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The Impact of the COVID-19 Pandemic and Recent Federal Policies on Small Business Health Insurance

Views from the Market

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Small business owners have long struggled to provide their workers with health insurance. But, relative to large businesses, they face high and often volatile premiums, a lack of market power for negotiating premiums, and high administrative costs associated with covering a small number of workers. These pressures, along with the high and rising prices for medical services, have contributed to a steady decline in the number of small businesses offering coverage, leaving small business employees more likely to be uninsured. With tens of millions of people employed by small businesses in the United States (SBA 2019), federal and state policymakers have pursued strategies to help small employers purchase and maintain affordable health coverage. These strategies, including insurance market reforms, small business tax credits, Small Business Health Options Program (SHOP) marketplaces under the Affordable Care Act (ACA), and the easing of regulatory standards and facilitation of health reimbursement arrangements, have resulted in a market buffeted by dramatic change.

In two previous reports from 2015 and 2017, we examined the effect of federal policy changes on the small-group market in six states (Arkansas, Minnesota, Montana, New Mexico, Pennsylvania, and Vermont) through interviews with market stakeholders, including small employers, insurers, and insurance brokers (Corlette et al. 2017; Lucia et al. 2015). For this brief, we reassess how the COVID-19 pandemic and recent federal health insurance policies have affected the small-group market in the same six states.

About US Health Reform—Monitoring and Impact

With support from the Robert Wood Johnson Foundation, the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. Through the US Health Reform—Monitoring and Impact project, which began in May 2011, Urban researchers are using microsimulation modeling to project the cost and coverage implications of proposed health reforms, documenting the implementation of national and state health reforms, and providing technical assistance to states. More information and publications can be found at www.rwjf.org and www.urban.org.

Background

National Trends in the Small-Group Market’s Offer and Enrollment Rates

Nationally, only 30.8 percent of small firms, which have 50 or fewer employees, offered their workers a group health insurance plan in 2019.¹ Small employers’ offers of health benefits have steadily declined since 2000, when almost 50 percent of small businesses offered their employees insurance.²

The number of small employers that offer health insurance coverage to their employees declined by 17.6 percent from 2011 to 2015 (Corlette et al. 2017). From 2016 to 2019, that trend slightly reversed, and the share of small employers offering coverage rose from 28.6 percent to 30.8 percent. The share of small business employees enrolled in their own firm’s coverage (not a spouse’s coverage) dropped 3.0 percent from 2011 to 2015 (data not shown). That trend continued from 2016 to 2019, when enrollment rates dropped another 2.9 percent (table 1).

TABLE 1

National Trends in Health Insurance Offer and Enrollment Rates among Private-Sector Firms with Fewer Than 50 Employees, 2016–19

	Percent of firms that offer health insurance	Percent of employees enrolled in own firm’s health insurance plan
2016	28.6	55.5
2017	30.2	55.4
2018	29.8	56.2
2019	30.8	53.9
Percent change, 2016–19	7.7	–2.9
Average annual percent change, 2016–19	2.5	–0.9

Sources: 2016–19 Medical Expenditure Panel Survey: Insurance Component, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.

National Trends in Small-Group Market Premiums

Premium increases for small-group market coverage slowed between 2011 and 2015, compared with such trends in the five years before the ACA was enacted. Premiums in the small-group market have historically aligned with trends in national health expenditures (Martin et al. 2017). From 2016 to 2019, however, premium increases in the small-group market were more akin to pre-ACA levels, rising an average of 4.5 percent per year for single workers and 5.6 percent per year for family coverage (table 2).

TABLE 2

National Trends in Health Insurance Premiums for Private-Sector Firms with Fewer Than 50 Employees, 2016–19

	Single total premium	Family total premium
2016	\$6,070	\$16,471
2017	\$6,421	\$17,649
2018	\$6,667	\$18,296
2019	\$6,920	\$19,417
Percent change, 2016–19	14.0	17.9
Average annual percent change, 2016–19	4.5	5.6

Sources: 2016–19 Medical Expenditure Panel Survey: Insurance Component, available at https://meps.ahrq.gov/survey_comp/Insurance.jsp.

