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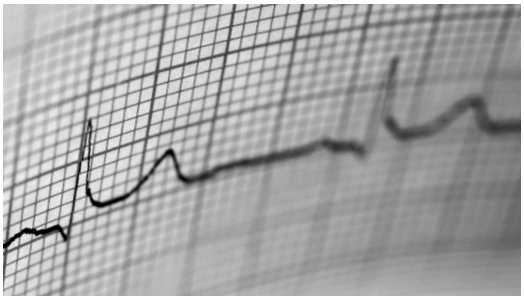
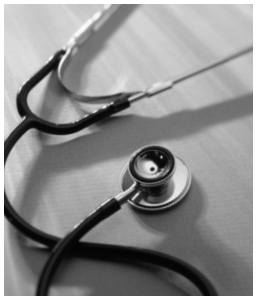
Larger Small Groups: Challenges to Bolstering New York's Small Group Market



AN ISSUE BRIEF



United Hospital Fund

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Larger Small Groups: Challenges to Bolstering New York's Small Group Market

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Introduction

A recent Fund issue brief[1] examined the impact of an Affordable Care Act (ACA) provision expanding the small group market in 2016 from firms with 1–50 employees to firms with 1–100 employees, and looked at options available to New York policymakers putting this rule into effect. We concluded that, while some lower-risk groups would be disadvantaged, bringing in these larger small groups could improve the small group market as a whole, depending on how the provision was implemented. In this follow-up issue brief, we examine the implementation of the ACA small employer redefinition in the broader context of recent trends in New York's small group market and regulatory gaps that could undercut the potential benefit of the change.

The new ACA small employer definition requires recalculating premiums for groups with 51–100 employees using community rating rules, in which rates vary only with family size and region, rather than experience rating rules, which use age, gender, and type of business to calculate premiums. On balance, the evidence suggests that implementing this change could have a beneficial effect on the 1–50 employee segment, since it would create a larger and slightly healthier risk pool that is more capable of spreading risk; however, it would also trigger premium increases in the 51–100 employee segment, particularly for lower-risk groups. Allowing these lower-risk groups to renew their current coverage, as permitted by federal "transition relief" rules, might delay those premium increases; however, it could also lead to increased premiums in the current 1–50 segment,[2] at least temporarily, via a phenomenon known as adverse selection.[3]

Preventing adverse selection—the concentration of higher-risk groups or individuals in a particular market segment or product that can drive higher premium increases over time—is an important goal for policymakers, a key responsibility for regulators, and a difficult challenge, given the porous nature of health insurance markets. A landmark analysis[4] mapping the unique "geography of insurance regulation" described how regulation invariably creates incentives for groups seeing an opportunity for a better deal to shift from one segment to another, aptly described in the analysis as "border crossings." Such shifts might take the form of small groups obtaining coverage in the large group market, or employer groups moving from the fully insured market to a self-insured arrangement. The ACA's small employer definition change is an example of a market reform that might trigger a move by employers to seek or retain a more favorable coverage arrangement.

[1] Newell P. March 2015. *Larger Small Groups: Implementing the New ACA Small Employer Definition in New York*. United Hospital Fund. Available at www.uhfnyc.org/publications/881037 (accessed April 3, 2015).

[2] Ibid.

[3] American Academy of Actuaries. March 2015. *Potential Implications of the Small Group Definition Expanding to Employers with 51–100 Employees*. Available at www.actuary.org/files/Small_group_def_ib_030215.pdf (accessed April 3, 2015).

[4] Hall MA. March 2000. The Geography of Health Insurance Regulation. *Health Affairs* 19(2): 173–184. Available at content.healthaffairs.org/content/19/2/173.full.pdf (accessed April 3, 2015).

Opting Out of the Fully Insured Market for Self-Insured Coverage

About 47 percent of New York employees in the private sector were enrolled in self-funded plans in 2013,[5] under which the employer group accepts risk for employees' medical claims rather than purchasing coverage, hires an insurer or other entity to administer claims, and sometimes purchases "stop-loss" insurance to guard against the catastrophic claims of a particular employee or the group as a whole. Even before the ACA, self-funding offered many advantages for business owners, such as freedom from state benefit requirements, savings from avoided premium taxes, and, potentially, better control over cash flow and income. Instead of paying a monthly premium to a health plan, the self-funded employer group can achieve savings in those months when claims are less than anticipated, and through investment income on funds reserved for future claims payments. Many ACA provisions increase the incentives to self-insure, and the small group redefinition will have a direct impact on many smaller employers.

