2014-commercial-health-insurance.pdf [https://perma.cc/6MEA-PG3C].

209. MILLIMAN 2015, *supra* note 6, at 6 fig.4.

210. MILLIMAN 2012, *supra* note 7, at 2 ("Agents and broker fees in the individual market are more than 40% less than the small group market on a PMPM basis."). *See also* MILLIMAN 2010, *supra* note 205, at 5 fig.1, 8 (noting that "[t]hese significant differences between the market averages for agents and brokers fees and commissions account for the majority of the difference in total administrative expenses by market").

211. Jon R. Gabel et al., *Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance*, 32 HEALTH AFF. 2032, 2034 (2013) ("Insurance agents and brokers play major roles in small employers' purchasing decisions, often serving as de facto benefit managers."); LESLIE JACKSON CONWELL, CTR. FOR STUDYING HEALTH SYS. CHANGE, ISSUE BRIEF NO. 57: THE ROLE OF HEALTH INSURANCE BROKERS 3 (2002), http://www.hschange.org/CONTENT/480/480.pdf [https://perma.cc/S9VM-PECW] (noting that small employers "tend to view brokers as their benefits staff").

small firms that buy insurance use brokers and agents.[212] Brokers and agents provide extensive services, including helping firms select health plans, educating employees about benefits, enrolling employees, determining employee premium contributions, and helping employees appeal denied claims.[213] But these services come with a price. Brokers fees of up to 8% of premium[214] are built-in to all premiums rather than charged directly to small firms. Thus, all small employers pay for brokers and agents, even if they do not use them.[215]

In sum, the small group health market offers no administrative cost savings. While cost savings through the transfer of some administrative functions from the insurer to the employer may work for a large employer, it does not work for a small employer. The small employer must rely on agents and brokers to perform those functions. The costs of those services are simply loaded into premiums and transferred back to the small firms, resulting in higher administrative costs.

C. Access to Insurance in the Individual and Small Group Markets

Access to insurance is the most straightforward of the group model's four core benefits. The group model jettisoned individual underwriting as a prerequisite for life insurance, thereby extending the availability of life insurance to those who would have been denied coverage in the individual market. Prior to the ACA, the small group market offered the same access benefit: small group employees were not subject to individual underwriting as a litmus test for coverage, although the benefit was provided by statute, not purely through the group model. On the other hand, applicants for individual coverage were subject to exclusion through underwriting. After the ACA, underwriting was eliminated in the individual market and middle- and lower-income applicants to that market were eligible for subsidized coverage, blunting the high cost of health insurance, which can be a significant barrier to coverage. These changes eliminated the access benefit of the small group market.

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212. *See* Gabel et al., *supra* note 211, at 2034 (noting that 80% of small firms that offer coverage use a broker or agent). A broker is an independent agent who works with many insurers. Agents work with a single insurer. *See* CONWELL, *supra* note 211, at 2.

213. *See* Gabel et al., *supra* note 211, at 2034–35.

214. *See* CONWELL, *supra* note 211, at 2.

215. *See id.*

1. Pre-ACA Access

Because medical underwriting was permitted in the individual insurance market in forty-five states and the District of Columbia prior to the ACA,[216] individual insurance was difficult for many Americans to purchase.[217] More than one in six applicants were denied when applying for coverage in the individual market,[218] and many others simply did not apply because they knew they would be denied.[219] Even if a person were not denied, their medical history could result in higher rates, an exclusion of a specified condition, higher deductibles, or limited or modified benefits.[220] In fact, by one estimate, over one quarter of the population today would be ineligible for coverage under pre-ACA underwriting.[221]

In contrast, while group coverage was "almost invariably" written without individual underwriting prior to the 1960s,[222] by the early 1990s, 40% of small groups and 20% of large firms used medical underwriting to exclude workers for specific preexisting conditions.[223] This changed after passage of HIPAA in 1996. Thereafter, individual underwriting was banned in the group health markets. HIPAA prohibited group health plans from excluding individuals from a group or charging them higher premiums based on their health status.[224] HIPAA also included guaranteed issue and renewability provisions that prevented insurers from refusing coverage to small groups based on the cost of their

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216. *See* Claxton et al., *supra* note 168, at 3.

217. Michelle M. Doty et al., *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, COMMONWEALTH FUND 2 (July 21, 2009), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2009_jul_failure_to_protect_1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf [https://perma.cc/QR3K-SZDK] ("[N]early half (47%) of adults who tried to purchase insurance in the individual market in the last three years found it very difficult or impossible to find a plan that fit their needs.").

218. Claxton et al., *supra* note 168, at 2 (estimating that 18% of individual market applicants were denied coverage); *see also* Buntin et al., *supra* note 167, at 81 (noting estimates of denials range from 8% to 18% of applicants).

219. *See* Claxton et al., *supra* note 168, at 2–3.

220. *See id.* at 6.

221. *See id.* at 2, tbl.1 (noting that 27% of adult Americans under the age of sixty-five have health conditions that would likely leave them uninsurable in the pre-ACA individual market).

222. *See* MACINTYRE, *supra* note 44, at 63.

223. *See* Joel C. Cantor et al., *Private Employment-Based Health Insurance in Ten States*, HEALTH AFF., Summer 1995, at 199, 205.

224. 29 U.S.C. §§ 1182(a), (b) (2012).

employees.[225] Nevertheless, access was limited by price and low offer rates. Although most states imposed some restrictions on premiums, such as rating bands, to prevent insurers from pricing out employers with high-cost employees,[226] high premiums still affected access. High prices have been the main reason small employers do not offer coverage.[227] And the percentage of small employer not offering coverage has grown from about half in the early 1990s to roughly two-thirds today.[228]

2. Post-ACA Access

After the ACA, underwriting is prohibited in the individual market. Access to coverage is guaranteed.[229] The ACA prohibits discrimination-based health status[230] and preexisting conditions,[231] and insurers may vary premiums only on family status, geographic rating area, age, and tobacco use.[232] And, as described in section III.D, the ACA offers tax subsidized coverage to middle- and lower-income applicants, reducing cost as a barrier to health coverage.

