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COLLOQUIUM ON TAX POLICY
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"Will Employers Undermine Health Care Reform by Dumping Sick Employees?"

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SCHEDULE FOR 2012 NYU TAX POLICY COLLOQUIUM

(All sessions meet on Tuesdays from 4:00-5:50p.m. in Vanderbilt Hall-208, NYU Law School)

1. January 17 – Michelle Hanlon, MIT, Sloan School of Management. "Taking the Long Way Home: Offshore Investments in U.S. Equity and Debt Markets and U.S. Tax Evasion." (with Edward L. Maydew and Jacob R. Thornock).

2. **January 24 – Amy Monahan, University of Minnesota Law School. "Will Employers Undermine Health Care Reform by Dumping Sick Employees?" (with Daniel Schwarcz).**

3. January 31 – Alex Raskolnikov, Columbia Law School. "Accepting the Limits of Tax Law and Economics."

4. February 7 – Victor Fleischer, University of Colorado Law School. "Tax and the Boundaries of the Firm."

5. February 14 – Heather Field, Hastings College of Law. "Binding Choices: Tax Elections & Federal/State Conformity."

6. February 28 – Daniel Shaviro, New York University School of Law. "The Financial Transactions Tax Versus the Financial Activities Tax."

7. March 6 – Edward Kleinbard, USC Law School. "Reimagining Capital Income Taxation."

8. March 20 – Susan Morse, Hastings College of Law. "Worldwide Corporate Income Tax Consolidation and a Corporate Offshore Excise Tax."

9. March 27 – Stephen Shay, Harvard Law School. "Unpacking Territorial."

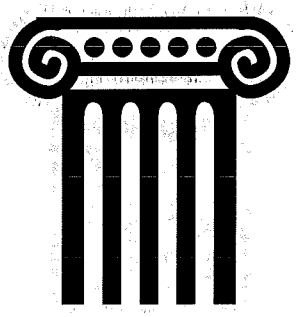
10. April 3 – Jon Bakija, Williams College Economics Department. "Jobs and Income Growth of Top Earners and the Causes of Changing Income Inequality: Evidence from U.S. Tax Return Date."

11. April 10 – Lane Kenworthy, University of Arizona Sociology Department. "Getting taxes right: What can we learn from the comparative evidence?"

12. April 17 – Yair Listokin, Yale Law School. "'I Like to Pay Taxes': Lessons of Philanthropy for Tax and Spending Policy." (with David Schizer).

13. April 24 – William Gale, Brookings Institution. "Fiscal Therapy."

14. May 1 – Rosanne Altshuler, Rutgers Economics Department, and Harry Grubert, U.S. Treasury Department. "A New View on International Tax Reform."



Will Employers Undermine Health Care Reform by Dumping Sick Employees?

Amy B. Monahan
Daniel Schwarcz

WILL EMPLOYERS UNDERMINE HEALTH CARE REFORM BY DUMPING SICK EMPLOYEES?

*Amy Monahan & Daniel Schwarcz**

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INTRODUCTION

OVER the next several years, our nation will implement a historic overhaul of its health care system. That system currently encompasses more than seventeen percent of the American econ-

omy, a figure that is trending upwards.[1] Fittingly, then, an unprecedented amount of time, effort, and debate contributed to assembling the blueprint for this reform, culminating in the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively "ACA").[2]

Nonetheless, the ultimate impact of ACA on the American health care system remains extremely unclear.[3] One of the central such uncertainties is how this reform will affect employer sponsored insurance ("ESI"), which currently covers over sixty percent of the non-elderly American population.[4] To date, commentators have generally focused on the prospect that employers will choose to drop health coverage entirely when ACA's core reforms are implemented in 2014.[5] This prediction is largely driven by the expec-

[1] See Christopher J. Truffer et al., Health Spending Projections Through 2019: The Recession's Impact Continues, 29 Health Aff. 522, 523 (2010).