Self-funding is much more common among larger employer groups than smaller ones. A federal survey[6] shows that 75 to 79 percent of New York employer groups with 500 or more employees offered at least one self-funded plan between 2010 and 2013, while 12 to 17 percent of New York private-sector firms with less than 100 employees did so during the same period. While this rate of self-funding for smaller groups may be overstated,[7] the adverse selection to the insured market that might result from shifts to the self-funded market has been a major focus of federal policymakers, regulators, and market analysts.[8] These concerns echo New York's efforts to address the problem in its own major market reform in 1992, the Community Rating and Open Enrollment law,[9] highlighted in a later report that it commissioned following the passage of the ACA (known as the HMA report).[10]

In fully insured coverage, an employer group pays a premium to a health insurer, who accepts the risk for the medical claims of employees and dependents covered under the policy. As we have discussed, under a self-funded arrangement, the employer group retains that risk for medical

[5] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2013 Medical Expenditure Panel Survey-Insurance Component (MEPS-IC). Table II.B.2.b.(1)(2013) Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and state: United States, 2013.

[6] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2010 to 2013 Medical Expenditure Panel Survey-Insurance Component. Table II.A.2.a (2010, 2011, 2012 and 2013) Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and state: United States. Available at meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2 (accessed April 3, 2015).

[7] In 2012 and 2013, MEPS-IC Table II.A.2.a, cited in the preceding note, shows groups of less than 50 with higher or equal rates of self-insurance than groups of under 100 workers. A recent survey of small businesses by the National Federation of Independent Businesses (NFIB), found firms employing 20–49 people self-funded in 7 percent of cases, and those employing 50–100 people in 13 percent of cases. The survey by NFIB (available at www.nfib.com/portals/0/pdf/allusers/research/studies/ppaca/nfib-aca-study-2013.pdf) also found that 4 percent of respondents say a switch to the self-insured market was highly likely in the next 12 months, with another 7 percent calling it "somewhat likely." A Rand Corporation study for the U.S. Department of Labor estimated that about 7 percent of employer groups with 3–49 workers offered self-insured plans as an option, and 11 percent of firms with 50–199 employees did so. See Eibner C, F Girosi, et al. 2011. *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)*. Technical Report by the Rand Corporation for the U.S. Department of Labor. Available at http://aspe.hhs.gov/health/reports/2011/LGHPstudy/EmployerSIDACA.pdf (accessed April 3, 2015).

[8] For a thorough bibliography of recent articles on self-funding and the ACA, see appendix C of *Stop-Loss Insurance, Self-Funding and the ACA*, a draft of a white paper by the National Association of Insurance Commissioners from August 16, 2014, available at www.naic.org/documents/committees_b_erisa_exposure_140908_stop_loss_white_paper_draft.pdf (accessed April 3, 2015).

[9] Chapter 501 of the Laws of 1992, Community Rating and Open Enrollment Law.

[10] Davis C, J Kent, et al. December 2012. *New York Insurance Markets and the Affordable Care Act*. New York State Department of Health. Available at www.healthbenefitexchange.ny.gov/resource/new-york-insurance-markets-and-affordable-care-act (accessed April 3, 2015).

claims, and the arrangement is not subject to state insurance law requirements related to mandated benefits and consumer protections. Smaller employer groups can protect themselves from unusually high claims expenses, however, by purchasing a "stop-loss" policy from an insurer licensed to sell this product, classified as accident and health insurance in New York. These policies typically include "attachment points" or limits for claims of an individual (specific limit) or the group as a whole (aggregate limit) that function much like a deductible. Until these limits are reached for an individual or the group, the employer group is responsible for the claims; after the limit is reached, the stop-loss insurer, which carefully underwrites each employer group it covers, repays the employer group for the claims.