The same access and rating provisions also apply to the small group market, giving the two markets similar access requirements. However, two additional potential access limits should be considered. First, the small group offers no special tax subsidy to the households most burdened by the cost of health insurance—middle- and lower-income households. Second, less than one-third of small group employers now offer group health coverage.[233]

In short, the post-ACA small group health market offers no access advantage over the individual market.

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225. For a detailed explanation of HIPAA's guaranteed issue and renewal requirement for small groups, see Jack A. Rovner, *Federal Regulation Comes to Private Health Care Financing: The Group Health Insurance Provisions of the Health Insurance Portability and Accountability Act of 1996*, 7 ANNALS HEALTH L. 183, 207–09 (1998).

226. *See supra* notes 159–160 and accompanying text.

227. *See* Gabel et al., *supra* note 211, at 2034 (finding that 75% of small firms not offering insurance cite the high cost as the reason coverage not offered).

228. *See supra* notes 4–5 and accompanying text.

229. 42 U.S.C. § 300gg-1(a) (2012). This is subject to enrollment periods. *Id.* § 300gg-1(b).

230. *Id.* § 300gg-4.

231. *Id.* § 300gg-3.

232. *Id.* § 300gg(a).

233. *See* AGENCY FOR HEALTHCARE RESEARCH & QUALITY, *supra* note 4 and accompanying text.

D. Tax Subsidy in the Individual and Small Group Market

Finally, does the small group market deliver a better tax subsidy than individual coverage? Prior to the ACA, the answer was unequivocally "yes." Now, the answer rests on the employee's household income. To be clear, employer-based group coverage still offers a tax subsidy. But for some employees—those with low or moderate household incomes—the individual market may offer a better tax subsidy.

1. Pre-ACA Tax Subsidy

Before the ACA, federal law generally offered little tax subsidy to those who purchased health insurance in the individual market.[234] Individuals paid premiums with after-tax dollars.[235] In comparison, group premiums paid by an employer on behalf of an employee were not treated as employees' taxable income[236] and employee contributions to premiums were paid with pre-tax dollars if made through a cafeteria plan.[237] The result was a significant advantage for employer-based group health insurance over the individual market. The subsidies lowered the price of insurance purchased through an employer relative to the individual insurance market.[238] This played a critical role in the growth

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234. Self-employed individuals may deduct the cost of their own health insurance premiums as well as the premiums they paid for their dependents as an ordinary and necessary business expense. I.R.C. § 162(l) (West 2006). Also, employees were allowed to purchase their own health insurance and then seek reimbursement in pre-tax dollars from their employer. *See infra* note 302 and accompanying text.

235. David Gamage, *Perverse Incentives Arising from the Tax Provisions of Healthcare Reform: Why Further Reforms Are Needed to Prevent Avoidable Costs to Low- and Moderate-Income Workers*, 65 TAX L. REV. 669, 676 (2012).

236. I.R.C. §§ 105(b), 106(a) (West 2012). Group health insurance premiums are also excludable from payroll taxes. I.R.C. §§ 3101(a), (b), 3121(a)(2) (West 2012).

237. I.R.C. § 125. Legislation authorizing cafeteria plans was enacted in 1978. Revenue Act of 1978, Pub. L. No. 96-600, tit. I, § 134, 92 Stat. 2763, 2783 (codified as amended at I.R.C. § 125).

238. Employees are thought to pay the employer's contribution in the form of lower wages. *See* Linda J. Blumberg, *Who Pays For Employer-Sponsored Health Insurance*, HEALTH AFF., Nov.-Dec. 1999, at 59 ("Economists tend to agree that, based upon both theory and the best empirical evidence, workers bear a large portion of health insurance costs through reduced wages."); David A. Hyman, *Employment-Based Health Insurance and Universal Coverage: Four Things People Know That Aren't So*, 9 YALE J. HEALTH POL'Y, L. & ETHICS 435, 437 (2009) ("[E]mployees actually foot the bill in the form of foregone salary and other benefits."). The tax benefit makes the wage-benefit tradeoff a good deal since dollars paid in the form of wages are taxed but dollars paid in the form of on health insurance benefits are not. For an illustration of the tax benefit of group insurance, see Amy B. Monahan, *The Complex Relationship Between Taxes and Health Insurance*, 3–4 (Univ. of Minn. Law Sch., Legal Studies Research Paper Series, Paper No. 10-01, 2010), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1531322 (last visited Aug. 8, 2018)

of employer-based group health insurance. As Melissa Thomasson has noted, "[b]y fostering an increase in the demand for group insurance relative to individual coverage, [the tax benefit] . . . ensured that health insurance in the United States would evolve as a group, employment-based system."[239]

Significantly, the tax subsidy of employer-provided insurance did not depend on the size of the firm,[240] but the subsidy may have been a more important benefit for small firms. Relying on variations in tax subsidies across Canadian provinces and U.S. states, economist Mark Stabile showed that provinces and states that offered greater tax subsidies for employer-provided insurance tended to have more small firms offer insurance than provinces or states that offered smaller tax subsidies.[241] Without the tax subsidy, Stabile concluded, about half of small firms (25 or fewer employees) would no longer offer coverage, while a loss of tax benefits would have little effect on the larger firms, most likely because the other benefits of group coverage still made large group coverage a better deal than individual coverage.[242]

2. Post-ACA Tax Subsidy

Although the ACA changed some tax laws that affected employer-based group coverage,[243] the tax benefits for employer-provided health insurance remained largely the same. However, the ACA substantially changed the tax laws for purchasers in the individual market by providing: (1) a premium tax credit to subsidize the purchase of health

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(demonstrating how a pre-ACA taxpayer in the 25% marginal tax bracket receives a subsidy of $1,412 by buying health insurance through an employer's group plan).

