THE PENNSYLVANIA STATE UNIVERSITY
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THE IMPACT OF PPACA ON EMPLOYER SPONSORED HEALTH INSURANCE: AN ANALYSIS OF EMPLOYER MOTIVATIONS TO SELF-INSURE HEALTH BENEFITS

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ABSTRACT

With the passing of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, health care reform is underway. The provisions of the act take effect over the next decade and will have varying effects on insurers, employers, and individuals. Currently, the most popular method of receiving health insurance is through an employer sponsored plan. Within employer sponsored plans, more than half of the covered workers are part of a partially or fully self-insured health benefits plan.

Given this significant number of people receiving coverage through employer sponsored plans and specifically through self-insured plans, this thesis will identify employers' motivations for self-insuring their employees' health benefits based on the changing environment of health care. It will discuss the importance of employer sponsored health benefits as well as the current health care environment and the inflation of health care costs to provide an understanding of the relevance of the topic.

Since PPACA has implemented and will implement many changes to employers' motivations for self-insuring health benefits, the thesis will contrast their motivations pre-PPACA and post-PPACA to provide a complete understanding of why employers choose to self-insure health benefits instead of purchasing a fully insured health plan from an insurer.

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Chapter 1—Introduction

Employer sponsored health benefits have become an expectation in today's society. As the most popular source of health insurance, employers who currently offer them face tough criticism when they discuss the possibility of discontinuing the benefits as a cost-cutting measure. As a result, many employers are exploring their options for saving some money while still providing health benefits to their employees. These options include implementing cost-sharing mechanisms to shift some of the costs to the employees as well as self-insuring the benefits to save on administrative expenses, to reduce premium costs, to improve their cash flows, and to retain control over the loss reserves.

While the above are some of employers' current motivations, the passing of the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010 has prompted employers to reconsider such options. The PPACA is legislation that will dramatically change the way that health care insurance is provided to individuals and employers. For example, qualified insurance coverage will be available to individuals through state exchanges and employers with more than 50 employers will face a penalty if they don't provide coverage. Provisions such as these create a lot of variables that need to be considered when making decisions about health care and how to pay for it. For large employers, the original motivations for providing health insurance as employee benefits may still hold true, but some provisions of PPACA may motivate them to self-insure their employee health benefits. To understand why employers' would opt to self-insure health benefits as opposed to fully insuring them, you must first understand why employers began offering these benefits and why they continue offering them.

It is the accepted norm in today's society, but why did employers begin offering health benefits? Offering employee benefits originates back to World War II when President Franklin

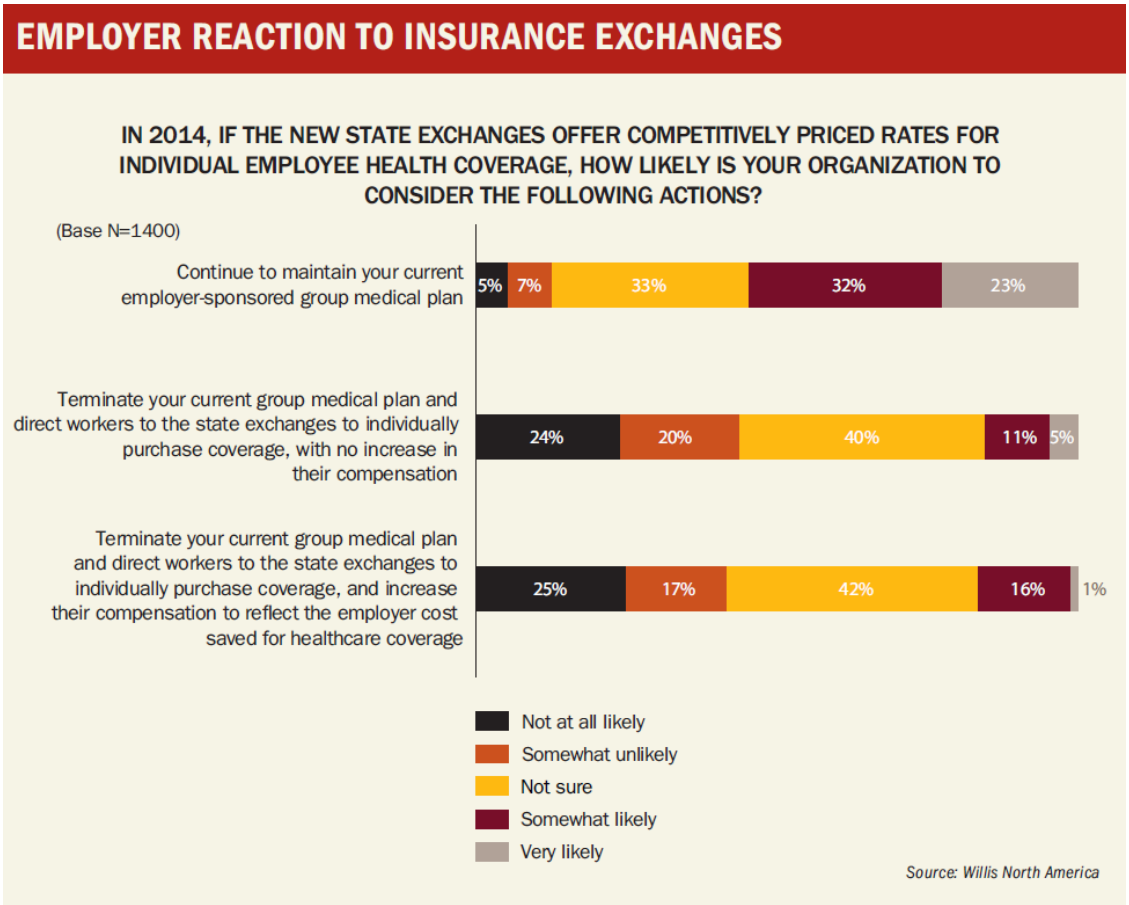
D. Roosevelt proposed a maximum income of $25,000 during the war (EBRI Databook). Although this was not implemented, the Revenue Act of 1942 enacted a progressive tax rate table, which made higher wages somewhat less desirable to employees. Employers had to be innovative in hiring and retaining employees, so they began offering benefits like health care. This allowed employees to remain in a lower tax bracket while receiving more compensation. The rising tax rates on wages were accompanied by tax preferences for employers who provided employee benefit plans, which provided even more incentive for employers to offer benefit plans to their employees. Furthermore, employer contributions to health insurance were tax exempt for employees and tax deductible for employers, so it made financial sense for employers to adjust their compensation plans to include employee benefit plans.

These tax advantages remain one of the main reasons employers continue to offer health benefits despite the increasing costs. In addition, employers have realized that full-time employees have an expectation that they will receive health benefits with their employment. As a result, we have not seen employers ceasing to provide health care coverage because of its rising cost. Instead, they are implementing cost-saving measures such as shifting some costs to the employee, changing to higher deductible plans, or reducing the coverage limits on the plans they currently offer. Specifically, there has been evidence of growth in high-deductible, account-based consumer-directed health plans (CDHPs) such as the high deductible health plans with a savings option (HDHP/SO), as is discussed in Section 2 of Chapter 2. Five years ago, only 3 percent of covered employees were enrolled in a CDHP while 13 percent of all covered employees are enrolled in a CDHP today (Spears, 2012). Thirty-two percent of all employers with 500 or more employees offered a CDHP in 2011, compared to only 23 percent of these large employers in 2010 (Spears, 2012). While the largest employers are more likely to offer a

CDHP, this plan design also saw growth among employers with 10 to 499 employees, increasing from 16 percent in 2010 to 20 percent in 2011 (Spears, 2012).

Despite the uncertainty surrounding the impact that PPACA will have on their costs, 55 percent of employers say that they will likely continue to maintain their health plans even if the state exchanges offer competitively priced rates (Reese, 2011). Only 16 percent of employers say they're likely to terminate their coverage and send employees to the state exchanges to purchase coverage without an increase to their employees' compensation levels (Reese, 2011). This only shifts to 17 percent of employers if an increase is provided to the employees' compensation levels (Reese, 2011). The complete survey results can be found in Figure 1 below.

Figure 1—Employer Reaction to Insurance Exchanges



Source: Reese, S. (2011). Few will send workers to exchanges. *Managed Healthcare Executive, 21*(1), 32-32. Retrieved from http://search.proquest.com/docview/848864034?accountid=13158.

Since employers are likely to maintain their offerings of employee health benefits, the next question is whether they will continue to fully insure these benefits or if they will transition to self-insuring their employee health benefits. This thesis will focus on employers' motivations for self-insuring health benefits and will address the question of whether these motivations will change as the provisions of PPACA become effective over the next several years. To accomplish this, I will provide background on the current health care environment, discuss the theories of adverse selection and moral hazard (as they apply to insured and self-insured employers), provide information on PPACA provisions that are relevant to employer sponsored plans, and compare large employers' motivations to self-insure before and after PPACA. I will conclude with a discussion of the changes in their motivations and also provide some comments about extending this thesis once the provisions of PPACA actually take effect.

Chapter 2—Current Health Care Environment

The current health care environment explains the need for reform of the present health care system in the United States. Although coverage can also be obtained privately or through government programs, most Americans receive their coverage through employers. This creates a problem because individuals lose their health care coverage if they become unemployed. As a result of high unemployment rates in the recent recession, the number of uninsured people in the United States has increased. This is evidence that reform needs to occur, but it is difficult to initiate change when employer sponsored health insurance has become an expectation in our society. This chapter addresses these aspects of the health care environment as background to the health care reform that is currently happening in the United States.