The proper "attachment point"—the threshold that marks where the employer group's responsibility for claims ends and where stop-loss coverage begins—has been the focus of ACA analyses on guarding against adverse selection. If the attachment point is too low, it will not represent a risk transfer but instead mimic a fully insured policy with a high deductible. There is an emerging consensus that the availability of this type of coverage could lead to adverse selection in the 1–50 employee market segment, since these arrangements will naturally be more appealing to lower-risk groups if the alternative is community rating.[11]

Through their review of policy forms submitted by insurers,[12] New York regulators have set an effective specific minimum attachment point of $25,000 for new stop-loss coverage and $20,000 for renewals. California adopted legislation in 2013 increasing its minimum attachment point to $35,000 in 2014 and $40,000 in 2016, but exempted policies in effect prior to September 1, 2013.[13] A working group of the National Association of Insurance Commissioners recently recommended that states raise the minimum individual attachment point to $60,000 from the $20,000 minimum established in 1995, based on an actuarial analysis it commissioned.[14] Although the change recommended by the work group has not been formally adopted, a recent study[15] modeled the impact of four differing minimum attachment points, ranging from $60,000 to $0, on the behavior of employer groups with 100 or fewer workers; it found that, without the higher minimum stop-loss attachment points, "coverage in fully insured small group insurance will be substantially lower and premiums will be significantly higher."

New York's stop-loss statute is silent on minimum attachment points, but the statute could be amended or the minimum could be increased administratively by the superintendent of the New York State Department of Financial Services (DFS), who enjoys broad authority under the statute.[16]

[11] See, for example, Gabel JR, H Whitmore, et al. November 2013. Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self Insurance. *Health Affairs* 32(11), available at content.healthaffairs.org/content/32/11/2032.short; Linehan K. December 21, 2010. *Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market*. National Health Policy Forum. Issue Brief No. 840. The George Washington University, available at www.nhpf.org/library/issue-briefs/IB840_PPACASmallGroup_12-21-10.pdf; Caslyn M and E Lee. June 19, 2013. *The Threat of Self-Insurance Plans Among Small Businesses*. Center for American Progress, available at www.americanprogress.org/issues/healthcare/report/2013/06/19/65790/the-threat-of-self-insured-plans-among-small-businesses/; Jost T and MA Hall. November 26, 2013. Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options. *NYU Annual Survey of American Law*, Vol. 685:539.

[12] Personal communication with the New York State Department of Financial Services, July 9, 2014.

[13] Chapter 443 of the Laws of California, 2013. Senate Bill No. 161. Available at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB161 (accessed April 3, 2015).

[14] O'Connor JF and EC Huth. May 2012. *Statistical Modeling and Analysis of Stop-Loss Insurance for Use in NAIC Model Act*. Available at www.naic.org/documents/committees_b_erisa_millman_naic_final_report.pdf (accessed April 3, 2015).

[15] Buettgens M and LJ Blumberg. November 2012. *Small Firm Self-Insurance Under the Affordable Care Act*. The Commonwealth Fund, Publication 1647, Vol. 30. Available at www.commonwealthfund.org/publications/issue-briefs/2012/nov/small-firm-self-insurance (accessed April 3, 2015).

[16] New York Insurance Law, section, 4237-a(e) notes that "The superintendent may promulgate such rules and regulations he deems necessary or desirable to establish financial requirements and standards for the form and content of stop-loss insurance policies authorized by this section."

Separate from a possible change to the minimum attachment point, another measure that has effectively safeguarded against the migration of small groups from the fully insured market to self-funding arrangements becomes more important with the small group redefinition. A 1992 provision[17] barring licensed insurers from selling small groups stop-loss coverage—adopted when New York approved its own landmark market reforms—now applies to groups of 1–100 employees because of the 2013 law increasing the small group size and making additional ACA conforming changes.[18] A pending bill,[19] however, would repeal this provision for groups of 51–100 employees. Adopting this legislation, intended to "preserve the existing stop-loss market for groups of 51–100 employees," would likely lead to increased premiums for the 1–50 segment, since it would allow sales of stop-loss coverage (with low minimum attachment points) to groups of 51–100 employees, thereby facilitating self-funding and making it easier for larger small groups to leave the small group market. The HMA report also stressed the importance of maintaining this safeguard with the adoption of the new small group definition.