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010). References to these bills initially used the acronym "PPACA." Recent federal publications, however, have switched to the shorter "ACA" and we follow that convention here. Throughout this Article, citations to "ACA" refer to PPACA and HCERA collectively, except for the instances where HCERA amended PPACA; in all instances, the statutes at large citation indicates in which of the two bills the relevant citation is located.

[3] In part, this is because much depends on how the states and federal government implement the statutory text. See Alan Weil & Raymond Scheppach, New Roles For States in Health Reform Implementation, 29 Health Aff. 1178, 1178–79 (2010). At the same time, a substantial amount of uncertainty stems from the fact that so many different constituencies helped to produce ACA's highly complicated and interconnected statutory text, resulting in 2800 pages of bills. See, e.g., John K. Iglehart, Nearing Negotiations—Reconciling Key Differences Between House and Senate Reform Measures, 362 New Eng. J. Med. e8(1) (2010) (describing some of the contentious battles that preceded the passage of ACA).

[4] See Elise Gould, The Erosion of Employer-Sponsored Health Insurance: Declines Continue for the Seventh Year Running, 39 Int'l J. Health Servs. 669, 669 (2009) ("Employer-sponsored health insurance (ESI) remains the most prominent form of health coverage in the United States, at 62.9 percent of the under-65 population; however, the rate of this coverage has fallen every year since 2000, when 68.3 percent had ESI."). As we make clear in Subsection II.B.2, we mean to include employers' prescription benefit plans within the ambit of ESI.

[5] See Kenneth S. Abraham & Daniel Schwarcz, Healthcare Supplement to Abraham's Insurance Law and Regulation 32 (5th ed. 2010) ("[V]arious employers were asked to state their level of agreement with the statement that 'Our organization would be better off if we dropped employee healthcare coverage and simply paid the fine.' 52.5% surveyed strongly disagreed, 15.3% somewhat disagreed, 18% somewhat agreed, and 14.1% strongly agreed."); David A. Hyman, Employment-Based Health

tation that, beginning in 2014, individual health insurance markets—wherein consumers purchase health insurance as individuals, just as they typically purchase auto and homeowners insurance—will prove to be a more attractive option than they are presently. If so, then employers that drop coverage will face correspondingly decreased employee backlash or recruiting difficulties, especially to the extent that they pass on the resulting cost savings to employees in the form of increased salaries.

This Article raises a different, but potentially even more distressing, risk regarding the future of ESI. It argues that there is a substantial prospect that ACA will lead some, and perhaps many, employers to implement a targeted dumping strategy[6] designed to induce low-risk employees to retain ESI but incentivize high-risk employees to voluntarily opt out of ESI and instead purchase insurance through the exchanges that ACA establishes to organize individual insurance markets.[7] Although ACA and other federal laws prohibit employers from excluding high-risk employees from ESI, these laws do little to prevent employers from designing their plans and benefits to incentivize high-risk employees to voluntarily seek coverage elsewhere. If successful, such a targeted dumping strategy would allow employers and low-risk employees to avoid the costs associated with providing coverage to high-risk employees, thereby lowering (perhaps substantially) the costs of coverage under the employer's group plan. Employers could pass on some of

Insurance: Is Health Reform a "Game Changer?," 1 N.Y.U. Rev. Emp. Benefits & Executive Compensation 1A-1, 1A-11 (2010) ("Although voters were promised 'if you like your coverage, you can keep it,' PPACA is likely to cause further unraveling of EBC, unless significant modifications are made to its design."). On the issue of early retirees losing their employer-provided health benefits generally, see Richard L. Kaplan et al., Retirees at Risk: The Precarious Promise of Post-Employment Health Benefits, 9 Yale J. Health Pol'y, L. & Ethics 287, 301–32 (2009).

[6] The general prospect of insurer dumping of high risks is prominent in the literature. See, e.g., Randall P. Ellis, Creaming, Skimping and Dumping: Provider Competition on the Intensive and Extensive Margins, 17 J. Health Econ. 537 (1998). ACA also clearly contemplates the dumping of high risks in certain limited contexts. See ACA § 1101(e), 124 Stat. at 142–43 (to be codified at 42 U.S.C. § 18001).