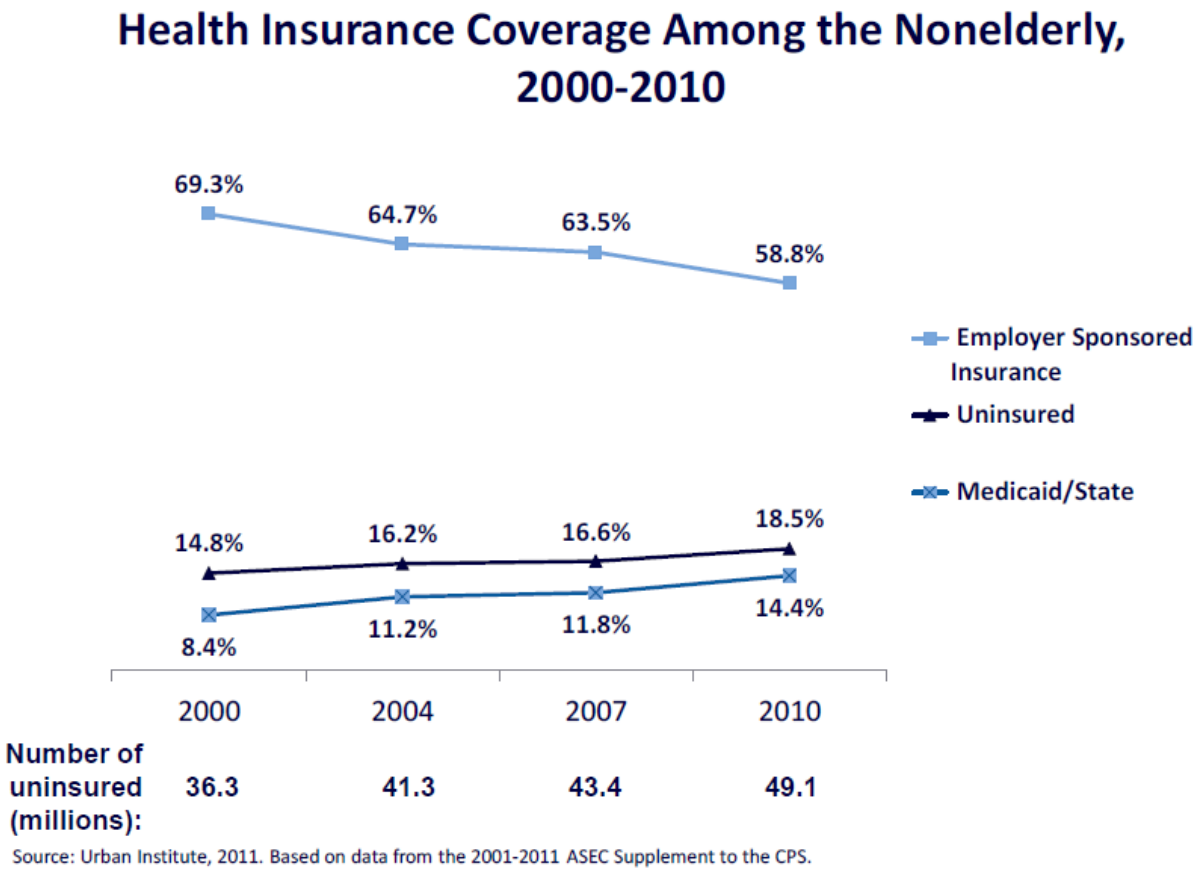
Section 1: How Americans Get Health Care Coverage

In the United States, citizens can get health care coverage in a variety of ways, but there are also a significant number of uninsured people across the nation. The insured individuals can be categorized based on age and source of coverage. Elderly Americans are eligible for Medicare. Nonelderly Americans receive insurance coverage in one of three ways: employer sponsored plans, government programs such as Medicaid, or individually purchased plans.

Employer sponsored plans are the most common avenue of coverage with 58.8 percent of the nonelderly population receiving coverage this way in 2010; however, that number has declined from 69.3 percent in 2000 (Holahan & Chen, 2011). This decline has been driven by the growing unemployment rate. It is not reflective of employers ceasing to provide coverage; instead, it is a result of the economic conditions in the past decade. This is further supported with the growing percentage of individuals receiving coverage from government programs and the growing number of uninsured individuals. Government programs, such as Medicaid or other

state sponsored plans, account for a significantly lower, but increasing, portion of the insured nonelderly population with 14.4 percent receiving these government benefits in 2010, up from 8.4 percent in 2000 (Holahan & Chen, 2011). In 2010, 18.5 percent of nonelderly Americans did not have insurance, as compared to 14.8 percent in 2000 (Holahan & Chen, 2011). Individually purchased plans were used as the only form of coverage for 3.7 percent of the non-elderly population and 6.1 percent of the non-elderly individuals used them as a supplemental coverage (DeNavas-Walt et al., 2011). The negative trend of health care coverage through employer sponsored plans versus the positive trends of participation in government programs and of the percentage of uninsured people can be seen below in Figure 2.

Figure 2—Comparison of Health Insurance Coverage among the Nonelderly



Source: Holahan, J., & Chen, V. (2011, December 15). Changes in health insurance coverage in the great recession, 2007-2010. In *Kaiser Commission on Medicaid and the Uninsured*. Retrieved from http://www.kff.org/uninsured/upload/8264.pdf.

Within employer sponsored health plans, the benefits may be fully insured or self-insured. In a fully insured plan, a commercial insurer or health maintenance organization (HMO) bears the risk. By contrast, the employer—and usually a stop loss insurer—bears the risk in a self-insured plan. The other main differences between these two arrangements are who performs administrative functions, who pays for the coverage, and how it is regulated. In a fully insured health plan, the commercial insurer is responsible for the administrative tasks, such as evaluating claims, paying covered claims, and maintaining documentation of loss reserves, and coverage is paid for with a combination of employer and employee premium contributions paid to the insurer. With a self-insured plan, the employer or, more likely, a third-party administrator performs administrative functions and the coverage is provided by employers paying incurred claims. This may be supplemented by an employee premium paid to the employer.

Fully insured health plans are primarily state regulated by the Department of Insurance while the self-insured health plans are mostly federal regulated by the Department of Labor. Being federally regulated is an advantage when an employer is operating in more than one state because the firm does not have to worry about meeting different requirements in each of the states where it has operations. Under federal regulation, an employer does not have to tailor their employee benefits based on the individual states, which creates a more uniform benefit design that makes administration easier. In contrast, a disadvantage of federal regulation is that not all states have the same health insurance needs. There may be states that would benefit from certain regulations that are irrelevant in other states. Given the evolving global business environment, federal regulation is appealing to more employers because they have employees across the nation as well as internationally.

Self-insured, as opposed to fully insured, plans are the most common source of health insurance coverage for workers in the United States. In 2009, 57 percent of covered workers were enrolled in a partially or fully self-insured health plan (Linehan, 2010). This percentage has increased steadily since the passing of the Employer Retirement Income Security Act (ERISA) of 1974, which is discussed in Section 1 of Chapter 5.

Individually purchased plans provide coverage to more than 14 million people who buy health insurance on their own (Yoo et al., 2009). Of the non-elderly population, 3.7 percent receive coverage solely from an individually purchased plan while 6.1 percent use individually purchased plans to supplement another form of insurance in 2010 (DeNavas-Walt et al., 2011). These individuals are forced to pay the entire cost of the premium, making the nature of the market for these plans very different from the market for group plans such as employer-sponsored plans. Many individuals in this market wait until they think they need health services before purchasing coverage, which causes higher premium rates in the risk pools. This problem of adverse selection is discussed in Chapter 3. In 2009, 40 percent of single policies were held by the 45 to 64 age group, 37 percent were held by people between 25 and 44 years old, and 23 percent were held by individuals under the age of 24 (Yoo et al., 2009). A similar trend is seen in family policies with the older ages accounting for greater percentages of policies. In 2009, 53 percent of family policies were bought by families headed by individuals between 45 and 64 years old, 42 percent were bought by families with heads of household in the 25 to 44 age group, and 5 percent were held by families headed by people younger than 24 years old (Yoo et al., 2009). Table 1 on the next page provides a further breakdown by age of the distribution of policies in the individual market.

Table 1—Distribution of Policies in the Individual Market in 2009

	Single		Family	
	Policies in Survey	Percent	Policies in Survey	Percent
Under 18	141,135	8%	22,185	3%
18 -24	272,090	15%	13,280	2%
25 -34	419,527	23%	103,906	13%
35 -44	262,534	14%	220,542	29%
45 -54	331,174	18%	263,258	34%
55 -64	398,441	22%	148,089	19%
All Age Groups (non-elderly)	1,824,944	100%	771,260	100%

Source: America's Health Insurance Plans.

Source: Yoo, H., Carpenter, L., & Heath, K. (2009, October). Individual health insurance 2009: A comprehensive survey of premiums, availability, and benefits. *America's Health Insurance Plans: Center for Policy and Research*. Retrieved from http://www.ahip.org/Issues/Individual-Market-Health-Insurance.aspx.

Medicare coverage is available to individuals age 65 and older, categorized as elderly, and to disabled persons. In 2010, this government program covered 39.6 million elderly people and 7.9 million disabled people for a total of 47.5 million covered individuals (Foster, 2011). Medicare has two components: hospital insurance or Medicare Part A and supplementary medical insurance or Medicare Part B and Part D. Part A helps pay for hospital stays, home health care, skilled nursing facility costs, and hospice care. Part B helps cover costs associated with physician visits, outpatient hospital services, home health care, and other services. Part D provides subsidies to offset the costs of prescription drug costs. In addition, Medicare has Part C, which serves as an alternative to traditional Part A and Part B coverage. Approximately 25 percent of covered individuals chose to enroll in Part C private health plans that contract with Medicare to provide Part A and Part B health services (Foster, 2011). Of the 47.5 million

enrolled in Medicare in 2010, 47.1 million were enrolled in Part A, 43.8 million were enrolled in Part B, and 34.5 million were enrolled in Part D (Foster, 2011). Below, Table 2 provides an overview of the enrollment broken down by elderly or aged and disabled as well as an overview of the assets and expenditures associated with Medicare.

Table 2—Medicare Data for Calendar Year 2010

		SMI		
	HI or Part A	Part B	Part D	Total
Assets at end of 2009 (billions)	$304.2	$75.5	$1.1	$380.8
Total income	$215.6	$208.8	$61.7	$486.0
Payroll taxes	182.0	—	—	182.0
Interest	13.8	3.1	0.0	16.9
Taxation of benefits	13.8	—	—	13.8
Premiums	3.3	52.0	6.5	61.8
General revenue	0.1	153.5	51.1	204.7
Transfers from States	—	—	4.0	4.0
Other	2.7	0.2	—	2.9
Total expenditures	$247.9	$212.9	$62.0	$522.8
Benefits	244.5	209.7	61.7	515.8
Hospital	136.1	31.9	—	168.0
Skilled nursing facility	26.9	—	—	26.9
Home health care	7.0	12.1	—	19.1
Physician fee schedule services	—	64.5	—	64.5
Private health plans (Part C)	60.7	55.2	—	115.9
Prescription drugs	—	—	61.7	61.7
Other	13.8	46.1	—	59.9
Administrative expenses	$3.5	$3.2	$0.4	$7.0
Net change in assets	−$32.3	−$4.1	−$0.4	−$36.8
Assets at end of 2010	$271.9	$71.4	$0.7	$344.0
Enrollment (millions)				
Aged	39.2	36.7	n/a	39.6
Disabled	7.9	7.1	n/a	7.9
Total	47.1	43.8	34.5	47.5
Average benefit per enrollee	$5,187	$4,786	$1,789	$11,762

Notes: 1. Totals do not necessarily equal the sums of rounded components.
2. "n/a" indicates data are not available.

Source: Foster, R. S. (2011, May 13). 2011 annual report of the board of trustees of the federal hospital insurance and federal supplementary medical insurance trust funds. *Centers for Medicare and Medicaid Services*. Retrieved from http://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf.