Reforms to the Small-Group Insurance Market

The ACA required several changes to the design and marketing of health insurance products sold to small employers, and most were implemented in 2014. Such changes included requirements that insurers cover a minimum set of essential health benefits, cap enrollees' annual out-of-pocket expenses, and waive cost sharing for certain preventive services. Insurers were also barred from using an employee group's health status to determine premiums and from imposing waiting periods on workers with preexisting conditions.³

The ACA also established a state-level SHOP to serve as a health insurance marketplace for small employers. In the early years, employers enrolling through the SHOP could access tax credits to offer health insurance, but those tax credits are no longer available. Additionally, the SHOP was intended to allow employees to choose from multiple insurers and plan options instead of just one, as is common in the traditional small-group market. Despite SHOP marketplaces' initial tax credits and the option for employees to choose among a range of insurers and plans, few small employers have shown interest in SHOP marketplaces. Insurers have also been largely unwilling to participate in the SHOP. However, a few states, such as California, Massachusetts, and New Mexico, have made investments to develop and market their SHOPS to the small business community and have reported resulting enrollment gains.⁴

The insurance reforms required by the ACA had a limited early impact on premiums and on the number of employers offering insurance (Corlette et al. 2017). However, ACA provisions and early

decisions by federal regulators to allow employers to retain pre-ACA policies (called “grandfathered” and “grandmothered” plans), combined with new self-funded plans designed for small employers, expanded the coverage options available, particularly for people with a relatively healthy risk profile.

In 2016, Congress created qualified small employer health reimbursement arrangements (HRAs) to enable small employers to drop their group health plans and use an HRA to help fund employees’ premiums for health insurance plans on the individual market. However, we found limited awareness of these new products in 2017, and many who were familiar reported the products were too complex to administer (Corlette et al. 2017). In 2019, federal regulators created yet another type of HRA, an individual coverage HRA.⁵ This HRA is similar to the qualified small employer HRA but is available to broader set of employers and lacks some of the qualified small employer HRAs’ limits, such as a cap on employer contributions. Individual coverage HRAs first became available to small business owners in January 2020 (table 3).

Federal regulators attempted to create an additional coverage option for small employers in 2018 by relaxing standards for multiple employer welfare arrangements (MEWAs), often referred to as “association health plans.”⁶ In particular, the new federal standards would have allowed self-employed individuals and small employers to jointly qualify as a single large group under the Employee Retirement Income Security Act. In doing so, these groups would be regulated as large-group coverage, exempt from many ACA requirements that apply to the small-group market. However, several state attorneys general successfully sued to enjoin the policy, meaning association health plans created under the more relaxed 2018 rules have been prohibited from being marketed to individuals or small employers.⁷

In March 2021, Congress enacted the American Rescue Plan Act in response to the pandemic.⁸ The bill included an increase in premium tax credits for ACA Marketplace plans and a 100 percent premium subsidy for individuals enrolled in continuation coverage through a former employer (known as COBRA coverage). The COBRA subsidies are available between April 1 and September 30, 2021, whereas the enhanced ACA premium tax credits will be available through 2022. Notably, the American Rescue Plan extended eligibility for ACA premium tax credits to those with incomes above 400 percent of the federal poverty level and increased subsidies for Marketplace enrollees with lower incomes. These enhanced premium tax credits, if made permanent, could make the individual market a more affordable alternative coverage option for small business employees, particularly those with lower incomes.⁹

About Our Study

We focused this study on trends in the small-group health insurance market in six states: Arkansas, Minnesota, Montana, New Mexico, Pennsylvania, and Vermont. These are the same states we studied in our previous reports (Corlette et al. 2017; Lucia et al. 2015). We originally selected these states based on data indicating large decreases in their small-group market enrollment and for their diversity in geography and approaches to insurance regulation.