[7] We use the term "high-risk employee" and "low-risk employee" to refer to the employee's expected future health care costs. "High-risk employees" thus encompasses employees who are already sick and those who possess characteristics suggesting they are particularly likely to become sick in the future. Of course, high-risk employees may not ultimately end up incurring large health care expenses. But from an insurance perspective, the key question is their risk of incurring future expenses.

these savings to high-risk employees through salary increases or through tax-free reimbursement of all or part of their individual health insurance premiums. Meanwhile, both employers and employees would avoid any financial penalties under the so-called individual and employer "mandates."[8]

At its core, the risk of this form of targeted employer dumping stems from two basic features of health care reform. First, starting in 2014, ACA ensures that all individuals will have guaranteed access to individual health insurance at rates that generally do not vary based on health status.[9] High-risk employees who opt not to enroll in employer plans will therefore have relatively attractive options available to them on the individual market. Second, despite its extensive regulation of individual insurance markets, ACA grants self-insured employers[10] tremendous freedom in designing the terms of their plans.[11] Such employers are consequently free to design plans that appeal to relatively young and healthy employees but are unattractive to high-risk employees. For example, an employer plan might provide very generous coverage of preventive, wellness, and health maintenance services, while imposing large cost-sharing requirements on those services that high-risk individuals are likely to utilize, such as hospitalization. The plan could even exclude from coverage certain high-cost conditions.

Ultimately, this Article demonstrates that targeted dumping of high-risk employees will prove attractive to employers not simply

[8] The individual and employer "mandates," contained in ACA, generally require individuals to purchase and employers to offer health insurance or face a monetary penalty. See ACA § 1501(b), 124 Stat. at 244–45 (to be codified at I.R.C. § 5000A); ACA § 1513, 124 Stat. at 253–56 (to be codified at I.R.C. § 4980H).

[9] See infra Subsection I.B.1. Contrary to a widely shared misconception, high-risk employees will be free to purchase coverage in the health insurance exchanges that ACA creates to organize individual insurance markets. See infra Subsection II.A.1. Under ACA, individual health insurance premiums are permitted to vary based only on age, geographic area, family size, and tobacco use. See infra note 32 and accompanying text.

[10] Employer plans are self-insured where the employer retains the risk of loss associated with claims under the health plan. See, e.g., Thompson v. Talquin Bldg. Prods. Co., 928 F.2d 649, 653 (4th Cir. 1991). For further explanation of self insurance, see infra Subsection I.C.3. Large employers that do not self-insure may also have substantial latitude to design dumping strategies. However, for reasons discussed later, it is almost certain that any large employer that chose to pursue a dumping strategy would self-insure. Id.

[11] See infra Subsection I.C.3.a.

because it can reduce health care costs, but because it can do so while protecting the interests of all employees. First, an employer-dumping strategy can be designed to protect low-risk, but risk-averse, employees from the prospect of suddenly becoming high-risk. This requires limiting the risk of medical expenses that cannot be anticipated in time for an enrollee to switch to more comprehensive coverage in an exchange. Because enrollment in insurance exchanges is limited to annual open enrollment periods, employers attempting to dump high-risk, but not low-risk, employees will likely need to cover medical expenses that cannot be anticipated more than a year in advance, even if the plan imposes significant cost-sharing with respect to such expenses.