Recent developments in "captive insurance" pose another challenge for policymakers and regulators in the self-funded arena. Captive insurers, insurance subsidiaries owned by and insuring only the risks of its owner or group of owners, came to prominence in the mid-1980s. Often licensed in offshore jurisdictions such as Bermuda or the Cayman Islands, or in states with less stringent regulatory requirements (e.g., Vermont), captives typically provided liability coverage but have now ventured into health benefits as well.[20] There is anecdotal evidence of a growing New York market presence. Promotional materials for one company making a mark in New York[21] pitch fully insured employer groups with 50–300 employees (and brokers in this market segment) on the benefits of a group captive arrangement, in which the captive insurer owned by member employer groups provides a middle layer of stop-loss coverage between each employer group's own claims exposure, and a conventional stop-loss policy purchased from an insurer. The group captive structure is a significant development in the long-running effort by states, with one hand tied behind their backs due to ERISA preemption issues, to limit adverse selection in the small group market.

Expanding the current prohibition on stop-loss sales from insurers to other licensees within state jurisdiction (such as brokers who arrange the group captive transactions), refining the definition of stop-loss coverage, or increasing minimum attachment points are options for policymakers to consider to shore up current limitations on the availability of stop-loss coverage to small groups.

[17] New York State Insurance Law, section 4317(e).

[18] Chapter 56 of the New York Laws of 2013. See New York Insurance Law sections 3221(h) and (i) and section 4317(a)(1).

[19] S.2366/A.1154 of 2015, bill text and sponsor's memorandum in support available at open.nysenate.gov/legislation/bill/S2366-2015 (accessed April 3, 2015).

[20] See, for example, Giles P. 2010. The Viability of Using Group Captives for Medical Benefits. *BNA, Inc. Pensions and Benefits Reporter*, available at www.captive.com/docs/default-source/sponsor-documents/the-viability-of-using-group-captives-for-medical-benefits.pdf?sfvrsn=15; O'Donnell G. 2008. *Employee Benefit Captives. Their Role in Managing Enterprise Risk*. Aon Consulting, available at www.aon.com/about-aon/intellectual-capital/attachments/human-capital-consulting/Benefits_Captives_041608.pdf; Wocjik J. September 4, 2011. Group Captives Help Firms Tackle Health Benefits Funding Issues. *Business Insurance*, available at http://www.businessinsurance.com/article/20110904/NEWS05/309049993 (all links accessed April 3, 2015).

[21] Background information for Pareto Captive Services is available at www.paretocaptive.com/index.php, and an explanation of the arrangement is available at www.paretocaptive.com/for-employers-how-it-works.php (accessed April 3, 2015).

Moving to Different Risk Pools Within the Fully Insured Market

The migration of fully insured business to self-funded coverage is one concern with the small group redefinition, but movement is also common within the fully insured market; differing premiums and rate-setting rules create incentives for individuals to move to group coverage, and for smaller groups to move to large group coverage. New York's community rating law included limitations on the ability of "associations" to aggregate individuals and obtain group coverage, and preventing larger groups from "cherry-picking" lower-risk small groups.[22] Some association plans were grandfathered in, and others were later given special exemptions,[23] but ACA rules adopted by New York[24] limit these types of arrangements. New York insurance regulations allow and in some ways encourage such structures, however. The NY44 Health Benefits Plan Trust[25] organizes health benefits for over 14,000 covered lives among 50 participating schools, districts, boards of cooperative educational services, and community colleges. The Greater Tompkins County Municipal Health Insurance Consortium, created pursuant to New York's Municipal Cooperative statute,[26] covers over 5,000 workers and dependents in 15 municipalities.