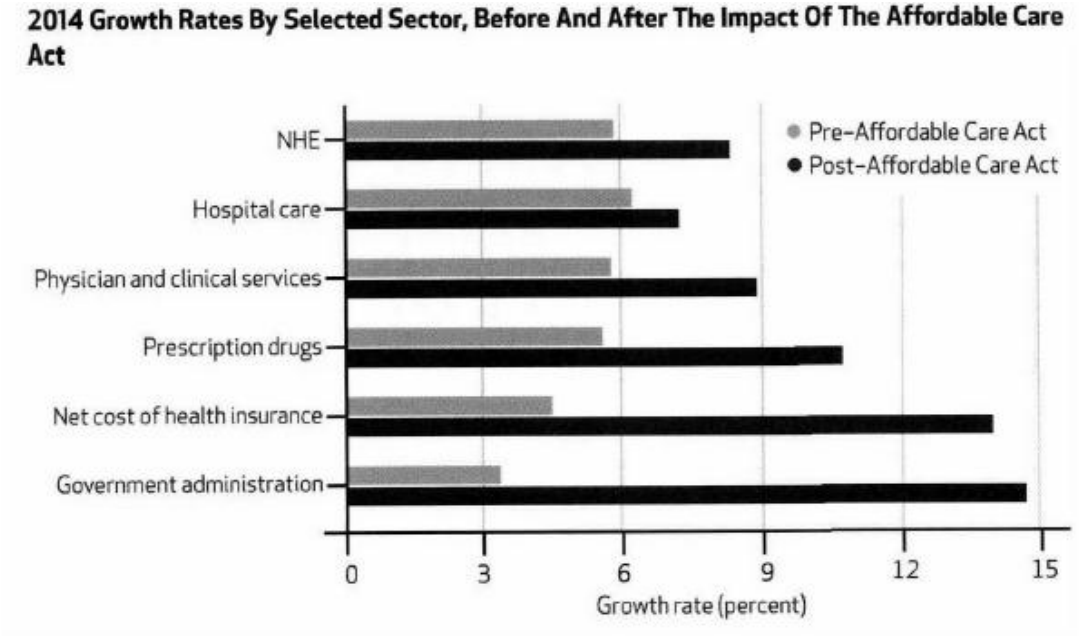
As described above, employer sponsored plans are the most common way that nonelderly people receive healthcare, which explains why employers are evaluating all of their options for continuing to offer health benefits to their employees. Then, within employer sponsored plans,

self-insured plans are the most common way that benefits are covered for workers. Based on these conclusions, identifying employers' motivations for self-insuring health benefits will provide valuable discussion for those interested in health care reform as well as for employers and employees being directly affected by PPACA.

Section 2: Health Care Cost Inflation and Health Insurance Premiums

The cost of health care in the United States continues to be higher than that of any other developed country. Since 1960, health care spending grew faster than GDP in all but eight years according to a report by McKinsey. In 2009, the rate of growth in health care spending was 3.8 percent, and in 2010, it increased slightly to 3.9 percent (The Economist, 2012). In 2011, growth in health care spending and GDP began to converge. This is impacted partially by a few initiatives of President Barack Obama including drug rebates and lower rates charged to Medicare providers; however, it is driven more by the decrease in consumption of health services. Previously, drugs, hospital care, and administrative costs fueled the growth in health care spending but spending in these categories has slowed significantly in recent years. The cost of prescription and over-the-counter drugs has also declined due to products losing their patents, and more services are now available at clinics, resulting in fewer hospital visits. Furthermore, insurers and employers have redesigned their health plans to increase transparency to consumers and to create more responsible health care expenditures. More significantly, however, are the rising unemployment rate and losses of health insurance coverage, because Americans were less able to consume as much healthcare as they did before the 2008 recession, thus limiting the growth of health spending.

Figure 3—Projected Growth Rates in 2014 by Sector



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Source: Keehan, S. P., Sisko, A. M., Truffer, C. J., Poisal, J. A., Cuckler, G. A., Madison, A. J., . . . Smith, S. D. (2011). National health spending projections through 2020: Economic recovery and reform drive faster spending growth. *Health Affairs, 30*(8), 1594-605. Retrieved from http://search.proquest.com/docview/887281817?accountid=13158.

This recent convergence should be a positive indication for the future outlook of health care spending, but health care spending is expected to grow an average of 5.8 percent per year through 2020 (Keehan et al., 2011). From 2011 to 2013, national health spending is projected to increase more rapidly than it has in the past few years with an average growth rate of 4.9 percent (Keehan et al., 2011). The driving forces of this growth in national health spending are the increased growth in private health insurance spending and the greater out-of-pocket spending that result from increases in disposable personal incomes during the economic recovery. Additionally, higher cost sharing in employer sponsored plans will also drive higher out-of-pocket spending. In 2014, national health spending growth is expected to reach 8.3 percent with major provisions of PPACA taking effect (Keehan et al., 2011). A graph comparing projected

growth rates in 2014 by sector based on pre-PPACA and post-PPACA can be found in Figure 3 on the previous page. The main impact will result from the estimated 22.9 million newly insured individuals receiving coverage from Medicaid, other state sponsored programs, or employer sponsored plans (Keehan et al., 2011). Medicaid spending is expected to increase 20.3 percent and private health insurance spending is expected to be 9.4 percent while out-of-pocket spending is expected to decline by 1.3 percent because of the increase of people with health insurance coverage (Keehan et al., 2011). An overview of average growth in national health expenditures, both overall and by category, can be found in Table 3 on the next page. Overall, these provisions will reduce the number of uninsured people by nearly 30 million (Keehan et al., 2011). This inflow of insured individuals will result in more spending in prescription drugs and physician services which will contribute to the growth of health care spending at a greater rate than gross domestic product (GDP). A graph comparing projected health expenditures under pre-PPACA and post-PPACA to GDP through 2020 can be found in Figure 4 on page 15.

Table 3—Overview of National Health Expenditures

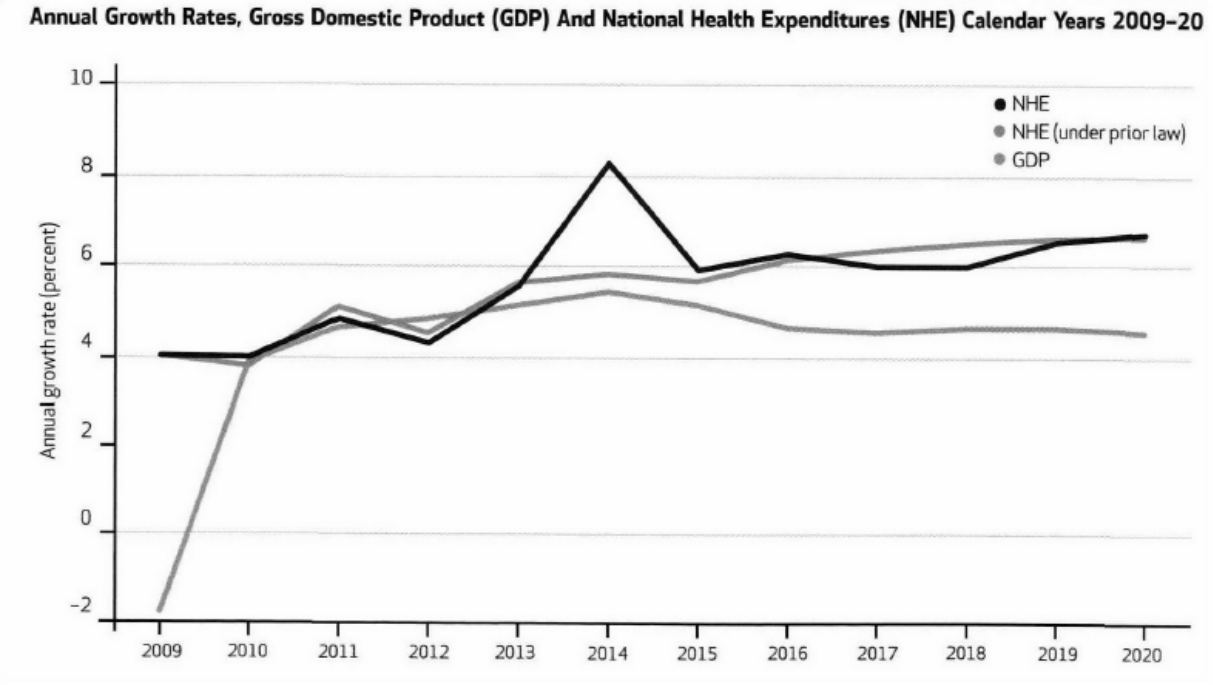
National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 2008–20

Spending category	2008	2009	2010	2011	2012	2013	2014	2020
NHE, billions	7.1%	4.0%	3.9%	4.8%	4.3%	5.5%	8.3%	6.2%
Health consumption expenditures	7.1	4.3	4.0	4.8	4.2	5.5	8.4	6.2
Personal health care (PHC)	7.0	4.6	3.7	4.6	3.9	5.4	8.0	6.2
Hospital care	7.2	5.1	4.6	4.7	5.0	5.3	7.2	6.2
Professional services	6.7	3.5	2.3	4.0	1.4	5.4	8.6	5.7
Physician and clinical services	6.7	4.0	2.4	4.0	0.8	5.6	8.9	5.6
Other professional services	7.0	5.3	5.0	5.5	2.4	5.2	10.7	6.5
Dental services	6.5	-0.1	0.2	3.2	3.7	4.7	6.1	5.5
Other health, residential, and personal care[a]	7.2	8.3	6.6	5.3	7.1	7.5	7.8	8.0
Home health care[b]	8.5	10.0	5.3	5.3	6.1	6.8	7.3	6.8
Nursing care facilities and continuing care retirement communities[b,c]	5.7	3.1	2.6	3.5	3.5	4.4	4.6	4.8
Retail outlet sales of medical products	7.4	4.2	3.3	5.9	4.6	4.8	10.2	6.7
Prescription drugs	8.8	5.3	3.5	6.6	5.3	5.2	10.7	7.2
Durable medical equipment	4.3	-0.8	2.3	3.8	1.4	3.0	6.5	5.0
Other nondurable medical products	3.7	2.2	2.7	3.6	2.9	3.7	10.4	4.9
Government administration[d]	7.0	2.0	9.9	8.7	8.4	9.0	14.6	6.8
Net cost of health insurance[e]	9.8	-1.2	8.1	5.6	6.6	6.0	13.9	5.6
Government public health activities	6.8	5.9	4.8	6.5	6.0	6.3	6.6	6.9
Investment	7.3	-0.6	2.4	4.8	5.6	6.1	6.5	7.0
Research[f]	6.8	4.8	10.1	6.8	6.3	6.5	6.3	6.4
Structures and equipment	7.5	-2.7	-0.8	3.9	5.2	6.0	6.5	7.3
Population (millions)	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.8
NHE per capita	6.1	3.1	3.0	3.9	3.3	4.6	7.3	5.3
GDP, billions of dollars	4.7	-1.7	3.8	4.6	4.8	5.1	5.4	4.7

SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis and Bureau of the Census. **NOTES** 2008 shows average annual growth, 2000–08; data from 2010 to 2020 are projections; percent changes are calculated from unrounded data. [a]Includes expenditures for residential care facilities (North American Industry Classification Codes [NAICS] 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in nontraditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid. [b]Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care. [c]Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (623311), state and local government nursing facilities, and nursing facilities operated by the Department of Veterans Affairs. [d]Includes all administrative costs (federal, state, and local employees' salaries; contracted employees including fiscal intermediaries; rent and building costs; computer systems and programs; other materials and supplies; and other miscellaneous expenses) associated with insuring individuals enrolled in the following public health insurance programs: Medicare, Medicaid, Children's Health Insurance Program, Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services administration, and other federal programs [e]Net cost of health insurance is calculated as the difference between calendar year premiums earned and benefits paid for private health insurance. This includes administrative costs, and in some cases, additions to reserves; rate credits and dividends; premium taxes; and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following public programs: Medicare, Medicaid, Children's Health Insurance Program, and workers' compensation (health portion only). [f]Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

Source: Keehan, S. P., Sisko, A. M., Truffer, C. J., Poisal, J. A., Cuckler, G. A., Madison, A. J., . . . Smith, S. D. (2011). National health spending projections through 2020: Economic recovery and reform drive faster spending growth. *Health Affairs*, *30*(8), 1594-605. Retrieved from http://search.proquest.com/docview/887281817?accountid=13158.

Figure 4—Comparison of National Health Expenditures to GDP

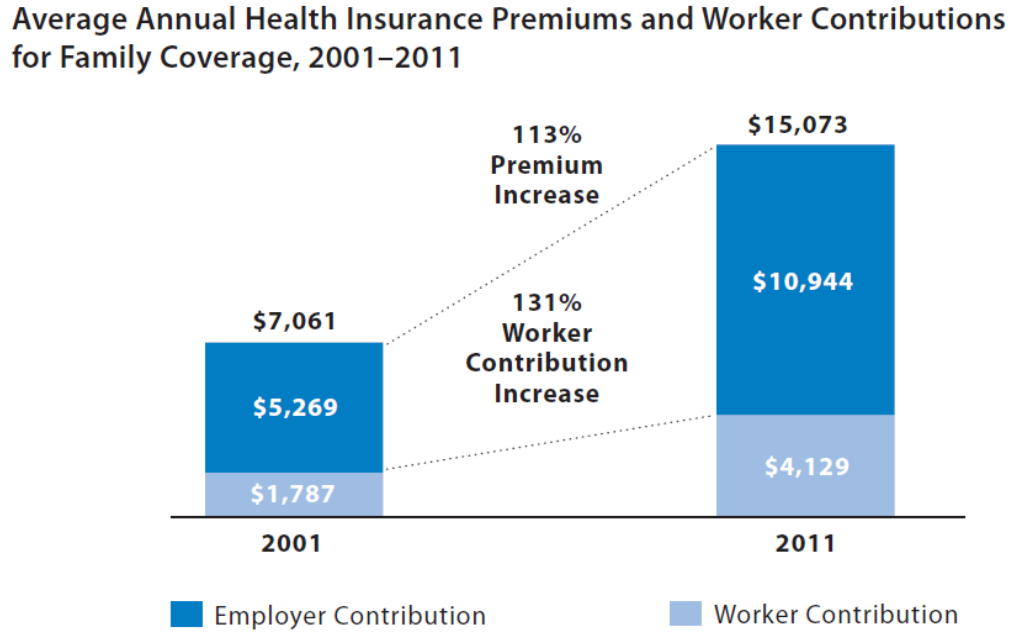


SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Department of Commerce, Bureau of Economic Analysis. **NOTES** 2009 is a historical estimate; 2010 through 2020 are projections. 2010–13 is based on recovery from recession, includes impact of some Affordable Care Act provisions, and a 2012 Medicare physician payment cut. 2014 reflects the beginning of the major Affordable Care Act coverage expansions. 2015–20 reflects that Affordable Care Act coverage expansions continue through 2017, and other provisions of the act impact payment and coverage. Elevated Medicare enrollment growth is due to baby boomers.

Source: Keehan, S. P., Sisko, A. M., Truffer, C. J., Poisal, J. A., Cuckler, G. A., Madison, A. J., . . . Smith, S. D. (2011). National health spending projections through 2020: Economic recovery and reform drive faster spending growth. *Health Affairs, 30*(8), 1594-605. Retrieved from http://search.proquest.com/docview/887281817?accountid=13158.

With the increasing costs of health care services, employers and their workers are contributing more to health insurance plans. In fact, workers are contributing 131 percent more than they were in 2001 (Kaiser, 2011). Figure 5 on the next page shows how much employer and worker contributions have increased over the past decade for family coverage. In 2011, the average annual premiums for family and single coverage were $15,073 and $5,049, respectively (Kaiser, 2011). These reflect annual increases in premium of 9 percent for family coverage and 8 percent for single coverage (Kaiser, 2011). For family coverage, this increase is significantly higher than the 3 percent growth in premium from 2009 to 2010 (Kaiser, 2011).

Figure 5—Comparison of Average Annual Health Insurance Premiums



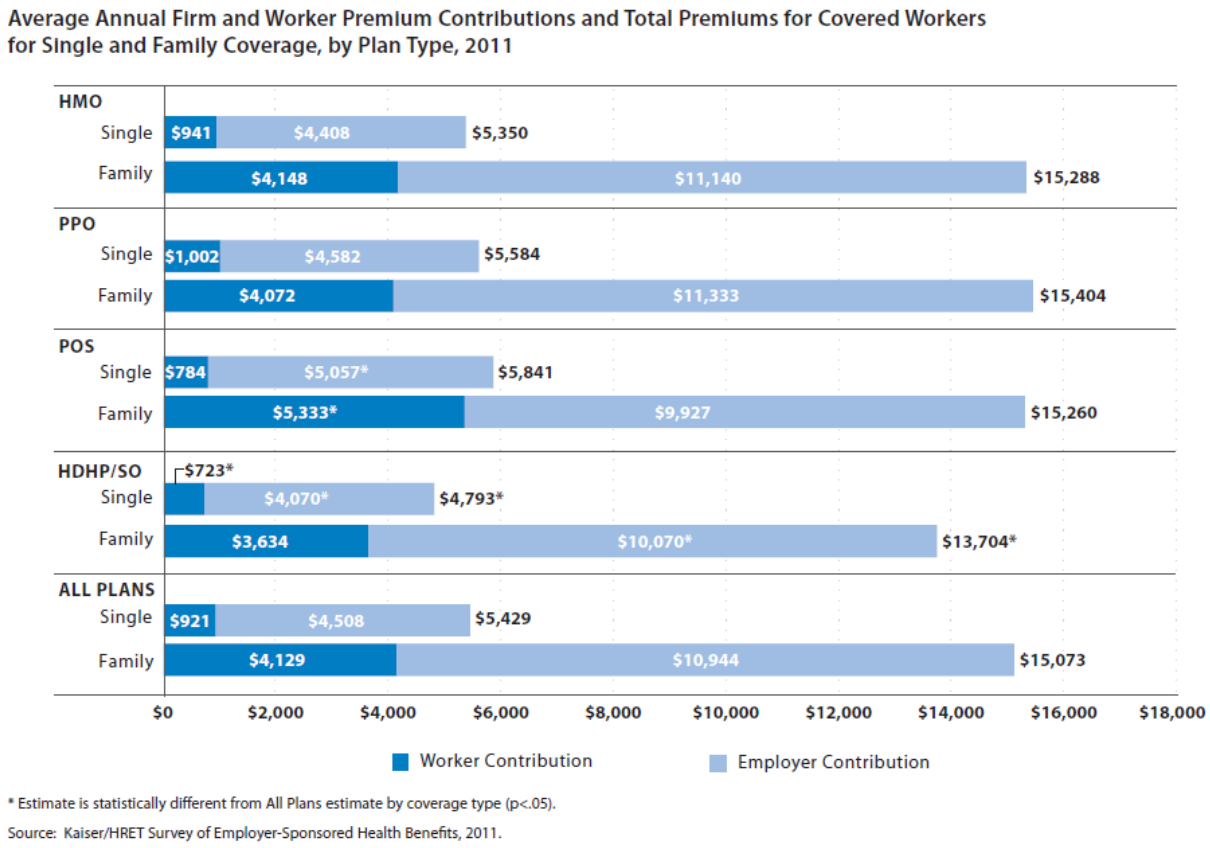
Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2001–2011.

Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

The cost of health care differs depending on the plan design chosen by the employer. Preferred provider organizations (PPOs) are the most common plan type representing 55 percent of covered employees (Kaiser, 2011). 17 percent of covered employees are enrolled in HMOs, HDHP/SOs continue to grow with 17 percent of covered workers currently enrolled, and point of service (POS) plans represent 10 percent of the enrollment (Kaiser, 2011). As the most common plan type, one may think that PPOs are also the cheapest; however, that is not the case. HDHP/SO is the cheapest plan design followed by HMOs, then PPOs. The average annual premiums for different types of health plans are compared to the annual average premium of all plans in Figure 6 on the next page. Not only is HDHP/SO the cheapest plan, but it is also the only plan that is cheaper and statistically different at a significance level of 5 percent from the

annual average premium of all plans (Kaiser, 2011). This supports the fact that there has been significant growth of this plan type over the past few years with employers looking to cut costs in their premium contributions. As mentioned above, 17 percent of covered employees were enrolled in a HDHP/SO in 2011 (Kaiser, 2011). This is up from 13 percent in 2010 and 8 percent in 2009 (Kaiser, 2011).