Second, a targeted employer dumping strategy can be designed to protect the interests of high-risk employees to the extent that employers are concerned about the labor market consequences of failing to provide this protection. In particular, dumping employers can largely offset the increased premium costs that a high-risk employee might face if she elected coverage on an exchange rather than ESI. Coverage through an exchange would ordinarily be substantially more costly to an individual than ESI, as employers contribute a substantial amount to ESI and all costs of ESI can be paid with tax-free dollars. But employers that pursue a dumping strategy can provide all migrating employees with a contribution to a health reimbursement arrangement ("HRA") equivalent to—or even larger than—the amount that the employer ordinarily contributes to an employee's coverage. High-risk employees can then use this amount, which is excluded from the employee's taxable income, to purchase coverage on the individual market.[12] As a result, the only expense to a high-risk employee of opting for coverage in the individual market would be that the difference between the cost of coverage on an exchange and the employer's contribution to the HRA would be paid on a post-tax basis. This amount that an employee would need to pay on a post-tax basis is likely to be small, given that employers currently pay on average eighty-three percent of the cost of employee-only coverage, and seventy-three

[12] For an overview of the tax benefits and requirements of health reimbursement arrangements, see I.R.S. Notice 2002-45, 2002-28 I.R.B. 93.

percent of the cost of family coverage.[13] In exchange for this moderate increase in cost, high-risk employees would be able to select among numerous insurance plans on an exchange, all of which offer federally mandated benefits without preexisting condition exclusions.

Although almost entirely unrecognized in the public debate leading up to ACA or in the regulatory fray since that time, ACA's failure to limit the strategic employer dumping we describe has the potential to substantially impair health care reform.[14] Most importantly, employer dumping of high-risk employees could undermine the exchanges on which individual markets are expected to operate by rendering the pool of policyholders seeking coverage in exchanges disproportionately risky relative to the general population. Such adverse selection, in turn, would simultaneously increase premiums, lower coverage rates, and increase the cost to the federal government of subsidizing coverage for low- and moderate-income individuals.[15] Ultimately, these forces could render insur-

[13] Kaiser Family Found. & Health Research & Educ. Trust, Employer Health Benefits: 2009 Annual Survey 68, available at http://ehbs.kff.org/pdf/2009/7936.pdf.

[14] Several sources mention in passing the possibility that employers may attempt to redesign their plans so as to induce some, but not all, employees to opt for coverage in an exchange. See Abraham & Schwarcz, supra note 5, at 32 (noting that "[a] third potential result [of reform] is that employers will continue to offer coverage, but that such coverage will contain limited benefits"); Hyman, supra note 5, at 1A-15 (noting that "some employers will make all-or-nothing coverage decisions for all employees in favor of 'nothing,' while others will experiment with changing the terms of coverage, and the boundaries of the firm and its staffing"); Timothy Jost, Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues 3 (2010), available at http://www.commonwealthfund.org/Content/Publications/FundReports/2010/Jul/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx (noting that "[a] particular concern is the possibility that employer-sponsored groups can 'self-insure' (thus escaping state regulation) as long as their employees are healthy, only to turn to the exchange once group members' health deteriorates"); id. at 8 (suggesting that "[s]elf-insured plans are subject to even less rigorous requirements under ACA, and they might offer coverage that is substantially less protective, and less costly, than exchange coverage").

[15] See Stephen Finan, Senior Director for Policy at the American Cancer Society Cancer Action Network, Testimony at the Interim Meeting of the National Association of Insurance Commissioners on Health Care Reform Implementation, Exchanges (B) Subgroup Meeting (July 22, 2010), available at http://www.naic.org/documents/committees_conliaison_1008_ntlmtg_materials.pdf. It is for these reasons that commentators have warned that adverse selection is the primary threat to insurance exchanges. See Timothy Jost, Consumer-Friendly Exchanges, Testimony at the Interim Meeting of the National Association of Insurance

ance exchanges unsustainable and thereby jeopardize health insurance reform writ large.

Not only could employer dumping adversely affect the functioning and costs of the individual market, but it would also subvert the principle of risk sharing that is at the core of reform.[16] Rather than sharing medical risks on a community basis at the employer level, targeted employer dumping would allow employers and low-risk employees to avoid the responsibility of cross-subsidizing the health care costs of high-risk employees. This, in turn, could corrode the willingness of the broader American population to shoulder the expenses of our country's comparatively high-cost population.