The trust, cooperative, and similar mechanisms are examples of government entities joining together to achieve efficiencies in order to control health care costs; another mechanism drawing scrutiny is the professional employee organization (PEO), also known as an employee leasing firm. In this arrangement, small and medium-sized businesses sign "co-employment" agreements with the PEO in exchange for payroll administration, human resources, and other services, as well as liability, workers compensation, health insurance, or other benefits under policies covering all employers that are part of the group. New York State Labor Law provisions adopted in 2002 provide for limited reporting requirements for PEOs and exempt these entities from small group rating rules.[27]

While PEOs provide smaller employers with important services and benefits to help run their businesses, there are concerns about whether these arrangements skirt existing prohibitions on cherry-picking lower-risk groups. In a recent article on a PEO's announcement of a new agreement with a New York City health plan, executives touted the benefits of the arrangement. "The companies we work with tend

[22] New York Insurance Law, sections 4317(d)(1) and (2) and 4317(e)(2).

[23] A demonstration program for independent workers through the Freelancers Union that provided an experience rate for the group was authorized in 2009 but expired in 2014, pursuant to Chapter 203 of the Laws of 2013.

[24] New York Insurance Law, sections 3231(g) and 4317(d).

[25] Background information on the NY44 Health Benefits Plan Trust is available at http://www.ny44.e1b.org/domain/3 (accessed April 3, 2015).

[26] Background information on the Greater Tompkins County Municipal Health Benefit Cooperative is available at http://tompkinscountyny.gov/hconsortium (accessed April 3, 2015).

[27] New York State Labor Law section 918 provides for registration by PEOs, and subdivision 7 of section 922 provides for the exemption. Text of law available at http://www.labor.ny.gov/formsdocs/wp/Article%2031.pdf (accessed April 3, 2015).

to be younger, tend to be healthier, so economically it's very attractive [for insurers]," said the company spokesman, asserting savings for participating small businesses of $200 to $300 per month per employee.[28] A national trade association for PEOs reports strong growth,[29] and more than 250 PEOs are currently registered with the New York State Department of Labor.[30] Legislation considered in 2013 along with the conforming ACA changes[31] would have repealed the PEO exemption but was not adopted.

New York's Eroding Small Group Market

The ACA preserves the existing employer-based coverage system, but employer responsibility provisions[32] require large employers to either provide coverage that meets ACA minimum requirements or pay assessments to offset the cost of employees covered through public Exchanges. These requirements do not apply to businesses with 50 or fewer employees, however. Another way that small group risk pools may diminish was unheard of in the pre-ACA era: the migration of individuals covered under small group policies to the individual market when an employer group decides to terminate coverage, sometimes known as "employer dumping."

In most states, permitted underwriting limited that option, and in New York, prohibitively costly premiums did. But, with premium and cost-sharing subsidies now available, some employers have decided that their workers, particularly lower-wage ones, get a better deal in the Exchange than by contributing their 20 or 25 percent share to employer-sponsored coverage.[33] The extent of this trend will become clearer when health plans report enrollment for 2014 later this year, but national evidence suggests the trend is taking hold. Anthem BCBS reported a drop of 300,000 in small group enrollment in the first three quarters of 2014 nationally,[34] a trend it expects to play out for the next five years. In this transition, company officials discussed the importance of "catchers"—a net of competitively priced individual products designed to catch former small group members when they drop out of that market, with the goal of offsetting declining small group enrollment through increased individual enrollment. One factor that might affect this trend is evolving federal rules on the tax treatment of pretax employer contributions for workers to help them buy

[28] Crain's. February 12, 2015. Empire Deal. *Crain's Health Pulse*.

[29] Background information on PEOs can be found at the National Association of Professional Employer Organizations, available at www.napeo.org (accessed April 3, 2015).

[30] A list of currently registered PEOs in New York is available at www.labor.ny.gov/workerprotection/laborstandards/employer/peo.shtm (accessed April 3, 2015).

[31] Executive Budget Proposal, Fiscal Year 2013–14. Health and Mental Hygiene Article VII bill, section 70, p. 237, available at www.budget.ny.gov/pubs/archive/fy1314archive/1314archive.html (accessed April 3, 2015).

[32] Internal Revenue Service. February 18, 2015. Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act. Available at www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act (accessed April 3, 2015).