For this brief, we reviewed and analyzed federal policies affecting the small-group market. We then conducted 19 structured interviews with market actors and observers across our study states, including insurance company representatives, brokers serving small business clients, and small employers and their trade associations. We also interviewed two benefit advisory firms with a particular interest in individual coverage HRAs. Participation in the small-group market varied among insurers in our study; the smallest insurer had 10 percent of their commercial group business in the small-group market, and the largest had 70 percent. Most of the brokers we spoke with had between 75 and 90 percent of their clientele in the small-group market. The small business associations and employers we spoke with represented a range of industries. We conducted these interviews in March and April 2021.

Findings

Despite Pandemic Disruptions, the Small-Group Market Has Remained Stable

Early in the pandemic, several market observers predicted that the economic fallout of social distancing requirements and stay-at-home orders would prompt significant numbers of small businesses not only to shed workers but also to discontinue benefits such as health insurance (Lucia et al. 2020). The stakeholders we interviewed suggested these predictions have not come true. Though small businesses were among the employers most negatively affected by the pandemic,¹⁰ respondents indicated that few major changes in offer rates, employer contributions to premiums, or benefits have occurred in the last year.

Many interviewees suggested that amid the global health crisis, small employers were determined to do everything they could to maintain coverage, even while facing significant economic uncertainty. Employer stakeholders emphasized this regardless of their financial situations. As a Minnesota business owner put it, “Through the pandemic we kept paying everyone’s health insurance, even when they were furloughed. That was pretty painful financially...but people can’t lose their health insurance during a pandemic.” Many respondents also noted that purchasing health coverage for employees is not an impersonal transaction for small employers. “When you’re a small business, you know what everybody’s health issues are...you know who is in cancer treatment...If you switch plans or take someone out of network, you know who you’re hurting,” one interviewee said. Employers also noted that retaining high-quality benefits is critical to their abilities to compete with larger employers for talented workers. As one small graphic design company put it, “We’re less than a mile from Target corporate headquarters, which hires the same designers and technical people we are trying to hire...It’s tough to compete with a company like Target on benefits.”

Insurer and broker stakeholders also noted that many pandemic-related layoffs, furloughs, and closures primarily affected employers that do not traditionally offer health benefits, such as those in retail, entertainment, and hospitality. This may be why fewer than half of people who reported a pandemic-related job loss also lost eligibility for employer-sponsored insurance (Fronstin and Woodbury 2020).

Insurer respondents said the sector's relative stability owed to their efforts in 2020 to extend premium relief, shift payment deadlines, and provide flexibility regarding workers' eligibility for benefits. Several insurers provided payment grace periods to all of their employer customers, and other insurers provided it on a case-by-case basis. Some insurers also allowed workers to remain on their health plans even after furloughs or reduced hours would have made them otherwise ineligible. Most of the insurer respondents noted that lower-than-expected claims in 2020 enabled them to provide premium discounts to customers for one or more months.

At the same time, several small employers heralded the federal Paycheck Protection Program, enacted under the Coronavirus Aid, Relief, and Economic Security, or CARES, Act of 2020, as a financial lifeline; the program enabled them not only to bring back staff but also to maintain benefits. "Being able to access loans...through the federal government if they kept their employees, that was a big deal [to my clients]," reported an Arkansas broker.