Fortunately, the threat posed by the prospect of strategic employer dumping of high-risk employees can be addressed through various statutory, and even regulatory, reforms. For instance, individuals with the option of employer-sponsored coverage could be denied access to coverage through health insurance exchanges, as is the case in Massachusetts's version of health care reform. Alternatively, employees who secured coverage from an employer with a plan designed to dump sick employees could be taxed under the individual mandate. Various other fixes are also possible. Although the desirability of health insurance reform has proven politically divisive, Republicans and Democrats alike should be able to agree that employers cannot be allowed to game health care reform by dumping only their sickest employees onto state insurance exchanges.

This Article proceeds as follows. Part I begins by providing a more detailed and comprehensive discussion of how and why ACA permits self-insured employers to dump high-risk employees onto individual insurance markets. Part II then describes various specific

Commissioners on Health Care Reform Implementation, Exchanges (B) Subgroup Meeting (July 22, 2010), available at http://naic.org/committees_b_exchanges.htm ("The biggest threat to the success of the exchanges will be adverse selection . . . .").

[16] Of course, ACA does create or recognize various different risk pools, and so it does not mandate that all health risks be shared equally across society. But ACA attempts to require that all risk pools are broad and diverse, so as to ensure the broad social sharing of health care costs by all individuals and employers. It is this general principal of risk sharing that employer dumping undermines, as it permits specific employers and employees to participate in unusually low-risk pools by inducing high-risk employees into other pools.

employer dumping strategies, each of which aims to induce high-risk employees to opt for coverage through exchanges while providing sufficient security and benefits to low-risk employees so that they retain employer provided coverage. Part III suggests that many employers are likely to find employer dumping to be an economically attractive option. It then offers several regulatory and legislative options for limiting this risk.

I. ACA, RISK CLASSIFICATION, AND THE PROSPECT OF TARGETED EMPLOYER DUMPING

One central premise of health care reform is that competition in insurance markets should be less focused on risk classification and more focused on improving health care delivery and efficiency. ACA takes radically different approaches to accomplishing this in individual and employer-sponsored insurance markets. Section A of this Part introduces the concept of risk classification and describes the various approaches that insurers employ to classify risks. It distinguishes between direct forms of risk classification, wherein insurance rates or coverage are linked to observed health-related factors and health history, and indirect methods of risk classification, wherein plans are designed and marketed so that they disproportionately appeal to individuals with particular risk profiles. Section B then describes how ACA radically reforms individual insurance markets to largely eliminate both direct and indirect forms of risk classification. By contrast, Section C shows that ACA does little that is new to affect risk classification in employer markets, especially for employers that self-insure the costs of their employees' coverage. Rather, it generally relies on and extends pre-ACA law, which prohibited direct risk classification by employers but largely ignored the prospect of indirect risk classification. It is this reliance on the pre-ACA paradigm—and its limited regulation of indirect risk classification by employers—that leaves employers free to design targeted dumping strategies whose purpose is to induce high-risk employees to opt out of ESI.

A. Background on Risk Classification

The idea that employers would consider dumping high-risk employees is hardly surprising. In fact, dumping of high-risk policy-

holders is merely a subset of the larger insurer practice of risk classification.[17] At its most fundamental level, risk classification involves pricing insurance based on the expected health care costs of a particular individual. But because the risks of some individuals can be difficult to predict or are predictably exorbitant, risk classification can also involve refusing to insure certain individuals or insuring them only with respect to specific types of costs or conditions. Historically, health insurers operating in most individual markets have spent substantial energy classifying individual risks in these ways—linking eligibility, premiums, or benefits to observations about the risk presented by the individual.[18]

Insurance economists have long recognized that in addition to these direct forms of risk classification, insurers can also indirectly classify individual risk by offering particularized sets of benefits that disproportionately appeal to certain types of individuals.[19] Such indirect risk classification does not require insurers to make explicit distinctions regarding individuals, but instead relies on individuals "revealing" their own risk characteristics through their insurance purchase decisions. Thus, an insurer wishing only to insure young, healthy people might attract them by offering policies that have high deductibles for hospitalizations, premium discounts

[17] See Donald W. Light, The Practice and Ethics of Risk-Rated Health Insurance, 267 JAMA 2503, 2503–04 (1992) (describing various methods of risk classification in health insurance markets).