Figure 6—Comparison of Average Annual Premiums by Plan Design

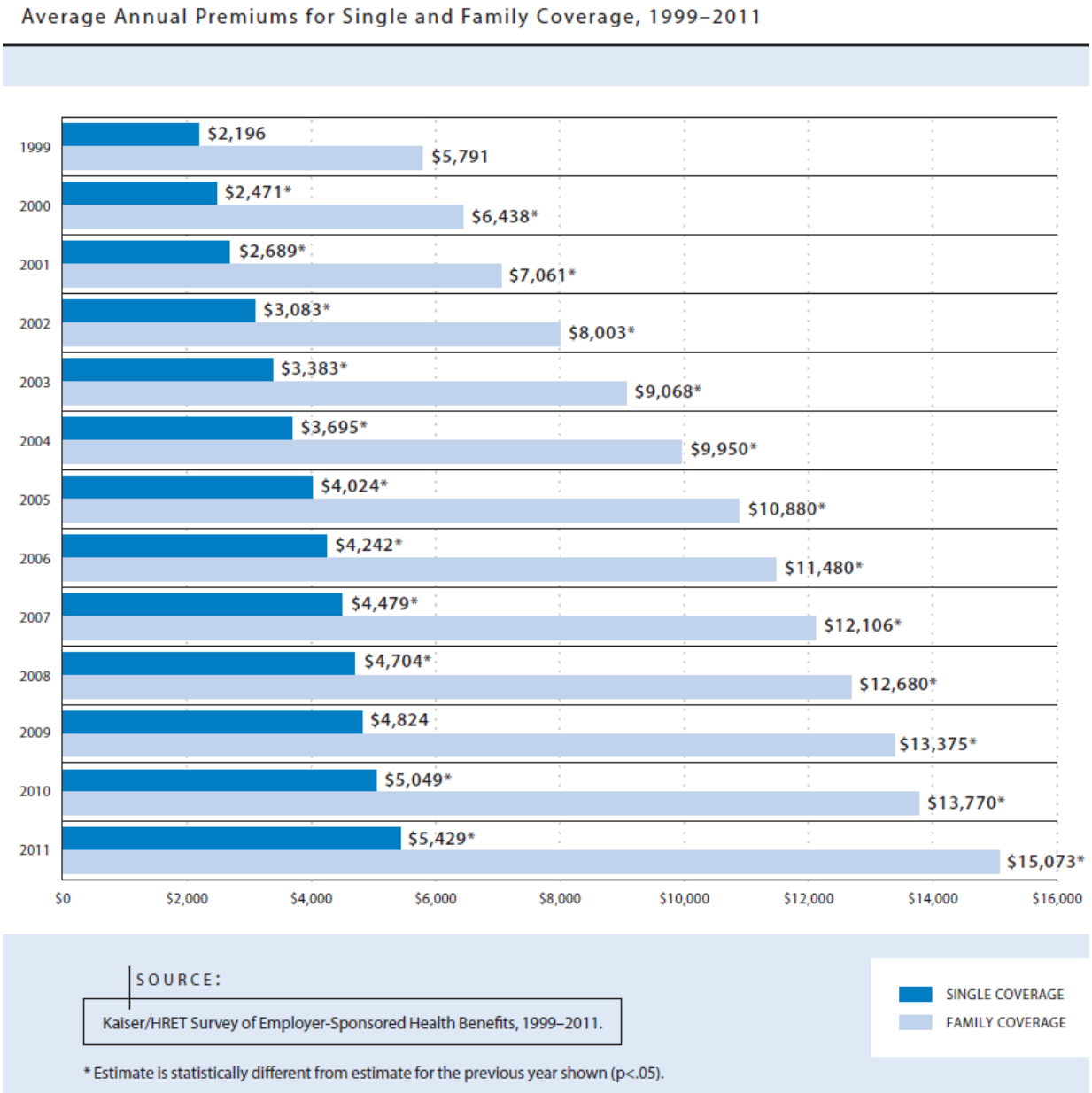


Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

Although specific plan designs have different prices, the annual premium average of all plans is a good indication of the trend of health insurance costs. Since 1999, average annual premiums of family insurance coverage have seen year over year increases that are statistically

significant at 5 percent every year (Kaiser, 2011). Single insurance coverage shows a very similar premium trend with statistically significant year over year increases in all years except 2009 (Kaiser, 2011). Figure 7 provides a year by year comparison of average annual premiums for single and family coverage from 1999 to 2011.

Figure 7—Trend of Average Annual Premiums for Health Care (1999-2011)



Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

Chapter 3—Discussion of the Theories of Adverse Selection and Moral Hazard

PPACA has three main goals: to expand coverage, to control health care costs, and to improve the health care delivery system. These goals address the issues of access, affordability, and quality. In order to achieve these goals, PPACA must be able to implement effective risk pooling to address the problem of asymmetric information. Specifically, PPACA needs to minimize the opportunities for adverse selection and moral hazard in our health care system. Adverse selection is the tendency of buyers with high expected losses to buy more coverage than buyers with lower expected losses when they are charged equal premiums, and moral hazard is the tendency of individuals to take on more risk if they do not have to bear the majority of its risk. Ultimately, the underlying goal of PPACA is risk reduction through the pooling of independent losses. Achieving this will allow the law to reach its goals of access, affordability, and quality.

The current health care system does not allow for the most effective risk pooling. Let's consider the differences in the risk pools of employer sponsored health plans and individually purchased health plans. With employer sponsored health plans, a certain level of health exists among members because they must be healthy enough to sustain a job. Combining the employees that have this health status with their dependents who may or may not have that same health status creates a risk pool. This risk pool is effective because there is a mixture of healthy and not healthy individuals. Minimal adverse selection exists because there is diversification of risk.

In contrast, the risk pool of the individually purchased health plans is not effective because it does not have a balance of healthy and not healthy individuals. Since there is no requirement that individuals have to purchase health insurance, the healthiest individuals are less

likely to choose to purchase it because they believe that their expected losses are less than the amount of premiums that they would be charged. As a result, the majority of individuals who purchase private health plans are those who are sick and know that they are going to need insurance to help with the costs of doctor visits, treatments, prescriptions, etc. This results in an ineffective risk pool because it does not contain a balance of low and high risk individuals. Without the uninsured healthy portion of the population, the remaining participants in the individual market are more likely to be heavily concentrated with high risk policyholders. As a result, the premiums for individually purchased health plans tend to be higher because of the greater expected losses that result from higher risk individuals. This is the problem of adverse selection, where only those who need the health insurance are going to purchase it.

The individual mandate is PPACA's way of diversifying risk to create more effective risk pools. By requiring every person to purchase the defined minimum limits of health insurance, PPACA is adding people to insurers' risk pooling arrangements and reducing adverse selection. With more independent participants in the risk pools, the standard deviation of the average loss is reduced. This results in the probability of extreme outcomes, such as a very high loss, being reduced. In the extreme case, the standard deviation per individual decreases to almost zero resulting in the risk becoming negligible for each individual as well. This is reflective of the law of large numbers, a common theory used in statistics. There is concern that the penalty for not purchasing the minimum required coverage is not high enough to make the healthiest people buy insurance, so problems may arise with creating a diversified pool if most of the healthiest individuals choose to pay the penalty rather than buy insurance.

The individual mandate is an alternative to the socialization of health insurance. The risk pool needs to be expanded, so requiring everyone to purchase minimum coverage allows lower

risk individuals to subsidize higher risk individuals. This is the same notion that socializing health insurance would achieve if implemented in our country. Both methods spread risk across policyholders using different mechanisms, but one difference is the sharing of insurance costs. Socialization creates an equal sharing of insurance costs among individuals while the individual mandate charges risk-based prices within the required medical loss ratio. Given only this slight difference, the individual mandate is our government's attempt to socialize insurance without officially socializing it.

Although PPACA is addressing the problem of adverse selection, it does not directly address the problem of moral hazard. Instead, moral hazard is being addressed by employers in their cost-sharing mechanisms. Previously, most health plans, such as point of service (POS), HMOs, and PPOs, required a minimal deductible if they required one at all. With a CDHP such as HDHP/SO, the deductible is much higher, so the consumer shares in the initial costs of the coverage. In addition to increasing the deductible of plans, employers are shifting more of the premium costs to their employees. Under PPACA, the only services that the deductible does not apply to would be preventive services. This provision is discussed in Section 5 of Chapter 5. Employers still pay the majority of the premium, but they are increasing the percentage that is paid by an enrolled employee. As a result, the employees have incentives to control their costs and make educated decisions about the services they choose. In other words, the problem of moral hazard is reduced because the consumers of the health care coverage are bearing more of the costs involved with their risks.

Between PPACA and employers' implementation of cost-sharing, the problems of adverse selection and moral hazard are being addressed in the current health care environment. Given the recent and upcoming changes, it is not possible to determine if the provisions of

PPACA can adequately address adverse selection and moral hazard by the above means. However, as data becomes available in the future, the concepts of adverse selection and moral hazard can be analyzed to determine the impact of the PPACA provisions on them.

Chapter 4—PPACA Relevant to Employer Sponsored Plans

Among the provisions of PPACA, there are certain mandates and regulations that apply specifically to employers and the group plans that they are enrolled in to provide coverage to their employees. Other changes apply to the insurers or the government programs but may still affect employers' decisions about their employee health benefits. Employers will be impacted and will have to make a decision about the future of their employees' health benefits. They will have to evaluate the impact of PPACA on their offerings as well as the advantages and disadvantages of continuing or terminating their health benefit plans. This chapter overviews the major provisions of PPACA that are relevant to employer sponsored plans and may impact their decision to continue providing employee health benefits.

Section 1: Grandfathered Health Plans

Employer sponsored health plans that are classified as grandfathered are exempt from many of the provisions defined in PPACA. Grandfathered health plans are plans that were already in effect before PPACA was passed on March 23, 2010. The stipulation on these plans is that they have not undergone significant changes since that time. Employers cannot make substantial changes to cost sharing, benefits, employee contributions, or access to coverage. If substantial changes have been made, the exemptions no longer apply. As long as the employer maintains consecutive enrollment in the grandfathered plan, new employees can be enrolled without affecting the grandfathered status.

Although these grandfathered plans are exempted from most of PPACA's provisions, they do have to comply with some of the standards as they become effective in the upcoming years. Employers with grandfathered plans must provide a uniform explanation of coverage and extend dependent coverage eligibility to age 26. Their medical loss ratios must be reported and if

they are not acceptable according to the standards set in PPACA, premium rebates must be provided. Grandfathered plans also have to meet the minimum lifetime and annual limits on essential health benefits as defined in PPACA and will be subject to the prohibition of these limits beginning in 2014. In addition, they will be required to prohibit health plan rescissions, coverage exclusions for pre-existing health conditions, and waiting periods greater than 90 days.

Table 4—Summary of the Percentage of Employers with Grandfathered Plans

Percentage of Firms with At Least One Plan Grandfathered under the Affordable Care Act (ACA), by Size, Region and Industry, 2011

	Percentage of Firms with At Least One Grandfathered Plan
FIRM SIZE	
3–24 Workers	76%*
25–49 Workers	54*
50–199 Workers	65
200–999 Workers	61*
1,000–4,999 Workers	59*
5,000 or More Workers	57*
All Small Firms (3–199 Workers)	**72%***
All Large Firms (200 or More Workers)	**61%***
REGION	
Northeast	68%
Midwest	71
South	72
West	75
INDUSTRY	
Agriculture/Mining/Construction	86%*
Manufacturing	46*
Transportation/Communications/Utilities	80
Wholesale	76
Retail	86*
Finance	72
Service	72
State/Local Government	82
Health Care	54
ALL FIRMS	**72%**

SOURCE:
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011.