Pandemic-Related Spending Has Raised Few Concerns to Date

Small employers we interviewed reported they had few challenges obtaining adequate coverage for services related to COVID-19, such as testing, treatment, and vaccines. Under federal (and many state) laws, insurers have been mandated to cover and waive cost sharing for COVID-19 diagnostic testing and related services throughout the public health emergency. However, insurers have not been required to cover the cost of testing workers to ensure workplace safety (CMS 2021). Additionally, many insurers voluntarily waived enrollee cost sharing for COVID-19 treatment during the height of the pandemic, though several have returned to their pre-pandemic coverage policies as the crisis has eased.¹¹

None of the small employers we interviewed reported requiring their workers to receive regular testing as a condition of employment, and none reported that employees have had problems with their coverage for either COVID-19 testing or treatment. A few insurers were concerned about the long-term costs of covering COVID-19 vaccines once the federal government discontinues purchasing them. Indeed, one of Vermont's insurers, MVP Health Care, estimates that covering COVID-19 booster shots alone will increase small-group enrollee premiums by 0.4 percent in 2022.¹²

Cost Pressures Lead More Small Employers to Shift to Coverage Exempt from ACA Rules

Small employers may have multiple options for providing health benefits for their workers, depending on their state and market and their employees' risk profile and demographics (table 3). In addition to purchasing an ACA-compliant group insurance policy from an insurance company, many small employers can also consider

- renewing a grandfathered or grandmothers health plan;

- self-funding a plan with a stop-loss policy to moderate the financial risk, sometimes called “level funding”;
- entering into a group purchasing arrangement, such as group captives, a professional employer organization (PEO), or a MEWA; or
- establishing an HRA employees can use to purchase nongroup coverage.

The range of options available to small employers can result in an unsettled market. “From a sales perspective,” observed one insurer, “in small group there’s always a lot of activity, because [employers are] so price sensitive that they’re always shopping and looking for a deal.” This activity can also raise the risk of adverse selection if significant numbers of employers with young and healthy employees leave the ACA-compliant market.

TABLE 3
Coverage Options for Small Employers, 2021

Coverage type	Definition	Mechanism to access
Fully insured	A plan in which the employer purchases health insurance coverage from an insurer who takes on the financial risk of paying claims for covered benefits.	Broker, insurer, or SHOP marketplace
Fully insured, grandfathered	Health plan in existence before the ACA was enacted in March 2010; allowed to exist indefinitely, provided its benefits and cost-sharing structure do not change significantly.	
Fully insured, grandmothers	Health plan that employer had and renewed in 2013 before the ACA’s primary benefit and rating reforms became effective. State insurance regulators may decide annually if these plans are allowed to continue.	
Self-funded	A plan for which the plan sponsor (e.g., employer) takes on the financial risk of paying claims for covered benefits.	Broker or third-party administrator
Level-funded arrangement	A bundled package that combines self-funding with stop-loss insurance and other services, such as access to a provider network and claims processing. Stop-loss insurance is an insurance policy that operates like reinsurance to reimburse sponsors of self-funded plans for claims above a specified level (called an attachment point).	
Group purchasing arrangement	An arrangement that bands together employers to provide health coverage or related products and other services.	Group purchasing entity, broker, or insurer
Association health plan	An arrangement in which health coverage is sold to employer members of an association, such as a professional or trade association.	
Multiple employer welfare arrangement	An arrangement of two or more employers or self-employed individuals established to offer health coverage.	
Group captive	An arrangement under which multiple employers form an insurance company, or captive, to allow the member employers to underwrite their own insurance rather than buy it from a separate insurer.	

Coverage type	Definition	Mechanism to access
Professional employer organization (PEO)	A company that technically “employs” the employees of multiple small- or mid-sized businesses. The PEO manages the payroll, taxes, and reporting requirements for the small employers, and many PEOs also offer health benefits. PEOs may also be called employee leasing companies.	
Health reimbursement arrangement	Plan that allows small employers to reimburse employees for health care expenses, including premiums for individual market plans. Reimbursements are pretax, and employers can set an annual contribution level.	Broker or benefit advisory firm
Qualified small employer HRA	Limited to employers with 50 or fewer employees, and contributions are capped at an annual dollar amount. Employees may qualify for Marketplace premium tax credits, but the amount must be reduced by the value of the HRA. Employer must discontinue group policy.	
Individual coverage HRA (ICHRA)	Available to employers of all sizes without caps on contributions. Employer may continue to offer a group plan, but employees cannot be offered a choice between the group plan and an ICHRA. Employees with ICHRAs are ineligible for Marketplace premium tax credits, unless the employer contribution renders the coverage unaffordable and the employee declines the ICHRA.	