[18] See Mary Crossley, Discrimination Against the Unhealthy in Health Insurance, 54 Kan. L. Rev. 73, 74 (2005) ("Discrimination against unhealthy persons is deeply ingrained in the health insurance industry and traditionally has been generally accepted as a legitimate application of underwriting and risk-classification principles."); see generally Deborah A. Stone, The Struggle for the Soul of Health Insurance, 18 J. Health Pol. Pol'y & L. 287, 287 (1993) (exploring a vision of health insurance premised on social solidarity as contrasted to a vision of health insurance premised on risk classification and "actuarial fairness" more generally). To be sure, insurers operating in some markets, particularly large group health insurance markets, have often focused less on risk classification, as such classification can only occur at the group level. See Crossley, supra, at 84. Other health insurers have been foreclosed from engaging in various forms of risk classification based on state laws. Id. at 85–117.

[19] This literature originated with Akerlof's famous article on lemons. See George A. Akerlof, The Market for "Lemons": Quality Uncertainty and the Market Mechanism, 84 Q.J. Econ. 488 (1970); see also Michael Rothschild & Joseph Stiglitz, Equilibrium in Competitive Insurance Markets: An Essay on the Economics of Imperfect Information, 90 Q.J. Econ. 629, 634–37 (1976).

for frequent gym usage, and exclusions for drugs that are disproportionately used by the chronically ill or sick.[20]

Risk classification is central to the operation of insurance markets ranging from life insurance to property insurance to health insurance.[21] In the absence of such classification, insurance markets are susceptible to adverse selection, wherein those who seek insurance are disproportionately high risk.[22] Adverse selection can be self-reinforcing and, in extreme cases, can lead to the collapse of insurance markets in a death spiral.[23] Even when adverse selection does not pose such dire risks—as is often the case[24]—risk classification is a central way in which insurers compete. Insurers that can more accurately predict policyholders' health care costs can win the business of low-risk individuals and avoid issuing coverage to high-risk individuals.[25]

Although risk classification is commonplace in all insurance markets, it has historically produced significant problems in many health insurance markets.[26] Prior to ACA, individuals with a negative health history or risk factors were often unable to obtain affordable health insurance or were denied coverage altogether, de-

[20] See, e.g., M.P. McQueen, Health Insurers Target the Individual Market, Wall St. J., Aug. 21, 2007, at D1 (noting that insurers, in an effort to attract young adults, have begun offering benefits such as gym memberships and teeth whitening).

[21] Of course, risk classification is different in the health insurance context for a variety of reasons, including the difficulty of predicting expenses and the fact that a large component of health insurance is actually closer to the pre-payment of expected costs than to classic insurance. For an overview of risk classification in health and non-health insurance markets, see Bryan Ford, The Uncertain Case for Market Pricing of Health Insurance, 74 B.U. L. Rev. 109, 115–29 (1994).

[22] Peter Siegelman, Adverse Selection in Insurance Markets: An Exaggerated Threat, 113 Yale L.J. 1223, 1235–37 (2004).

[23] The self-reinforcing tendency of adverse selection stems from the fact that, if the insured population consists disproportionately of high-risk individuals, insurance companies will respond by raising premiums. As premiums rise, only individuals with higher levels of risk will find insurance purchase worthwhile, in response to which insurers will raise premiums even higher. Siegelman, supra note 22, at 1254.

[24] Id. at 1224–25; see also Bradley Herring & Mark V. Pauly, The Effect of State Community Rating Regulations on Premiums and Coverage in the Individual Health Insurance Market 20 (NBER Working Paper No. W12504, 2006), available at http://www.nber.org/papers/w12504.