239. Thomasson, *supra* note 87, at 1374.

240. Rather, the subsidy depended on the marginal tax rate of each employee. Mark Stabile, *The Role of Tax Subsidies in the Market for Health Insurance*, 9 INT'L TAX & PUB. FIN. 33, 48 (2002).

241. *Id.*

242. *Id.* at 47–48.

243. The most notable is the ACA's so-called Cadillac Tax, which imposed a 40% excise tax on employer contributions to health plans considered overly generous. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. IX, § 9901, 124 Stat. 199, 848 (2010) (codified as amended at I.R.C. § 4980I (2012)). Congress suspended its operation until 2020. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. P, tit. I, § 101(a), 129 Stat. 2242, 3037 (2015). Small employers with fewer than twenty-five full-time employees and average wages of less than $50,000 were also offered a tax credit to provide health insurance to employees. The employer had to pay at least 50% of the cost of such coverage. The credit is only available for two consecutive taxable years. I.R.C. §§ 45R(d), (e)(2). For a discussion of the ACA's tax provisions, see Gamage, *supra* note 235, at 686–92.

insurance[244] and (2) cost sharing subsidies to reduce out-of-pocket costs, such as deductibles, coinsurance, and copays.[245] But not all individual market purchasers are eligible for these subsidies. Subsidies are only available for policies purchased through state[246] or federal[247] health insurance exchanges.[248] To be eligible for the premium tax credit, purchasers must have a household income between 100% and 400% FPL.[249] To receive the cost sharing subsidies, purchasers must have income between 100% and 250% of FPL.[250] Employees and dependents offered "affordable" health insurance by an employer are also not eligible for the subsides.[251]

Tables 3 and 4 illustrate how the subsidies work. Table 3[252] estimates the premium tax credits, cost sharing subsidies, and total subsidy for a family of four with a single earner who bought health insurance from a state or federal exchange in 2016.[253] The premium tax credit subsidies are highest at 100% of FPL[254] and thereafter decrease as the purchaser's household income approaches 400% FPL. Likewise, the value of the cost sharing subsidies peaks at 100% FPL and decreases as the purchaser's income approaches 250% FPL. Above 400% FPL, buyers receive no subsidies.

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244. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1401(a), 124 Stat. 119, 213 (codified as amended at I.R.C. § 36B (2012)).

245. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, tit. I, § 1402, 124 Stat. 119, 220 (codified as amended at 42 U.S.C. § 18071 (2012)).

246. 42 U.S.C. § 18031.

247. *Id.* § 18041.

248. Health insurance exchanges (also called marketplaces) are online markets in which individuals and small businesses can purchase health insurance. For an overview of the health insurance exchanges, see generally VANESSA C. FORSBERG, CONG. RESEARC. SERV., No. R44065, OVERVIEW OF HEALTH INSURANCE EXCHANGES 1–13 (2018), https://fas.org/sgp/crs/misc/R44065.pdf [https://perma.cc/PK5D-GQAB].

249. I.R.C. § 36B (West 2012); 26 C.F.R. § 1.36B-2(b) (2017).

250. 42 U.S.C. § 18071; 45 C.F.R. § 155.305(g) (2017).

251. I.R.C. § 36B(c)(2)(B) (2012), (C); 26 C.F.R. § 1.36B-2(c)(3) (2017).

252. Table 3 is adapted from Gamage, *supra* note 235, at 688 tbl.1, which was adapted from STEPHANIE RENNANE & C. EUGENE STEUERLE, TAX POLICY CTR., HEALTH REFORM: A TWO-SUBSIDY SYSTEM (2010), http://www.taxpolicycenter.org/sites/default/files/legacy/numbers/content/PDF/S10-0001.pdf [https://perma.cc/25JL-FXXT].

253. While the figures in this table may vary under the new tax law, the Tax Cuts and Jobs Act, Pub. L. 115-97, 131 Stat. 2054 (2017), the underlying analysis remains the same. Households will receive subsidies at 100% that decrease as income approaches 400% of FPL.

254. From 100% FPL to 133% FPL, households are also eligible for Medicaid coverage in those states that expanded Medicaid eligibility under the ACA. *See* Gamage, *supra* note 235, at 687 n.93.

Table 3:
Estimated Value of Exchange Subsidies (Family of Four, 2016)

Household Income (% of FPL)	Household Income (Cash)	Premium Tax Credits (PTC)	Cost Sharing Subsidies (CSS)	Total Exchange Subsidy (PTC+CSS)
100	$24,000	$13,598	$4,834	$18,433
125	$30,000	$13,473	$4,834	$18,307
150	$36,000	$12,595	$3,021	$15,617
175	$42,000	$11,738	$3,021	$14,759
200	$48,000	$10,940	$604	$11,544
225	$54,000	$9,869	$604	$10,473
250	$60,000	$9,053	-	$9,053
275	$66,000	$7,776	-	$7,776
300	$72,000	$6,952	-	$6,952
325	$78,000	$6,468	-	$6,468
350	$84,000	$5,761	-	$5,761
375	$90,000	$5,165	-	$5,165
400	$96,000	$4,570	-	$4,570
425	$102,000	-	-	-
450	$108,000	-	-	-

Table 4[255] shows the gains and losses for a family of four if it buys subsidized individual market coverage rather than receive employer-based group coverage. Based on the assumptions of this model,[256] the tradeoff point for a family of four is right around 400% FPL. A family of four with income at or below 400% FPL will realize a financial gain by buying subsidized coverage in the individual market rather than through

255. *See* Gamage, *supra* note 235, at 696 tbl.2.