Source: Authors’ compilation of small business health insurance options.

Notes: SHOP = Small Business Health Options Program. ACA = Affordable Care Act. HRA = health reimbursement arrangement.

^a Vermont requires all fully insured small-group plans to be purchased through the SHOP.

EMPLOYERS WITH OLDER, SICKER WORKERS TEND TO DROP GRANDFATHERED OR GRANDMOTHERED PLANS

The ACA created opportunities for small employers to retain health plans in place before the law’s insurance reforms were implemented, referred to as grandfathered or grandmothered plans (table 3). However, insurers cannot enroll new employer groups into these products, so the extent to which insurers and small employers have maintained these plans varies. A representative of an Arkansas insurer noted that the insurer still has “quite a few” small employers with grandfathered and grandmothered plans and said the groups will face significantly higher premiums if they shift to an ACA-compliant product. “They’re fighting the best way they can to stay on those plans,” the insurer said. At the same time, as employees in these plans age and acquire more health conditions, the grandfathered and grandmothered market is dwindling. Insurers offering these plans can use health status to set premiums, resulting in price hikes when an employee develops a significant health issue. The employers will then find it advantageous to switch to an ACA-compliant plan. As a Pennsylvania broker reported, “I lost one more grandmothered [employer group] last year, because...they had one employee that had some very expensive medications, [they were quoted] a very high renewal rate, and the ACA [market] was cheaper.”

SELF-FUNDED PLANS HAVE GAINED POPULARITY AMONG SMALL EMPLOYERS

Insurers and brokers across our study states, except New Mexico, observed significant growth in level-funded health plans among small employers. In Pennsylvania, an insurer estimated that at least 20 percent of the small-group market is in a self-funded plan.

This growth is driven by level-funded plans that combine a self-funded employer plan, which is exempt from most ACA market rules, with a stop-loss insurance policy and administrative services. As structured, these plans appear to employers to be almost identical to a traditional, fully insured health plan. However, the premiums for the stop-loss insurance are underwritten, meaning the insurer assesses the potential health risk of the employees before agreeing to cover the group. Most respondents observed that large national carriers such as Aetna, Cigna, and UnitedHealthcare have been heavily marketing these level-funded packages, but regional plans and Blue Cross Blue Shield affiliates are also selling these products to avoid losing market share.

Self-funded plans “are now the highest growth area” for insurers in the small-group market, observed a Minnesota broker. Industry observers in Vermont reported that self-funding has boomed in the last few years in the state, even among groups as small as two or three employees, which insurers have historically avoided because of the challenges assessing their claims risks.

If an employer group has low health spending, the employer can capture partial savings with a level-funded plan. If, however, an employee develops a costly health condition, the insurer is likely to drop that employer group at the end of the year, at which point their only option is to return to the ACA-compliant market where underwriting is prohibited. Many stakeholders emphasized that this is particularly problematic for small employers because it only takes one employee’s or dependent’s health issue to affect a significant share of a group’s health risk.

Level-funded products have advantages for insurers: They allow insurers to assess the health risk of an employee group up front, and the ACA-compliant market is unpredictable. The latter owes in part to the risk-adjustment program, which requires insurers that attract a relatively healthy mix of small groups to remit payments to insurers that attract a relatively sicker mix of groups. Because it can be challenging for insurers to predict the mix of risk they will attract, they may incur unexpected required payments to a competing carrier. “With risk adjustment, it really hits us hard because we’re such a small part of the overall state,” said one regional insurer, adding, “We don’t know where [risk adjustment is] going to land...It’s harder for us to manage [than level-funded plans].”