* Estimate is statistically different from estimate for all other firms not in the indicated size, region, or industry (p<.05).

Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

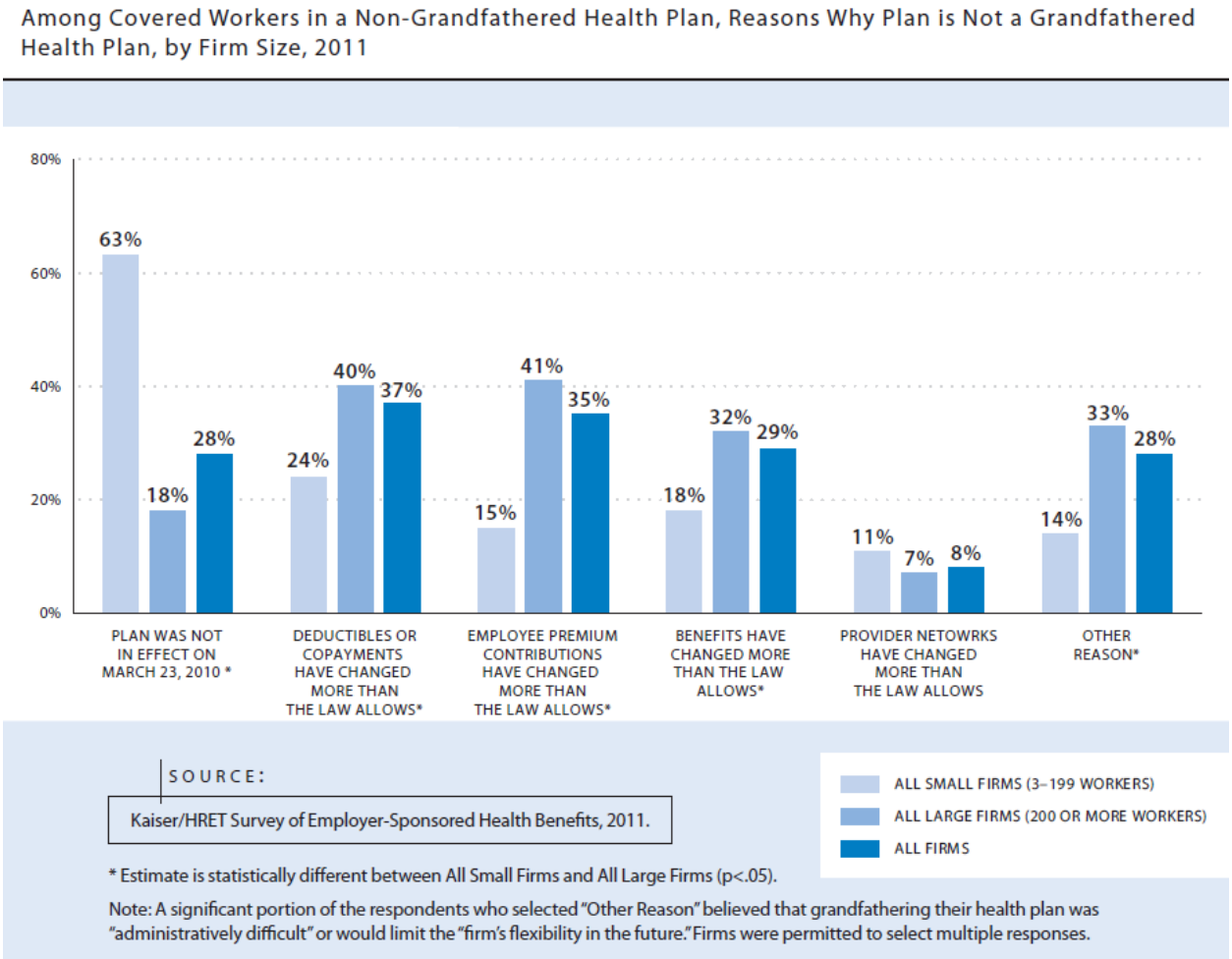
Employers had to decide whether to grandfather their current plans and limit the changes that they could make to the plan designs or whether to comply with the full set of new health reform provisions. At least one health plan has been grandfathered by 72 percent of employers, and small employers were more likely to have at least one grandfathered plan (Kaiser, 2011). A complete summary of the percentage of employers with at least one grandfathered plan according to firm size, region, and industry is available in Table 4 on the previous page.

Employers who chose not to grandfather their health plans gave various responses in support of their decision not to have their plans classified as grandfathered. The main reasons cited were as follows:

- The plan was not in effect when PPACA was passed on March 23, 2010.
- Deductibles or copayments have changed more than PPACA allows for grandfathered plans.
- Employee premium contributions have changed more than PPACA allows.
- Benefits have changed more than PPACA allows.
- Provider networks have changed more than PPACA allows.

Some firms also found that being grandfathered was administratively difficult while others did not like how grandfathering their health plans limited their flexibility in the future. Small firms were more likely to have a plan that was not in effect on March 23, 2010 while large firms were more likely to have a plan that had experienced changes in deductibles or copayments, employee contributions, or benefits (Kaiser, 2011). A complete summary of employers' responses based on firm size can be found in Figure 8 on the following page.

Figure 8—Summary of Reasons for Not Grandfathering a Health Plan



Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

Section 2: PPACA Provisions that Became Effective in 2011

Some of the most immediate provisions to take effect concern mandates that apply to all group health plans. These provisions are effective for plan or policy years beginning on or after September 23, 2010 or for calendar year plans beginning January 1, 2011.

All plans were required to extend coverage eligibility for covered workers' children, so coverage must be provided to employees' children up to age 26, regardless of financial dependence. The one exception was grandfathered plans, which do not have to extend eligibility

until 2014. Twenty percent of employers' reported that they had to enroll at least one child who would not have been eligible for enrollment otherwise (Kaiser, 2011). The number of dependents enrolled under this provision varied by the size of the employer. 70 percent of large firms enrolled an eligible dependent while only 19 percent of smaller firms enrolled an eligible dependent (Kaiser, 2011). A complete summary of the percentage of firms who enrolled dependents as a result of this provision is available in Table 5 on the next page. This table provides overall percentages as well as percentages by size, region, and industry. Overall, a total of approximately 2.3 million adult dependents were enrolled in employer-sponsored health plans due to this provision of PPACA (Kaiser, 2011).

Other provisions that have already taken effect include prohibitions on the basis of exclusions and rescissions as well as restrictions on lifetime and annual benefit limits. PPACA instituted a prohibition on preexisting condition exclusions stating that plans cannot exclude enrollees under the age of 19 due solely to a preexisting condition. Another provision that took effect is the prohibition on rescissions, which states that plans cannot cancel or discontinue coverage unless there is evidence of fraud or intentional misrepresentation of a material fact. Another restriction pertains to lifetime and annual dollar limits of health insurance plans. Lifetime dollar limits on essential benefits cannot be imposed and plans can only impose certain restricted annual limits on essential benefits as defined by the Secretary of Health and Human Services. For a plan year beginning between September 23, 2010 and September 23, 2011, the annual limit may not be less than $750,000. For a plan year beginning between September 23, 2011 and September 23, 2012, the annual limit may not be less than $1.25 million. For a plan year beginning between September 23, 2012 and December 31, 2013, the annual limit must not

be less than $2 million. Annual limits are completely prohibited for plans beginning on or after January 1, 2014.

Table 5—Summary of Employers who Enrolled at least One Adult Dependent

Percentage of Firms Offering Family Coverage That Enrolled Adult Dependents up to 26 Years of Age Because of the Affordable Care Act (ACA), by Size, Region, and Industry, 2011

	Percentage of Firms Who Enrolled Adult Dependents Because of the ACA
FIRM SIZE	
3–24 Workers	13%*
25–199 Workers	37*
200–999 Workers	66*
1,000–4,999 Workers	86*
5,000 or More Workers	90*
All Small Firms (3–199 Workers)	**19%***
All Large Firms (200 or More Workers)	**70%***
REGION	
Northeast	27%
Midwest	21
South	19
West	15
INDUSTRY	
Agriculture/Mining/Construction	3%*
Manufacturing	25
Transportation/Communications/Utilities	33
Wholesale	58*
Retail	9*
Finance	26
Service	22
State/Local Government	11
Health Care	13
ALL FIRMS	**20%**

SOURCE:
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011.

* Estimate is statistically different from estimate for all other firms not in the indicated size, region, or industry (p<.05).

Note: The question asked firms if they enrolled adult dependents who would not have been eligible before the ACA provision took effect.

Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

Section 3: Minimum Essential Benefits Requirement

Under the jurisdiction of PPACA, all qualifying health insurance plans will be required to cover minimum essential benefits. These will likely vary by state, but the idea is that every insured individual will have access to these minimum benefits. Some of the potential benefits to be included in these minimum coverage requirements are:

- Hospitalization;
- Outplacement hospital and clinic services;
- Physician and other health professional services;
- Medical equipment, services, and supplies;
- Mental health, substance disorders, and behavioral health;
- Prescription drugs;
- Rehabilitative and habilitative services;
- Maternity; and
- Well-baby, well-child care and other child services to age 21.

Some employers do not currently offer all of these benefits, so the added costs of expanding their coverage are a major concern to many employers. This minimum essential benefits requirement is accompanied by an automatic enrollment with opt-out rights. In addition to these comprehensive coverage requirements, PPACA mandates that plans cover at least 60 percent of the actuarial value of the covered benefits. Temporary relief for grandfathered plans is provided until 2018 but is subject to certain restrictions as discussed in Section 1 of this chapter.

Section 4: Pay or Play Mandate for Employers

A provision taking effect in a few years is the requirement that employers provide coverage or pay a penalty. This is more commonly referred to as the “play or pay” mandate for

employers. All employers with 50 or more full-time employees will be required to offer coverage. Those who do not offer coverage and who have at least one full-time employee receiving a premium tax credit will be assessed a fee of $2,000 per full-time employee in excess of 30 employees. Those employers who offer coverage but who have at least one full-time employee receiving a premium tax credit will be assessed the lower of $3,000 per employee receiving a premium tax credit or $2,000 per full-time employee in excess of 30 employees. This provision is effective January 14, 2014 and employers with less than 50 employees will be exempt from any of the mentioned penalties. Some employers have expressed that the penalties are too low and that they will pay the penalty instead of the higher expense of providing health insurance even though they receive no value from the penalty.

Section 5: Cost Sharing of Preventive Benefits

Health care reform promotes a shift in the approach that Americans take in the treatment of their health. Previously, most health plans provided support for treatment after a diagnosis of illness occurred, but in an effort to create a healthier society, the reform encourages plans to take a proactive approach to preventing illness. PPACA requires health plans to cover certain preventive services without deductibles, copayments, or other cost sharing mechanisms. Grandfathered plans are able to conform to this provision without losing their grandfathered status as well.