256. The analysis makes several simplifying assumptions that are implied in the data. First, the employer offers only cash wages or cash wages and health insurance benefits. *See* Rennane & Steuerle, *supra* note 252, at 2 n.5. Second, individuals and families get the same health plan in the individual market and from the employer, with a premium of $5,200 and cost sharing of $1,900 for individuals or a premium of $14,100 and cost sharing of $5,000 for families. *See id*. at 2 tbl.1, cols. (C), (C'), (D), (D'), 4 tbl.3, cols. (C), (C'), (D), (D'). Third, the employer's costs per employee are the same regardless of whether the employer offers group coverage. *See id.* at 2 tbl.1, cols. (R), (R'), 4 tbl.3, cols. (R), (R'). Finally, the analysis does not consider income from sources other than the employer. Although these assumptions simplify the calculations, they do not alter the final analysis: from a tax subsidy perspective, households with lower incomes will be better off choosing subsidized individual coverage while households with higher incomes will be better off choosing employer-based group coverage.

group coverage. Conversely, if the family's income exceeds 400% FPL, it will be worse off if it buys subsidized coverage in the individual market rather than through group coverage.

Table 4:
Estimated Household Gain/Loss in Tax Subsidies
After Switch to Exchange from Small Group Insurance
(Family of Four, 2016)

Household Income (% of FPL)	Household Income (Cash)	Total Exchange Subsidy	Total Increase in Paid Taxes	Net Benefit of Exchange Coverage[257]
100	$24,000	$18,433	$(124)	$18,557
125	$30,000	$18,307	$2,297	$16,010
150	$36,000	$15,617	$4,568	$11,049
175	$42,000	$14,759	$5,536	$9,223
200	$48,000	$11,544	$5,456	$6,088
225	$54,000	$10,473	$4,493	$5,980
250	$60,000	$9,053	$3,544	$5,509
275	$66,000	$7,776	$3,544	$4,232
300	$72,000	$6,952	$3,544	$3,408
325	$78,000	$6,468	$3,544	$2,924
350	$84,000	$5,761	$3,544	$2,217
375	$90,000	$5,165	$3,544	$1,621
400	$96,000	$4,570	$3,544	$1,026
425	$102,000	-	$3,544	($3,544)
450	$108,000	-	$4,134	($4,134)

The tradeoff point will vary depending on household size. But, for households eligible for subsidized individual coverage, there is an income level at which they would realize a larger tax subsidy by purchasing health insurance in the individual market. The tradeoff point for a family of four in 2016 is an annual income of just above $96,000.

In sum, post-ACA, the small group market offers only a partial tax subsidy advantage over the individual market. For households with incomes at or below 400% FPL, the individual market offers a better

257. Since this table assumes only small group coverage, Table 4 does not include a reduction for the employer mandate. Gamage and Rennane & Steuerle both incorporate the employer mandate and assume the cost of the mandate penalty is passed along to the employee. Gamage, *supra* note 235, at 696–97, 696 tbl.3; Rennane & Steuerle, *supra* note 252, at 2 tbl.1.

deal. For higher income households, the small group market still offers a better subsidy than the individual market.

This split benefit raises a difficult question. Given its decline, should the small group market be sustained to support this one benefit? While tax subsidies have played an influential role in the group health markets, it would seem arbitrary to sustain the small group market solely to deliver a tax benefit for one group: high-income households.

IV. ADDITIONAL CONSIDERATIONS ON THE POSSIBLE DEMISE OF THE SMALL GROUP MARKET

As the analysis in Part III demonstrates, the small group market fails to deliver the core benefits of group insurance, with the exception of the tax subsidy for high-income households. This Part discusses additional considerations raised by these findings. First, section IV.A examines whether small group coverage provides consumer benefits, aside from the core benefits, that might weigh in favor of preserving the market. Section IV.A asks two questions. First, are people more likely to acquire and maintain health coverage if it is provided through a group rather than the individual market, all else being equal? Second, are employers better than employees at selecting health insurance that more closely meets the needs of the employees? Next, section IV.B queries whether small group insurance benefits employers. Is there a business case for small employers to preserve small group coverage? Section IV.C briefly discusses various policy changes that have been suggested as ways to improve the small group market and considers whether these potential fixes would help the small group market deliver group benefits. Finally, section IV.D identifies the main winners and losers if the small group market is allowed to die.

A. Does Small Group Coverage Provide Other Consumer Benefits?

1. Are People More Likely to Acquire Health Coverage if It Is Offered Through a Group Market?

Purchasing health insurance in the individual market can be an onerous undertaking fraught with information frictions, time costs, and procedural hurdles. Consumers must estimate their health care needs in advance, search for coverage (through an online exchange, from an

insurer directly, or through broker[258]), and select a single product that best meets their needs from an array of options. At the end of each year, consumers must reevaluate their coverage needs and either renew their plan or select new coverage. The purchasing process is also subject to strict time pressures—there is typically a short time frame to purchase coverage.[259] Once insured, consumers must ensure timely premium payments; otherwise coverage will be lost.[260]

This cumbersome process is complicated by the limited capacity of consumers to effectively shop for insurance. Many consumers have an incomplete understanding of key insurance concepts[261] and suffer from limited health literacy and numeracy.[262] Behavioral economics research suggests that consumers are rationally bounded—they have a limited ability to absorb and process the information relevant to complex decision making.[263] The result can be flawed choices due to the use of mental shortcuts[264] and procrastination.[265]

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258. Katherine Hempstead, *The Off-Exchange Individual Market and Small Group Market: New HIX Compare Data*, HEALTH AFF. BLOG (Oct. 24, 2016), https://www.healthaffairs.org/do/10.1377/hblog20161024.057190/full/ [https://perma.cc/2RU3-AUNB] (noting that ACA-compliant individual plans are available on an exchange, directly from an insurer, or through a broker and that over 25% of ACA-compliant individual market products sold in 2016 were sold off the exchange).

259. 42 U.S.C. § 300gg-1(b) (2012) (allowing enrollment to be restricted to limited periods). Open enrollment—when anyone could sign up for coverage—runs from November 1 to December 15. 45 C.F.R. § 155.410(e)(3) (2017).