[33] See, for example, Hancock J. December 15, 2014. Small Businesses Drop Coverage as Health Law Offers Alternatives. *Kaiser Health News*, available at kaiserhealthnews.org/news/small-businesses-drop-coverage-as-health-law-offers-alternatives/; Cowley S. December 11, 2013. Dropping Health Plans, to Pick Better Coverage. *The New York Times*, available at www.nytimes.com/2013/12/12/business/smallbusiness/changing-the-health-insurance-equation-for-small-employers.html (accessed April 3, 2015).

[34] WellPoint's (WLP) CEO Joe Swedish on Q3 2013 Results—Earnings Call Transcript. October 29, 2014. Available at seekingalpha.com/article/2610925-wellpoints-wlp-ceo-joe-swedish-on-q3-2014-results-earnings-call-transcript?page=1 (accessed April 3, 2015; registration required).

individual coverage. The IRS recently postponed the scheduled imposition of a tax penalty on employers who maintained these arrangements.[35]

Over 28,000 firms employing about 2.5 million workers fall into the current small group category (1–50 employees) in New York.[36] Offer rates by New York employers of this size dropped from 54 percent in 2000 to 44 percent in 2013,[37] and we estimate that enrollment in New York's 1–50 employee segment, about 1.8 million in 2006,[38] will decrease to about 1.3 million in 2016.[39] In addition to the declining enrollment, some health plans have limited their participation in the market in recent years due to mounting financial losses in the market,[40] as regulators seek to restrain annual rate increases.

New York's experience tracks national trends, so it is no surprise that bolstering the small group market was a focal point of the ACA. In addition to the larger small group size, the ACA provided an immediate premium tax credit for very small employers with lower-wage workers and a special small group Exchange, or SHOP, that eases administrative burdens for small employers, simplifies comparisons, and expands choices. But takeup of the tax credit has been disappointing nationwide.[41] Even in New York, which fully implemented all SHOP provisions (unlike states with federal exchanges), enrollment has fallen far short of projections, similar to the national experience.[42]

[35] U.S. Internal Revenue Service Notice 2015-17, available at www.irs.gov/pub/irs-drop/n-15-17.pdf (accessed April 3, 2015).

[36] New York State Department of Labor, Division of Research and Statistics, Office of Statistics, data on employment in the fourth quarter of 2013, based on the Quarterly Census of Employment and Wages.

[37] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2013 Medical Expenditure Panel Survey-Insurance Component. Table II.A.2 (2000 and 2013) Percent of private sector establishments that offer health insurance by firm size and state: United States. Available at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=2 (accessed April 3, 2015).

[38] Gorman Actuarial, LLC. October 2008. *Merging the Markets: Combining New York's Individual and Small Group Markets into Common Risk Pools*. United Hospital Fund. Available at www.uhfnyc.org/publications/711071 (accessed April 3, 2015).

[39] Newell P. March 2015. *Larger Small Groups: Implementing the New ACA Small Employer Definition in New York*. United Hospital Fund. Available at www.uhfnyc.org/publications/881037 (accessed April 3, 2015). See Appendix, pages 13–14.

[40] Newell P and A Baumgarten. May 2014. *The Big Picture V: New York's Private and Public Insurance Markets, 2012*. United Hospital Fund. Available at www.uhfnyc.org/publications/880980 (accessed April 3, 2015).

[41] U.S. Government Accountability Office. May 2012. *Small Employer Health Tax Credit. Factors Contributing to Low Use and Complexity*. GAO-12-549. Available at www.gao.gov/assets/600/590832.pdf (accessed April 3, 2015).

[42] U.S. Government Accountability Office. November 2014. *Small Business Health Insurance Exchanges: Low Initial Enrollment Likely Due to Multiple Evolving Factors*. GAO-15-58. Available at www.gao.gov/products/GAO-15-58 (accessed April 3, 2015).

Discussion and Policy Considerations

New York policymakers and regulators face many challenges in implementing the ACA expanded small group requirements. In addition to the immediate issues explored in our earlier issue brief, decisions on how to address the border crossings to the self-funded market and within the fully insured market add another layer of complexity. Given limitations on state regulation of self-funded plans, tackling issues related to the drain of fully insured coverage to self-insurance options would benefit from federal assistance.