For small employers, the advantage of a level-funded plan depends on how healthy their employees are. “For really small groups, they’re only going to get a good price if they’re healthy,” reported a broker. Conversely, insurers and brokers alike report that sicker groups are generally quoted a price for a level-funded product above what they would pay for an ACA-compliant plan.

In Montana, however, some industry observers believed the level-funded market has peaked. This may be partly because of how the products have been structured in that state; carriers market a self-funded plan that caps providers’ payments at approximately 165 percent of the Medicare rate

(referred to as “reference pricing”). Often, these providers then simply bill patients for the balance of their fee, which may be significantly higher than the reference price. “I’d say level funding has plateaued and maybe moved backwards because people have gotten burned by the reference-based pricing,” observed one insurer.

Most insurers and brokers agreed that allowing level-funded plans in the small-group market will have long-term negative consequences. “The [small-group market] pool gets worse and worse because your healthy small groups are going out into level-funded [plans] while they’re healthy, then coming back into the [ACA-compliant market], so it is becoming a high-risk pool,” reported a Montana broker. An insurer reported a similar trend: “It’s not a death spiral yet, but it does worry me.” Industry experts in Pennsylvania similarly said they have begun seeing the effects of adverse selection in the ACA-compliant small-group market. Further, they noted that the ACA-compliant market has shrunk over time, and the groups that remain have increased morbidity. “Selection spirals don’t end well,” a broker noted.

THE AVAILABILITY OF ALTERNATIVES SUCH AS MEWAS, PEOS, AND GROUP CAPTIVES VARIES BY MARKET

As with the self-funding option, MEWAs (or association health plans), PEOs, and group captives (table 3) can be a more affordable coverage option for employer groups with relatively healthy employees. However, the availability of these options varies across our study states. Though MEWAs created under the 2018 federal rules are currently barred from marketing to employers or individuals, these arrangements are permitted to operate as a single large employer plan under the Employee Retirement Income Security Act if they can meet the higher pre-2018 federal standards. However, the US Department of Labor has largely left determining whether a MEWA qualifies for this status up to state insurance regulators. In Pennsylvania, for example, a broker observed that MEWAs are not a large portion of the market for two reasons. First, that broker believed the insurance department takes a “very strict” approach to the regulation of the solvency and marketing of MEWAs. Second, employers in the state have had bad experiences with such arrangements. “We’ve had some [MEWAs] blow up,” he said, adding, “one that left people with millions of dollars in medical claims.” Stakeholders in Arkansas, Minnesota, and New Mexico also suggested MEWAs are a small percentage of the small-group market.

Conversely, insurers and brokers in Montana reported a robust market for MEWAs in the state. Montana officials have taken a relaxed approach to regulating MEWAs, and some MEWAs formed after the ACA’s enactment had to shut down because of financial difficulties (Corlette et al. 2017). However, a few market observers suggested access to MEWAs has been a boon for small employers in the state and argued MEWAs fill an important role by enabling small employers to enjoy more customization of health benefits than they can from insurers in the ACA-compliant market. Perhaps most significantly, because the MEWAs in the state are considered a single large employer group for regulatory purposes, they do not have to comply with the ACA’s rating rules for the small-group market. This enables them to adjust premiums based on the risk profile of each employer group.

Interest in and the availability of group captives and PEOs also varied by region. Vermont, which views itself as the “capital of captives,” reportedly has several small-group market captive arrangements, but stakeholders in other states suggest such arrangements are rare. “Every once in a while we see brokers try to set up a captive,” said a Minnesota insurer. “But none of them have really taken hold.” A Vermont insurer reported that captives are appealing because “there’s just a lot more flexibility with what you can do with captives, and generally the regulation is a lot lighter even than self-funded [plans].”