260. *See* Robert Pear, *One-Fifth of New Enrollees Under Health Care Law Fail to Pay First Premium*, N.Y. TIMES (Feb. 13, 2014), https://www.nytimes.com/2014/02/14/us/politics/one-in-5-buyers-of-insurance-under-new-law-did-not-pay-premiums-on-time.html (last visited Aug. 25, 2018) (reporting that 20% of new enrollees in the individual market in 2014 pay failed to pay their premiums on-time and therefore did not receive coverage). The ACA provides a three-month grace period for exchange enrollees who fail to pay premiums timely. 42 U.S.C. § 18082(c)(2)(B)(iv)(II); 45 C.F.R. § 156.270(g). If, however, coverage is lost through non-payment of premiums beyond the grace period, the individual may not simply re-enroll. Instead, she must wait for the next open enrollment period to resume exchange coverage. Catherine E. Livingston et al., *Third-Party Payment of Premiums for Private Health Insurance Offered on the Exchanges*, 8 J. HEALTH & LIFE SCI. L. 1, 9–10 (2015).

261. *See, e.g.*, George Loewenstein et al., *Consumers' Misunderstanding of Health Insurance*, 32 J. HEALTH ECON. 850, 858 (2013) (reporting that only 14% of survey respondents could answer four simple multiple-choice questions about insurance cost-sharing features and that most respondents were unable to accurately estimate the cost of their medical services).

262. Brietta Clark, *Using Law to Fight a Silent Epidemic: The Role of Health Literacy in Health Care Access, Quality, & Cost*, 20 ANNALS HEALTH L. 253, 260 (2011) (noting results from a survey conducted in 2003 that found only 12% of the 19,000 adults surveyed were proficient in health literacy); Christopher R. Trudeau, *Plain Language in Healthcare: What Lawyers Need to Know About Health Literacy*, MICH. B.J., Oct. 2016, at 36, 37 (noting that about 88% of Americans have problems understanding health information).

263. *See* Russell B. Korobkin & Thomas S. Ulen, *Law and Behavioral Science: Removing the Rationality Assumption from Law and Economics*, 88 CALIF. L. REV. 1051, 1143 (2000) ("To save

Group coverage, on the other hand, provides a more streamlined process for obtaining and maintaining health insurance, thereby reducing the potential hitches and hassles that could prevent or interrupt individual market coverage. Plan choice is simplified; the employer offers only a limited number of plans. Enrollment occurs at the beginning of employment, payment for coverage is made by the employer, and the employee's contribution is deducted from payroll. Enrollment continues so long as the employee remains employed and does not cancel coverage. The simplicity and tidiness of this process suggests that group coverage may be more effective at achieving enrollment than the individual market.[266]

Intuitively this seems correct; people may be more likely, assuming comparable coverage and prices in both markets, to acquire and maintain coverage in the group market than the individual market. Yet there is no evidence to support this claim. Moreover, there is some evidence that employment-based group plans do not always translate into coverage—even in cases where the employer covers the premium (that is, the worker pays no additional premium above wages), and the employee has no other access to coverage.[267] In a study by Chernew et al., which examined the effect of premium reductions on participation in employer-sponsored health plans by low-income workers employed by small firms, the authors estimated that even when the employer paid 100% of the premium, approximately 10% of low-income individuals remained

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time, avoid complexity, and generally make dealing with the challenges of daily life tractable, actors ofteu [sic] adopt decision strategies or employ heuristics that lead to decisions that fail to maximize their utility.").

264. *Id. See also* Brendan S. Maher, *Some Thoughts on Health Care Exchanges: Choices, Defaults, and the Unconnected*, 44 CONN. L. REV. 1099, 1106 (2012) ("Insurance purchasing is widely believed to be an area in which humans are extremely susceptible to cognitive biases and flawed decision-making.").

265. *See, e.g.*, Ted O'Donoghue & Matthew Rabin, *Choice and Procrastination*, 116 Q.J. ECON. 121, 124 (2001) (finding that additional options and important decisions can induce procrastination).

266. *See, e.g.*, Brendan S. Maher, *Unlocking Exchanges*, 24 CONN. INS. L.J. 125, 137–38 (2017) ("Tying health insurance to the labor deal increases the likelihood that it will be purchased . . . .").

267. *See* Michael Chernew et al., *The Demand for Health Insurance Coverage by Low-Income Workers: Can Reduced Premiums Achieve Full Coverage?*, 32 HEALTH SERV. RES. 453, 464–66 (1997) (estimating that about 10% of low-income workers remain uninsured, even if the employer charges no premium and the worker has no other source of coverage); Philip F. Cooper & Jessica Vistnes, *Workers' Decisions to Take-up Offered Health Insurance Coverage: Assessing the Importance of Out-of-Pocket Premium Costs*, 41 MED. CARE III-35, III-42 (2003) (finding results similar to Chernew et al., but, due to data limitations, unable to exclude workers with outside sources of insurance).

uninsured.[268] The authors offered several possible explanations for this finding. One possibility was that these individuals preferred to remain uninsured. While this preference could be irrational, for example due to the belief by some of these individuals that they will never need medical care, Chernew et al. also noted that the decision to remain uninsured could also be rational.[269] For instance, some health insurance includes expensive cost-sharing that would not be waived by health care providers, and uninsured low-income individuals might be better off forgoing insurance in favor of low- or no-cost public care for both emergent and non-emergent medical needs.[270] Another possibility was that these individuals could have been deterred by the administrative costs of enrolling or that they lacked sufficient information about the benefits of the insurance and simply skipped coverage.[271] In short, there may be personal and financial factors that could deter an individual's decision to take up coverage, even in the context of group insurance without premium. The study also suggests that group coverage may still present information and administrative barriers that impede coverage by some individuals.