As a result of this provision, some employers changed their policy regarding cost sharing for preventive benefits and others adjusted the services categorized as preventive. 23 percent of covered employees are enrolled in plans where employers' changed their policy of copayments or coinsurance for preventive services, and employees of large firms were more likely to be part of such a plan than employees of smaller firms (Kaiser, 2011). 31 percent of enrolled employees'

are part of an employer sponsored health plan that changed the services considered preventive because of this provision of the PPACA (Kaiser, 2011). This change was also more common among large employers than among small firms. A table comparing the percentage of small firms and of large firms who made changes to cost sharing for preventive services can be found in Table 6 on the next page.

Table 6—Summary of Employers and their Cost Sharing for Preventive Services

Among Covered Workers, Changes to Cost Sharing for Preventive Services Because of the Affordable Care Act (ACA), by Firm Size, 2011

	Percentage of Workers in a Plan Where Cost Sharing Changed for Preventive Services Because of the ACA	Percentage of Workers in a Plan Where the Services Considered Preventive Changed Because of the ACA
FIRM SIZE		
All Small Firms (3–199 Workers)	13%*	25%*
All Large Firms (200 or More Workers)	28%*	34%*
ALL FIRMS	23%	31%

SOURCE:
Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2011.

* Estimate is statistically different between All Small Firms and All Large Firms (p<.05).

Source: Kaiser Family Foundation & Health Research and Educational Trust. (2011, September 27). Employer health benefits: 2011 annual survey. *Kaiser Family Foundation*. Retrieved from http://ehbs.kff.org/pdf/2011/8225.pdf.

Section 6: Tax Credit for Small Employers

Providing health benefits to employees is more expensive for smaller employers because they do not have access to a large number of participants to create a large risk pool like the bigger firms. To help with the costs of offering employer-sponsored health insurance, PPACA provides a temporary tax credit to some small employers that offer coverage to their employees. Eligible firms are those who:

- Have fewer than 25 full-time equivalent employees
- Have an average annual payroll of less than $50,000 per employee
- Contribute at least 50 percent of the cost of health insurance offered to employees

The tax credit value is based on a sliding scale that phases out as the number of employees and average payroll of workers increases. From 2010 to 2013, the maximum tax credit is 35 percent of employer premium costs, 25 percent for tax-exempt employers. In 2014, this will increase to 50 percent of premium contribution for eligible employers, 35 percent for tax-exempt employers, if the coverage is purchased on an exchange. Employers with ten or fewer full-time employees with average annual wages of less than $25,000 per employee are eligible for the full tax credit amount.

Section 7: Excise Tax on High-Cost Health Plans

To help with the financing of the health care reform, an excise tax will be imposed on high-cost health plans beginning in 2018. This tax will be enacted on insurers of employer-sponsored health plans that have aggregate values in excess of $10,200 for individual coverage and in excess of $27,500 for family coverage. These threshold values will be set each year according to the consumer price index beginning in 2020. The tax will be equal to 40 percent of the value of the plan that exceeds the threshold amounts mentioned previously. The value of the plan includes reimbursements from a flexible spending account for medical expenses or health reimbursement arrangement, employer contributions to a health savings account, and coverage for supplementary health insurance coverage, not including dental and vision benefits. This is relevant to employers because insurers may increase the premium of these plans to offset this tax if they are able to do so while staying within the required medical loss ratio. I would expect that

there will be a lot of movement away from these high-cost health plans as a result of this provision.

Section 8: Supreme Court Review of the Constitutionality of PPACA

Health care in the United States has been a controversial topic over the past couple of years and the debate has escalated following the passing of PPACA. Several lawsuits have been filed challenging different provisions of the reform. While the majority of them were dismissed, the United States Supreme Court is reviewing issues relating to the constitutionality of two provisions: the individual mandate and the Medicaid expansion. Two cases in the 11th Circuit Court of Appeals, National Federation of Independent Business v. Sebelius and Florida v. Department of Health and Human Services, were filed in the state of Florida to initiate the evaluation, and the Supreme Court consolidated them in its review of the issues.

The first case, filed by the National Federation of Independent Businesses and two private plaintiffs, focuses on the validity of the individual mandate. Their argument is that the individual mandate is not a valid exercise of Congress's legislative powers. The second case, filed by the State of Florida and joined by 25 other states, contests the expansion of mandatory Medicaid eligibility starting in 2014. Their argument states that this expansion is an unconstitutional exercise of Congress's Spending Clause power based on improperly coercing states to participate in the Medicaid program.

In the lower federal appellate courts, various decisions have been reached in response to suits challenging the constitutionality of the PPACA. In the cases from the 11th Circuit Court of Appeals, the individual mandate was struck down while the Medicaid expansion was upheld. Both the D.C. Circuit Court of Appeals and the 6th Circuit Court of Appeals upheld the individual mandate. In other circuits, cases have been barred or dismissed for other reasons, and

all pending cases have been put on hold awaiting the Supreme Court's decision. A summary of the Circuit Court decisions as of January 2012 can be found in Table 7 on the next page.

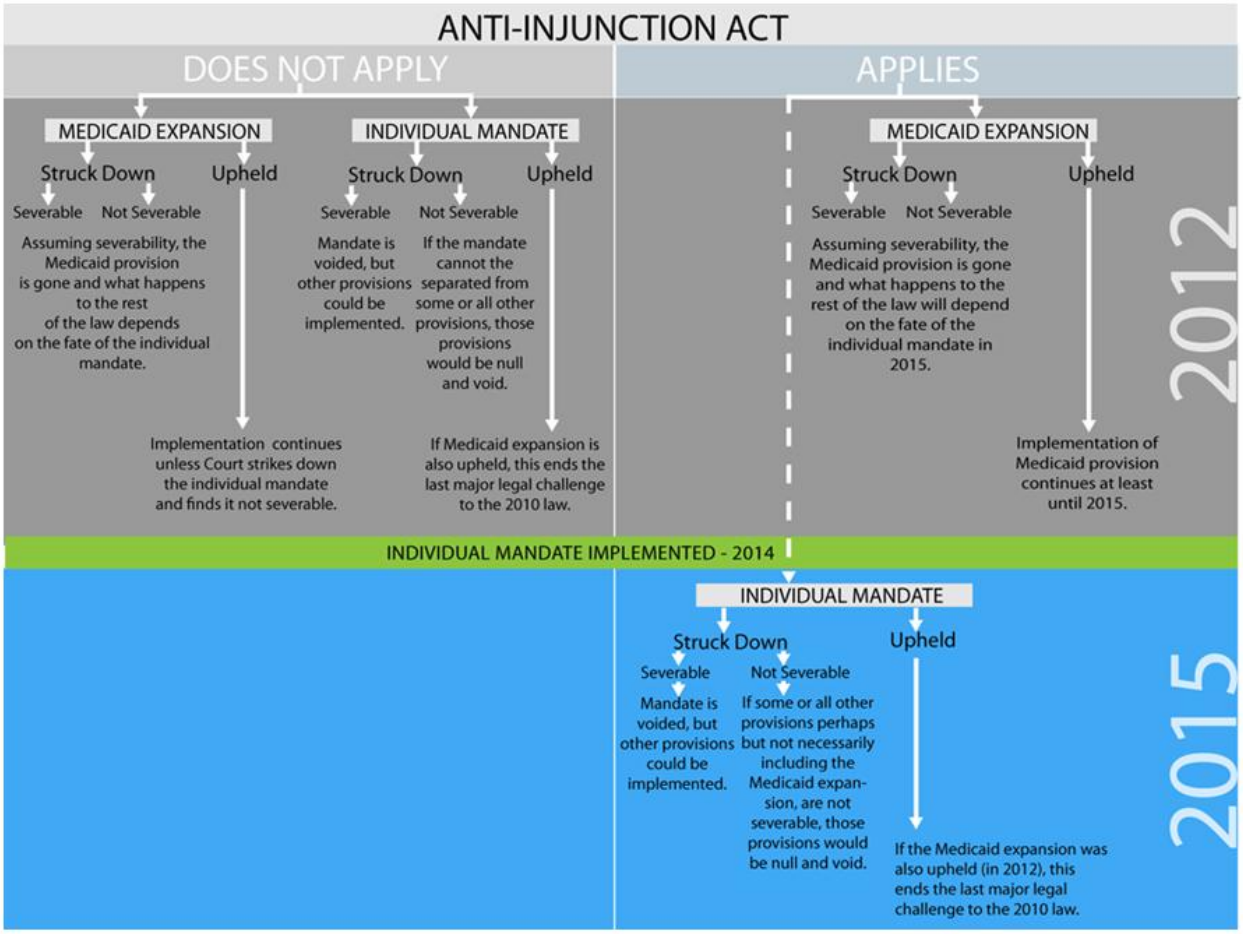
Table 7—Summary of Circuit Courts of Appeals Decisions in PPACA Litigation

	Plaintiffs' Standing	Anti-Injunction Act	Individual Mandate	Medicaid Expansion
3rd Circuit	No standing			
4th Circuit		ACA cases barred		
6th Circuit			Upheld	
8th Circuit	No standing			
9th Circuit	No standing			
11th Circuit			Struck down	Upheld
D.C. Circuit			Upheld	

Source: Kaiser Commission on Medicaid and the Uninsured. (2012, February 1). A guide to the supreme court's review of the 2010 health care reform law. *Kaiser Family Foundation*. Retrieved from http://www.kff.org/healthreform/upload/8270-2.pdf.

In addition to the issues that arose from these two cases, the Supreme Court will be reviewing the application of the Anti-Injunction Act related to the lawsuits about the individual mandate. The Court will evaluate whether now is the appropriate time for courts to rule on the PPACA's constitutionality or if the Anti-Injunction Act prevents courts from ruling until after taxpayers have incurred the financial penalty for failure to comply with the individual mandate. Ultimately, the Supreme Court will be upholding or striking down the two provisions that are under review. If the Anti-Injunction Act applies, the Court will not rule on the individual mandate until after it is implemented, but it will still rule on the Medicaid expansion immediately. In addition, if the Court strikes down either of the provisions, it will have to decide whether it is severable or not severable from the rest of the reform law. A visual description of how the Supreme Court's decision could impact these provisions and the rest of the law can be found in Figure 9 on the next page.

Figure 9—Potential Impacts of the Supreme Court's Decision



Source: Kaiser Commission on Medicaid and the Uninsured. (2012, February 1). A guide to the supreme court's review of the 2010 health care reform law. *Kaiser Family Foundation*. Retrieved from http://www.kff.org/healthreform/upload/8270-2.pdf.