The ACA tiptoed into the regulation of self-insured plans—requiring, for example, that adult children be covered under fully insured *and* self-funded employer-sponsored coverage. ACA "guaranteed issue" provisions, however,[43] provide a fully insured safety net. A self-funded employer group that incurs unsustainable costs through its self-insured plan, or sees the need for more comprehensive benefits, can always return to the fully insured market. While such "remigrations" back to fully insured coverage may be comparatively rare, they might occur more when smaller employers move to self-insurance.

Federal policymakers and regulators are aware of the potential for market disruptions due to self-funding, soliciting data on stop-loss coverage, and commissioning reports on the large group market and self-funding,[44] but they have so far resisted taking a more active role in regulating the self-funded market, despite the various approaches offered by many commentators.[45] Federal regulators could greatly assist states seeking to preserve their small group markets by allowing the assessment of a "reentry fee" to employer groups returning to the fully insured market. The existence of a potential fee would be a factor for employer groups to consider in making coverage decisions, and would help offset adverse claims experience to the small group market when an employer group traded up from a minimum benefit plan with a low actuarial value to the comprehensive coverage available in the small group market, or incurred catastrophic claims experience that makes fully insured, community-rated coverage more affordable.

Within the realm of issues more directly under its control, New York took its first major step in the implementation of the new ACA small employer definition when DFS notified health plans recently that it would not delay the definition as permitted by federal transition relief.[46] There is still a chance that federal regulators may present a new option for states, and decisions remain on many more related questions—including the issue of permitting employer groups to "early renew" coverage for groups of 51-100, legislation to restrict migration of small groups to other fully insured markets

[43] Affordable Care Act, Section 1201 (Public Health Service Act, Section 2702, Guaranteed Availability of Coverage).

[44] Affordable Care Act Section 1253, Annual Report on Self-Insured Plans. See, for example, Brien M and CW Panis. May 23, 2011. *Self-Insured Health Benefit Plans*. Deloitte and Advanced Analytical Consulting Group for the U.S. Department of Labor, available at www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport033113.pdf; Affordable Care Act Section 1254, Study of Large Group Market. See also Eibner C, F Girosi, et al. 2011. *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)*. Technical Report by the Rand Corporation for the U.S. Department of Labor. Available at http://aspe.hhs.gov/health/reports/2011/LGHPstudy/EmployerSIDACA.pdf (accessed April 3, 2015).

[45] Jost T and MA Hall. November 26, 2013. Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options. *NYU Annual Survey of American Law*, Vol.685:539.

[46] New York State Department of Financial Services. March 16, 2015. FAQs for Small Group Expansion to 1–100 Employees. Available at www.dfs.ny.gov/insurance/health/faqs_sm_grp_expansion_1to100.htm (accessed April 3, 2015).

through PEOs or other mechanisms, extending the limitation on sales of stop-loss coverage to groups of 51–100 employees, and the regulatory treatment of the coverage generally, in terms of attachment points, group captives, and other issues.

The decision on transitional relief required weighing the interests of individual employer groups against the potential benefits of a larger, healthier small group market, and the risks of adverse selection to the 1–50 employee segment should lower-risk companies be permitted to renew their existing coverage, and for how long. The second tier of policy and regulatory issues described here also requires this careful balancing, and making decisions about whether to grandfather in existing arrangements, with the risk that the benefits of the larger small group size to smaller employers could be undercut.

Employer groups, aided by advisors serving their clients and entrepreneurs seeking to exploit gaps in regulation, search for the best deal for their businesses and employees, whether it is self-funded coverage, an association plan, a captive arrangement, or a PEO. For health plans, fully insured coverage provides better margins, but administering self-funded coverage counts as covered lives too; some major health plans operate exclusively in the self-funded market, and health insurers compete with each other and with non-insurers for this business. Policymakers and regulators have the added responsibility, however, of taking a longer view, and preserving an insurance market for employer groups that are too small to self-fund, lack the sophistication for complicated arrangements, or cannot afford them. Given recent trends in the small group market and the potential for the loss of additional enrollment to the individual market, the adoption of this longer-term view is critical.

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