2. *Are Employers Better than Employees at Selecting Health Insurance?*

A second potential consumer benefit is that employers can act as sophisticated and beneficial purchasing agents by selecting health insurance that more closely meets the needs of their employees. Unlike individual market consumers, employers (or their brokers or agents) have more resources to devote to the purchase of health insurance,[272] and, unlike consumers, are not disadvantaged by bounded rationality.[273] Moreover, employers have, at least in theory, an incentive to provide optimal coverage. Because employers vie for employees in a competitive labor market, and because employees are thought to value health

268. Chernew et al., *supra* note 267, at 466.

269. *Id.* at 467.

270. *Id.*

271. *Id.* Indeed, the authors observe that many low-income individuals also forego public benefits, such as food stamps, despite their eligibility, due to barriers such as information deficits or perceived administrative burdens. *Id.* Also, the authors raise the possibility that the 10% uninsured figure could be a statistical artifact. However, they discount this possibility by noting that estimates for coverage of other subsets of individuals in the study were highly accurate. *Id.* at 466–67.

272. *See* Hyman & Hall, *supra* note 11, at 30.

273. *See id.* (noting that employers provide "informational intermediation" for their employees, compensating for their bounded rationality).

insurance coverage, employers face pressure to offer attractive plans; otherwise they risk losing employees to firms that offer more favorable coverage.[274] Perhaps this explains why survey data suggests that most employees are satisfied with their employer's choice of plans.[275]

But there is no evidence to support the notion that employers are superior purchasers of insurance. Moreover, the employer-employee relationship is fundamentally adversarial with respect to compensation and benefits.[276] While the employee benefits from coverage, the employer picks the terms and cost of the insurance benefit. And survey data suggests that employers are more likely to choose a health insurance plan based on their own financial interests rather than on the preferences of their employees.[277]

B. Does Small Group Coverage Benefit Employers?

Do small firm employers benefit from offering health coverage? The answer appears to be "largely, no" with a possible exception for small employers employing high-income workers.

Group coverage is thought to provide two benefits to employers. First, "[e]mployers might benefit from providing health insurance . . . if it allow[s] them to recruit and retain high-quality workers."[278] The assumption underlying this belief is that group coverage provides a better deal than individual coverage—it is less expensive, subsidized by taxes, and accessible without individual underwriting. If true, offering group coverage could help employers attract and retain quality

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274. *See* Jonathan T. Kolstad & Michael E. Chernew, *Quality and Consumer Decision Making in the Market for Health Insurance and Health Care Services*, 66 MED. CARE RES. & REV. 28S, 31S (2009); Pamela B. Peele et al., *Employer-Sponsored Health Insurance: Are Employers Good Agents for Their Employees?*, 78 MILBANK Q. 5, 7 (2000) ("Economists would argue that employers are likely to act effectively as agents because, if they do not, they will ultimately bear the cost of that ineffectiveness in higher total compensation costs and/or greater employee turnover.").

275. *See* Peele et al., *supra* note 274, at 19 (finding that large employers "perform reasonably well as agents for their individual employees in the health insurance market").

276. *See* Brendan S. Maher, *Regulating Employment-Based Anything*, 100 MINN. L. REV. 1257, 1261 (2016).

277. *See Employer Perspectives on the Health Insurance Market: A Survey of Businesses in the United States: Research Highlights*, ASSOCIATED PRESS-NORC CTR. FOR PUB. AFFAIRS RESEARCH, http://www.apnorc.org/projects/Pages/HTML%20Reports/employer-perspectives-on-the-health-insurance-market-a-survey-of-businesses-in-the-united-states-research-highlights.aspx [https://perma.cc/4G45-W5JS] (reporting survey finding that 86% of employers that offer health insurance say the cost to the organization is very or extremely important, while less than 40% said employee preference was important).

278. *See* Ellen O'Brien, *Employers' Benefits from Workers' Health Insurance*, 81 MILBANK Q. 5, 6 (2003).

employees. But to the extent that small group coverage does not provide a better deal than individual coverage to low- and moderate-income workers, there is little reason to think that offering group coverage will help small firms recruit and retain high-quality workers from those groups. Low- and moderate-income workers get a better tax subsidy if they buy individual insurance from an exchange and risk losing the better subsidy if they are offered "affordable" small group coverage.[279] On the other hand, small employers who want to attract and retain higher income workers—those with household incomes over 400% FPL and who get no tax subsidy in the individual market—could benefit from offering group health insurance.

Second, there is thought to be a "business case" for offering group coverage. Offering coverage can improve the employer's bottom line by reducing some employee-related costs. Based on a review of relevant scholarship, however, economist Thomas Buchmueller concluded that offering employer-based health insurance has limited potential to offer four "spillover benefits" to small employers: (1) reduced turnover, (2) lowered workers' compensation costs, (3) reduced absenteeism, and (4) increased productivity.[280] As Buchmueller noted:

> The most promising source of spillover benefits comes from the fact that health insurance is negatively associated with employee turnover. However, the benefit of reducing turnover . . . is likely to be smallest for the types of firms that are least likely to offer insurance—small firms employing less-skilled workers. The scholarly literature provides even less support for the notion that offering health insurance will reduce employers' costs associated with workers' compensation or employee absenteeism. Similarly, the literature gives no reason for employers to expect that offering insurance will cause worker productivity to increase dramatically. Thus, it appears that for the small firms that choose not to offer health benefits, the decision is one that makes sound business sense.[281]

279. *See supra* note 251 and accompanying text.

280. THOMAS C. BUCHMUELLER, THE BUSINESS CASE FOR EMPLOYER-PROVIDED HEALTH BENEFITS: A REVIEW OF THE RELEVANT LITERATURE 18 (2000), https://pdfs.semanticscholar.org/ab68/d2bf7205938d1b6fc2ffa16c75e472302e5b.pdf [https://perma.cc/34BG-4JPB].

281. *Id. But see* O'Brien, *supra* note 278, at 34–35 (arguing that more study is needed).