Chapter 5—PPACA's Impact on Motivations of Employers to Self-Insure Health Care

I briefly mentioned employers' original motivations for offering health benefits to their employees in Chapter 1. In this chapter, I will expand on these motivations to provide an understanding of why employers may choose to self-insure their employees' health benefits instead of purchasing an insurance plan and if their motivations to self-insure have changed because of PPACA. There are many advantages to self-insuring, but to do so successfully, employers must be able to manage the variability in costs from year to year. Typically, this requires having a larger workforce to spread out the risk over a diversified pool of employees and their dependents. As a result of this required characteristic, this discussion will focus on large employers. To provide a clear understanding of whether or not employers' motivations have changed with the passing of PPACA, I will contrast the motivations of employers to self-insure prior to the passing of PPACA with their motivations to self-insure after the passing of PPACA.

Section 1: Motivations of Large Employers to Self-Insure before PPACA

Self-insured health plans are governed by the Employee Retirement Income Security Act (ERISA), which means that they are not subject to state insurance regulations, benefit mandates, and premium taxes that are assessed on fully insured health plans. This is the first motivation for employers to self-insure. Being governed by ERISA, self-insured health plans have more flexibility in the types and amounts of coverage that they can offer. In addition, employers can save money by not having to pay premium taxes that are required on fully insured health plans. ERISA motivates employers to consider self-insuring because of this flexibility and savings.

By self-insuring their employees' health benefits, employers retain greater control over designing plan benefits, provider networks, and employee cost sharing mechanisms. Employers

can include the benefits that are a good fit for their workforce and exclude any benefits that they feel are not an effective use of their dollars allocated for health spending. They can determine provider networks based on their own criteria rather than on criteria set forth by an insurer. These personalized criteria usually focus on the cost of services but may also include things like location, patient capacity, or the diversity of available services. Some of these motivations originate from ERISA, but others are the result of not being under the jurisdiction of an insurer.

When an employer fully insures its employees' health benefits, it pays a premium to the insurer and the insurer handles the payment of claims. A problem with this setup is that employers do not see the cost of their employees' claims, and there is little to no transparency of the costs of health services. Being pooled with other companies adds to this problem because their premiums are determined by the overall experience of the pool, rather than being based on their own experience. As a result, if their claims experience was good while the majority of other employers in the pool had bad claims experience, their premiums may increase. Self-insurance corrects for this problem because costs are based on the employers' own claims experience and the employer sees how much the employees' claims are costing throughout the year. This is especially beneficial for employers with a young, healthy workforce because they would expect to have lower than expected claims experience.

Another motivation for employers to self-insure health benefits is improved cash flows. The improvement in their cash flows is the result of maintaining control of their loss reserves and not having to pre-pay for coverage. In a fully insured health plan, the employer has to pay the annual premium up-front to the insurer, which is a disadvantage because that is a large outflow of cash in a single transaction. The insurer also controls the loss reserves for the plan in a fully insured setup which means that they retain any interest that is earned on the money. Furthermore,

they retain the excess reserves when claims are lower than expected. In contrast, a self-insured health plan allows an employer to pay out smaller cash flows as claims arise throughout the year and to retain control over its loss reserves. In terms of cash flows, self-insurance is better because the employer is able to spread this expense over the year rather than having it deducted in one transaction. By being in control of its loss reserves, the employer keeps any interest that is earned on this money and it also retains the excess dollars when it has good claims experience. Retaining control of the loss reserves is a big motivation for employers because it incentivizes them to help their workforce be healthier. In turn, they see better work performance from their employees, which is another added benefit.

Another reason that employers currently self-insure their health plans is to save money on plan administration. With a growing presence of internal risk management in firms, many employers feel that they have the expertise to administer health benefits to their employees. This saves them on the overhead expenses that would be paid as part of their premium to the insurers in a fully insured plan. In addition, it eliminates the expense of profit loading for the insurer and the commission fees if their coverage is purchased through a broker. The extent of these expenses varies, but in the current economic environment, employers are considering all of their options to save money including performing more tasks internally like administering health insurance benefits.

Section 2: Motivations of Large Employers to Self-Insure after PPACA

Although PPACA provisions will affect the individual and small-group markets the most, it also has effects on the large-group and self-insured markets. More than half of employees receive health benefits from self-insured plans in which their employers bear all or some of the risk of the insurance (Linehan, 2010). Most of these covered workers are in large firms. With the

current health care environment and the changes that are taking place with the passing of PPACA, have employers' motivations for self-insuring health care changed or will they change as more of the provisions go into effect?

Despite being subject to the unlimited annual and lifetime benefits provisions of PPACA like the fully insured plans, the costs of self-insured benefits will remain lower because these plans are still not subject to the state benefit mandates or premium taxes that increase the costs of such plans when fully insured. This is because they remain under the governance of ERISA, which forbids states from directly regulating employers about their offerings of employee health benefits. Therefore, the motivations of saving on administrative and overhead expenses will remain after the passing of PPACA.

Insurers are required to maintain a minimum medical loss ratio under the provisions of PPACA. Insurers have to spend 85 percent of collected premiums from groups of 100 or more on medical care, which leaves only 15 percent for overhead costs (Wojcik, 2012). This is likely to add to the rising costs of fully insured health plans, because brokers will now be forced to seek compensation directly from the purchasers of insurance. As a result, this requirement may result in more employers transitioning to self-insurance of health benefits, unless the brokers' compensation declines in an effort for them to sell more insurance. This supports the motivation of saving on the profit loading and commission fees that can be expensive on fully insured plans.

One potential negative of self-insuring health benefits is that stop-loss coverage is subject to premium taxes. Stop-loss insurance is coverage that employers' purchase as a safety net to their self-insurance. This coverage can be purchased to cover large losses that exceed a limit on an individual or group basis. When you compare the cost of self-insured plans with stop-loss coverage to the cost of fully insured plans, the employer still saves. The aggregate amount paid

for self-insurance with stop-loss coverage is much less than that paid for fully insured plans because the premiums for stop-loss coverage are lower than premiums for fully insured benefits. As a result, this tends to still be a positive motivation for employers to transition to self-insurance if they do not already self-insure their health benefits. In fact, this may be a driving motivation that results in significant growth in the self-insuring of health benefits.

Section 3: Self-Insurance of Health Care by Medium to Small Employers

In the past, stop-loss coverage has not been as readily available to employers as it is today. According to Aron Minken, a director at PriceWaterhouseCoopers LLP in New York, stop-loss insurance is more available now than it has ever been in the past and insurers are offering greater protection, so there have been companies with rather low individual stop-loss deductibles. Furthermore, many health insurers have increased their efforts to sell administrative services only plans rather than fully insured plans because these plans are more profitable than the traditional insurance plans because of the minimal risk for which the insurer is taking responsibility. Another reason for this shift is that the administrative services only plans are not subject to the required medical loss ratio, which is beneficial to insurers. Insurers are even going as far as including self-insuring proposals in the renewals of fully insured employers regardless of whether or not the employer has requested it for comparison.

This growth of the stop-loss insurance market facilitates medium to small firms' ability to self-insure their employees' health benefits. With a smaller risk pool, medium to small employers experience more variability in the losses of their employees compared to larger firms. As a result, it is important for the medium to small firms to be able to purchase stop-loss insurance to cover large losses that exceed the limits of their self-insurance capabilities. The growing availability of stop-loss insurance gives medium to small employers the added option of

self-insuring employee health benefits when they're deciding how to provide health benefits to their workforces. Insurers are willing to issue administrative services only plans with stop-loss insurance to medium or small employers because the administrative services only plans are not subject to the medical loss ratio requirement of PPACA.

Section 4: PPACA's Potential to Facilitate More Regulation of Self-Insured Plans

With the passage of PPACA and the increase in the number of employers choosing to self-insure their employee health benefits, discussion has already begun about the possibility of heightened regulation of stop-loss insurance. More employers are realizing the advantages of self-insuring health benefits coupled with a safety net of stop-loss insurance. This growth concerns regulators because many employers are choosing self-insurance to bypass requirements set forth by PPACA. In an effort to curb this shift in how health benefits are provided, discussions have begun about regulating stop-loss insurance to a greater extent than the current law does. The goal of this heightened regulation would be interference with employers' decisions based on circumventing some of the requirements of PPACA.

Although stop-loss insurance has been regulated in the past, self-insured plans have not been subject to extensive federal regulation. Given the increasing amounts of regulation in all aspects of health insurance, the passage of PPACA could open the door to increased federal regulation of self-insured plans. As discussed above, there is already discussion of further regulating stop-loss insurance, so the next logical step would be to regulate self-insured plans. By increasing regulation of self-insured plans, the government could create a disadvantage for employers to self-insure health benefits. Any increased regulation creates more considerations that need to be included in an employer's evaluation of how to provide health benefits to their employees, regardless of the size of the employer. This uncertainty in the regulatory environment

creates some hesitance among employers to shift to self-insurance because the regulations have the potential to be stricter than the regulations of fully insured plans.

Chapter 6—Conclusions and Personal Observations

PPACA is going to impact all aspects of the health insurance market, whether it is directly or indirectly. The impact on employers depends on the size of the employer. The pay or play mandate presents an interesting decision for employers with 50 or more employees. This decision has three possible outcomes: offer fully insured health benefits, self-insure health care coverage for workers, or pay a penalty for not offering employee health benefits. Several journal articles discuss that the penalty is not significant enough and that many employers will choose to pay the penalty instead of continuing its employee health benefits. I disagree with this because of the expectation that our society has for the existence of employer sponsored health care coverage and because the employer does not get anything in return for paying the penalty. It is a totally lost cost, so I don't think that comparing it directly with the insurance premium is a good indication of its sufficiency. The penalty needs to be compared with the cost of the insurance less the value that the employer gains from the insurance.

The real question is whether employers will fully insure their health benefits after PPACA or if they will self-insure the coverage. This depends on the motivations of employers to self-insure health benefits. Prior to PPACA, employers' motivations included flexibility of plan design, cost-savings on administration and overhead expenses, improved cash flows, and control of the loss reserves. After the passing of PPACA, these motivations will remain to be driving forces behind employers' decisions to self-insure, and they have the potential to become even more prominent as more provisions take effect over the next several years. In addition, the growing availability of stop-loss insurance will further motivate employers to self-insure health benefits because it was not readily available in the past.

It will be interesting to see how the health insurance market changes as provisions of PPACA take effect in the next several years. As I have discussed, I think that there are a lot of motivating factors that will result in more employers self-insuring their health benefits, but there is still only minimal research on self-insuring health benefits. There is very little data available because companies tend to keep this information internally. As a result, there is a lot of further research and analysis that could be done in the future on this topic. An interesting extension of this thesis would be to revisit these motivations to see if they were driving forces behind the growth of the self-insurance of health care. Another potential extension would be to consider small employers' motivations for self-insuring health benefits. There has been some discussion of how they can successfully self-insure if they also purchase stop-loss insurance, so it would be interesting to see a thesis address their motivations and compare them to the motivations of large employers. In addition, a case study with employers who fully insure and employers who self-insure could add interesting analysis to a future thesis.

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