Brokers and insurers across our study states reported that PEOs are somewhat more common than captives, though the market varies by region. A national insurer in New Mexico reported that the state has very few PEOs, but they are more common in neighboring Texas. A broker attributed this to New Mexico’s approach to regulating these entities, saying, “I don’t see a path forward for them.” A broker in Minnesota also pointed out that PEOs are not always structured to appeal to small employers seeking affordable health benefits, noting they often involve high fees to manage a wide range of employee services in addition to the health plan: “The employers do that for simplicity, they don’t do that for cost saving,” he said. Further, a Montana broker reported that his clients have been deterred from PEOs because they tend to be self-funded and unregulated by the state. If a PEO “goes belly up,” as one broker said, the employer is left responsible for costs.

Absent policy and regulatory changes, level-funded plans, MEWAs, PEOs, and other coverage arrangements that fall outside ACA regulation will always persist, as several respondents suggested. “Employers are always looking for a more efficient, effective way to provide employee benefits,” said one insurer, adding, “and brokers are always looking at opportunities to present those to employers.” Several insurers in our study reported they would prefer not to market these alternative products but do so to avoid losing market share to competitors. “Anytime you split up the risk pools,” said one insurer, “it becomes more challenging on the stability side...The bottom line is we’d like to see the market stabilize and grow rather than continue to slice and dice it.”

No Significant Shift to the Individual Market Has Occurred Yet

When the insurance market reforms under the ACA took effect in 2014, some observers predicted many employers would shed their group health plans and send workers to the individual market for coverage (Lucia et al. 2020). That did not happen in significant numbers, but our previous reports found that some “micro” employer groups, typically with five or fewer employees, initially shifted to the individual market. However, the micro groups returned to the group market after experiencing premium increases and instability in the early years of the ACA Marketplaces (Corlette et al. 2017). However, in the past two to three years, premium differences between the individual and small-group markets have narrowed in many places, and more Marketplace enrollees have a broader choice of insurers.

MANY SMALL EMPLOYER GROUPS REMAIN RELUCTANT TO MOVE EMPLOYEES TO THE INDIVIDUAL MARKET

Brokers reported that individual market plans are less appealing to their employer clients for three reasons. First, individual market plans tend to have smaller networks of providers and do not usually cover out-of-network services (Polsky and Weiner 2015); for employers that have traditionally offered plans with a relatively unfettered choice of providers, individual market plans can be hard to sell to employees. Second, individual market policies are “age rated,” meaning an older person can face premiums up to three times higher than a younger person. Most enrollees in group health plans are insulated from such age-adjusted premiums, and many employers are reluctant to expose their older workers to higher premium costs. Third, individual market plans, especially for employees with moderate to high incomes (above 250 percent of the federal poverty level, or \$31,900 for an individual), often come with significantly higher deductibles and other cost-sharing obligations relative to other group health plans.

ENHANCED SUBSIDIES UNDER THE AMERICAN RESCUE PLAN MAY INDUCE SOME SHIFTS TO THE INDIVIDUAL MARKET

We conducted several of our interviews after the American Rescue Plan was enacted in March 2021. A few brokers indicated that the law’s enhanced premium tax credits for individual Marketplace coverage were making an impact, particularly among their micro group clients. “Since the American Rescue Plan came into effect, I’ve been moving a lot of people to Medicaid or...the Marketplace because the company just can’t afford to pay benefits,” one broker said. The primary limitation for these employer groups is the temporary nature of the American Rescue Plan’s subsidies. Several brokers reported that they considered it a waste of time and effort to encourage employers to drop their group plans for just one year, only to have to return to the group market when the enhanced premium tax credits expire. In addition, cost-conscious consumers are not only concerned about the cost of premiums but the cost-sharing obligations they face when seeking care. The American Rescue Plan did not change eligibility for cost-sharing reductions for those who are fully employed during 2021, which will still leave moderate- to high-income enrollees with higher deductibles and copayments.