C. Proposed Improvements to the Small Market: Will They Deliver Group Benefits?

Scholars and policymakers have offered various suggestions to improve the small group market, including regulating or prohibiting stop-loss insurance to reduce small firm self-insurance; promoting the use of an online exchange, such as the Small Business Health Options Program (SHOP) exchange; and merging the small and individual markets.[282] If any of these fixes are implemented, will the small group market deliver group benefits? Will these policy changes help the small group market offer a better deal than the individual market? Probably not. No doubt, these suggested changes, if implemented, could very well improve how the small group market performs. But they are unlikely to transform small group insurance into a better deal for insureds than individual coverage.

1. Restricting Stop-Loss Insurance

Self-insurance was appealing for small firms before the ACA. Self-insured plans were not subject to state insurance laws, including mandated benefits requirements, premium taxes, and consumer protection requirements.[283] The ACA has made self-insurance even more desirable for some firms, especially those with younger and healthier employees, because it can provide lower premiums than a community-rated small group market pool.[284] It also exempts small firms from the ACA's small group market reforms.[285]

To slow the spread of self-insurance by small firms, many have recommended limits on stop-loss insurance.[286] Stop-loss coverage covers the employer's losses above a certain threshold[287] and protects small

282. For a wide-ranging discussion of policy options to "save" the small group market, see Monahan & Schwarcz, *supra* note 9, at 1975–87.

283. *See* Gabel et al., *supra* note 211, at 2037.

284. *Id.*

285. *See* Jost & Hall, *supra* note 9, at 550–52.

286. *See, e.g.*, Gabel et al., *supra* note 211, at 2039 ("To prevent this potential erosion of insurance, states need to reform their stop-loss markets so that stop-loss coverage is not de facto health insurance."); Jost & Hall, *supra* note 9, at 556 (arguing that the federal and state governments should regulate stop-loss coverage to protect the small group market); Monahan & Schwarcz, *supra* note 9, at 1975–77.

287. This is the attachment point, which is the dollar amount where stop-loss insurance begins to pay claims. *See* Jost & Hall, *supra* note 9, at 546.

employers from large claims that could bankrupt the firm.[288] By making stop-loss coverage less attractive or available to small firms, the number of small firms choosing to self-insure could decrease,[289] possibly reducing adverse selection against the small group market. But regulation of stop-loss will not solve the small group market's adverse selection problem. If a small firm is denied the ability to buy stop-loss insurance (or denied the amount of stop-loss insurance it wants), it can still select against the small group market by self-insuring anyway (at greater risk) or by opting out of coverage completely. Moreover, restricting stop-loss coverage will not transform small group coverage into a better deal than individual coverage by lowering administrative costs, increasing access, or altering existing tax subsidies.

2. Promoting SHOP Exchanges

SHOP exchanges are online marketplaces through which small employers can provide coverage to their employees. SHOP exchanges were designed to provide, among other things, administrative services to small firms.[290] Most small firms use brokers and those brokers provide many administrative services to small firms,[291] driving up the cost of coverage. Since the SHOP exchanges were expected to perform many of the same administrative functions at a lower cost, they were anticipated to be a less expensive alternative to brokers.[292] This is one of the reasons advocates have argued for increased use of SHOP exchanges. In addition, some small firms using SHOP exchanges are also eligible for a temporary tax credit.[293] But there are two impediments to reaping the benefits of the SHOP exchanges.

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288. Monahan & Schwarcz, *supra* note 9, at 1966 ("In the absence of [stop-loss] coverage, a single employee or employee family member becoming very sick could jeopardize a small employer's business.").

289. *Id.* at 1975 ("[M]aking stop-loss insurance less available to small employers . . . could decrease the attractiveness of self-insurance for these employers."). Of course, some small firms might continue to self-insure without stop-loss, ultimately relying on the bankruptcy process should they be unable to pay employee claims.

290. *See* Gabel et al., *supra* note 211, at 2033.

291. *See id.* at 2038.

292. *See id.* ("The SHOP exchanges will perform many of the same functions [as brokers], and with superior technology and economies of scale they will be able to do so at a lower cost than brokers can offer.").

293. *See id.* at 2033, 2036.

First, the SHOP exchanges have not worked out as planned. Enrollment has been disappointing[294] and few small firms have taken advantage of the tax break, for multiple reasons, including its short two-year duration, the significant costs and complexities required to claim the tax credit, and the small size of the credit.[295] As a result, the Centers for Medicare & Medicaid Services has ended the federal SHOP exchanges,[296] which operated in thirty-three states.[297] SHOP exchanges, however, are not dead. More than a dozen states still operate SHOP exchanges. But there is a catch when trying to get small firms to the SHOP exchanges. This is the second problem. Brokers remain a major source of information and guidance for small firms. To be successful, SHOP exchanges have to rely on brokers to drive them business. But brokers will not do so if they lose commissions by sending small employers to the SHOP.[298] This creates a *Catch-22* of sorts: administrative costs can be lowered in the SHOP exchanges, but small firms are unlikely to go to SHOP exchanges unless brokers earning high commissions bring small employers to the SHOP exchanges.

3. Merging the Small and Individual Markets

The ACA gives states the ability to merge their individual and small group health insurance markets.[299] But this option would not combine all aspects of these markets. Instead, there would only be a merger of the small group and individual market risk pools.[300] This would create a

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294. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-15-58, SMALL BUSINESS HEALTH INSURANCE EXCHANGES: LOW ENROLLMENT LIKELY DUE TO MULTIPLE, EVOLVING FACTORS 20–22 (2014), https://www.gao.gov/assets/670/666873.pdf [https://perma.cc/25GR-HPMR].

295. *See* JAMES R. MCTIGUE, JR., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-16-491T, SMALL EMPLOYER HEALTH TAX CREDIT: LIMITED USE CONTINUES DUE TO MULTIPLE REASONS 5–10 (2016), https://www.gao.gov/assets/680/675969.pdf [https://perma.cc/Z5RT-5D45].