NEW HEALTH REIMBURSEMENT ARRANGEMENTS HAVE LIMITED APPEAL

Individual coverage HRAs have been available to employers since January 2020. Though interviewees acknowledged that these products could make health benefit costs more predictable for employers, they pointed to several limitations. Most respondents said individual coverage HRAs are too complicated for employers to easily make the shift from group coverage. A New Mexico broker said he has had difficulty explaining individual coverage HRAs to his small business clients, and most would also need the services of an accountant to set one up. Another broker shared similar views, noting that most of his peers do not fully understand individual coverage HRAs, partially because a tax preparer is better trained and suited to work with employers to set up the accounts. Others noted that the significant role brokers play in small businesses’ decisionmaking about benefits can heavily influence what coverage options gain traction in the market. Individual coverage HRAs can create more work for

a broker than selling a single group plan, because the broker must advise multiple employees about their individual market coverage options. At the same time, the commissions that insurers offer brokers for selling individual market policies have generally been lower than those offered for selling group plans.

Additionally, some stakeholders believe the enhanced subsidies in the American Rescue Plan have made individual coverage HRAs less attractive. One noted that if employees are offered such plans, “it could put [them] in a worse situation, where they’re getting less money because their employer isn’t offering them the same amount that the government would be.” In other words, the value of the enhanced premium tax credits in the individual market may be greater than the employer’s contribution to an individual coverage HRA. However, being offered an individual coverage HRA disqualifies workers from eligibility for premium tax credits. This suggests small groups with higher-income employees who would not otherwise be eligible for premium tax credits could more easily offer individual coverage HRAs, but these employers are often already providing coverage to attract talent.

However, use of individual coverage HRAs appears to be growing in some states. As national individual coverage HRA vendors noted, states that have successfully stabilized their individual market through reinsurance programs are best suited to such HRAs. In our study, stakeholders in Minnesota reported rising interest in individual coverage HRAs among employers, in part because small-group market premiums have been rising relative to individual market premiums. Individual coverage HRA administrators also indicated such plans could grow in popularity among small groups that have not previously offered health benefits.

Discussion

Our interviews with stakeholders in six study states provide a window into the small-group market and how it is responding to significant changes in federal health policies and disruptions from the pandemic. Though each state’s regulatory and market environments are unique, the trends we observed are likely similar to trends across the country.

In our study states, small businesses that offer health insurance are highly incentivized to maintain it to attract and retain skilled employees, even in the face of rising costs and the economic uncertainties wrought by the pandemic. Indeed, the national health crisis prompted many to attach an even higher value to health benefits than they might have otherwise. Some small businesses have also been unwilling to expose employees to the vagaries of the individual market, even though the ACA, the American Rescue Plan, and recent changes to HRAs may have made that option more attractive.

Policymakers’ efforts to create new options for this market, such as the ACA’s SHOP marketplaces or the newer HRA products, have largely failed to gain traction. Market observers cited several reasons for this, but policymakers should bear in mind that small employers rely heavily on insurance brokers to help them with health benefit decisions. Small employers are less likely to have a robust human resources department or in-depth knowledge of health benefits, leading them to rely heavily

on brokers to learn about new options. Programs or policies that do not incentivize brokers and other professionals to promote them are unlikely to achieve much success, at least in the short term.

Over the past 20 years, the share of employers offering comprehensive health benefits dropped from almost half to less than one-third. The anecdotal evidence collected for this and our past reports suggests the marketing and sale of level-funded and other products are steadily siphoning healthier and younger employees away from small-group insurance, leaving a more costly pool of enrollees for insurers to cover. Observers in our interviews predicted the small-group market's higher morbidity—and resulting higher premiums—will only accelerate without state or federal regulatory action to promote a more diverse and stable small-group market.

Notes

- ¹ See the 2019 Medical Expenditure Panel Survey—Insurance Component, accessible from <https://www.meps.ahrq.gov/mepsweb/index.jsp>.
- ² See the 2000 Medical Expenditure Panel Survey—Insurance Component, accessible from <https://www.meps.ahrq.gov/mepsweb/index.jsp>.
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