296. CTRS. FOR MEDICARE & MEDICAID SERVS., THE FUTURE OF THE SHOP: CMS INTENDS TO ALLOW SMALL BUSINESSES IN SHOPS USING HEALTHCARE.GOV MORE FLEXIBILITY WHEN ENROLLING IN HEALTHCARE COVERAGE (2017), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/The-Future-of-the-SHOP-CMS-Intends-to-Allow-Small-Businesses-in-SHOPs-Using-HealthCaregov-More-Flexibility-when-Enrolling-in-Healthcare-Coverage.pdf [https://perma.cc/UFP5-LVYA].

297. *See* Timothy Jost, *CMS Announces Plans to Effectively End the SHOP Exchange*, HEALTH AFF. BLOG (May 15, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170515.060112/full/ [https://perma.cc/4EJP-FAR3].

298. Jon R. Gabel et al., *An Early Look at SHOP Marketplaces: Low Premiums, Adequate Plan Choice in Many, but Not All, States*, 34 HEALTH AFF. 732, 739 (2015).

299. 42 U.S.C. § 18032(c)(3) (2012).

300. JILL S. HERBOLD, MILLIMAN, MERGING THE INDIVIDUAL AND SMALL GROUP MARKETS 1 (2011), https://www.in.gov/healthcarereform/files/Merge_Ind_SG.pdf [https://perma.cc/89NC-

larger and more stable risk pool for the purpose of projecting future rates, but a larger risk pool will not stop small group adverse selection, reduce small group high administrative costs, increase access, or alter existing tax subsidies. In short, a merged risk pool would do nothing to improve the small group market's ability to provide a better insurance deal than the individual market.

D. Who Wins and Who Loses if the Small Group Market Dies?

The demise of the small group market would yield two big winners: the individual market and insurers who sell in that market. First, the individual market is the most logical landing spot for the 14.7 million people with small group coverage. While it is unlikely that all 14.7 million customers would shift to the small group market, the millions that would move to the individual market would make the that market larger, more stable, and less susceptible to rate fluctuations. Second, insurers in the individual market could benefit from the potential for greater profits from a larger customer base and more stability in the market.

The biggest losers would be the insurance companies (and their brokers and agents) that sell small group coverage, and households insured through the small group market with incomes above 400% FPL. Despite the market's declining enrollment, insurers in the small group remain profitable.[301] If the small group market were allowed to decline and die, those insurers (and their brokers and agents) would lose a profitable line of business. Additionally, households insured through the small group market with incomes above 400% FPL would be losers if those households had no other access to group coverage. If forced into the individual market, those households would lose their group tax subsidy and be ineligible for exchange subsidies. They would pay much more for their insurance. Yet if Congress wanted to maintain a tax benefit for these households, it could do so by allowing small employers to reimburse their employees for individually purchased health insurance

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8RE8] (observing that the ACA's merger provision "means that individual premium amounts and small group premium amounts are based on the combined health cost experience of the small group and individual risk pools. This does not automatically require health benefit plans and premium amounts in the individual and small group markets to be the same.").

301. *See* Tammy Tomczyk & Peter Kaczmarek, *New Analysis: Enrollment and Profitability Trends in the Individual and Small-Group Markets*, OLIVER WYMAN HEALTH (Sept. 8, 2016), http://health.oliverwyman.com/maximize-value/2016/09/new_analysis_enroll.html [https://perma.cc/8NLL-E2W2] (reporting that small group insurers continue to be profitable, though profits have been declining).

with pre-tax dollars, as they had been allowed to do prior to the ACA.[302] Indeed, federal law does permit some small employers without group health coverage to reimburse employees for individual health insurance premiums, but only under limited circumstances.[303]

CONCLUSION

Group insurance has long been the dominant vehicle for delivering health insurance in this country. The reason for that dominance was simple: group health coverage offered insurance buyers a better deal than the individual market. Prior to the ACA, this better deal was true for small group coverage, despite the adverse selection problems and volatility of the small group market. The ACA, however, altered this calculation by changing the nature of the individual market. As a result, the small group market no longer offers a better deal than the individual market with respect to three of the four core benefits of the group model: reduced adverse selection, lower administrative costs, and increased access to coverage. With respect to the fourth benefit, tax subsidies, there is a split. Although the small group market continues to deliver the tax benefits it did before, low- and moderate-income households will get a better tax subsidy in the individual market. Households above 400% FPL, which are excluded from subsidies in the individual market, will do better in the small group market.

Of course, additional dismantling of the ACA will alter this analysis. But if the ACA remains in place, one thing seems clear: absent further intervention, the small group market will continue to decline. The findings in this Article suggest that scholars, legislators, and policymakers should respond carefully to the problems of the current

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302. Beginning in 1961, employees were allowed to purchase their own insurance and then seek reimbursement in pre-tax dollars from their employer. Rev. Ruling 61-146, 1961-2 C.B. 25. This came to an end under the ACA. I.R.S. Notice 2015-17 (April 6, 2015) (noting in Guidance Answer 1 that arrangements under which an employer reimburses an employee for premium expenses incurred for an individual market health insurance policy fail to comply with the ACA market reforms and may subject the employer to an excise tax under I.R.C. § 4980D (2012)); I.R.S. Notice 2013-54 (Sept. 13, 2013) (stating in Guidance Answer 1 that employer payment plans that reimburse employees for individual market health insurance premiums fail to meet required ACA market reforms for group health plans).

303. Small employers can provide tax-favored reimbursements to employees for the purchase of individual health insurance by setting up a "qualified small employer health reimbursement arrangement" (QSEHRA) that meets specific criteria. The employer must not offer group health coverage to any of its employees, the QSEHRA must be offered to all full-time employees, no salary reductions are permitted, and annual employer contributions are capped at $4,950 for a single individual or $10,000 for a family, subject to indexing. I.R.C. § 9831(d) (West 2012 & West Supp. IV 2016); I.R.S. Notice 2017-67 (Oct. 31, 2017).

small group market and ask: What benefits does the small group market offer and what would the health insurance landscape would look like if no further efforts to prop up the small group market were taken?