[25] See generally Kenneth S. Abraham, Distributing Risk: Insurance, Legal Theory, and Public Policy 64–100 (1986).

[26] See Light, supra note 17.

pending on the insurance laws of their state.[27] Those who did acquire coverage were subject to preexisting condition exclusions[28] and the prospect of rescissions. Insurers sometimes retained substantial discretion to define preexisting conditions broadly and to rescind coverage even for innocent and potentially irrelevant omissions or misstatements in policyholders' applications for coverage.[29]

B. ACA's Reform of Risk Classification in Individual Markets

ACA radically reforms individual insurance markets to substantially reduce risk classification. This Section describes the ways in which ACA attempts to eliminate both direct and indirect forms of risk classification by insurers.

1. ACA's Regulation of Direct Risk Classification in Individual Markets

Starting in 2014, ACA will fundamentally change the individual health insurance market by prohibiting virtually all direct methods of risk classification.[30] At that time, all health insurers will be pro-

[27] See Crossley, supra note 18, at 109–13 (reviewing various state laws addressing discrimination based on health status).

[28] Individuals were protected from preexisting condition exclusions only where they had coverage for at least eighteen months, most recently under an employer group plan, and had not had a break in coverage of sixty-three days or longer. 29 U.S.C. § 1181 (2006).

[29] See, e.g., Comm. on Energy & Commerce, Case Studies: Examples of Health Insurance Companies Rescinding Individual Policies (July 27, 2009), available at http://energycommerce.house.gov/ Press_111/20090727/15%20Fact%20Sheet- Examples%20of%20Health%20Insurance%20Companies%20Rescinding%20Individual%20Policies.pdf. An investigation and hearing by the House Committee on Energy and Commerce in 2009 found that insurers often abused their authority to rescind policies in order to avoid paying expensive claims, targeting patients with breast cancer, lymphoma, and numerous other serious conditions for rescission and praising employers for terminating the coverage of such policyholders. Id. Additionally, it concluded that insurers frequently rescinded coverage based on trivial omissions in policyholders' applications that were often unrelated to the policyholder's illness. Id.; see also Memorandum from the Comm. on Energy & Commerce Staff to Members and Staff of the Subcomm. on Oversight and Investigations, Supplemental Information Regarding the Individual Health Insurance Market 7–8 (June 16, 2009), available at http://energycommerce.house.gov/Press_111/20090616/rescission_supplemental.pdf (finding approximately 20,000 rescissions by three large insurance companies over five years, saving those insurers $300 million in claims).

[30] Like most insurance markets, individual health insurance markets prior to ACA were regulated almost entirely at the state level. States varied dramatically in how

hibited from denying coverage to an applicant, limiting coverage of an individual's preexisting conditions, or rescinding a contract for unintentional misstatements once coverage has been granted.[31] Insurers will be required to price coverage on a modified-community rating basis, where premiums can vary only based on age, family size, tobacco use, and geographic area, and even then only within certain ranges.[32]

Prohibiting the use of these practices raises significant adverse selection concerns.[33] After all, if insurers are required to offer coverage to everyone who applies, at community rates, with no exclusion of preexisting conditions, then individuals will be inclined to wait to purchase health insurance coverage until it is needed. In order to combat the prospect of such adverse selection, ACA re-

tightly they regulated these markets. See Kaiser Family Found., Individual Market Rate Restrictions (Not Applicable to HIPAA Eligible Individuals), 2010, http://www.statehealthfacts.kff.org/comparetable.jsp?ind=354&cat=7 (last visited Nov. 5, 2010). Most states, however, allowed insurers in individual insurance markets to engage in some forms of risk classification. See id.

[31] ACA § 1001, Pub. L. No. 111-148, 124 Stat. 119, 130–31 (2010) (adding § 2712 to the Public Health Service Act (PHSA)) (rescissions) (to be codified at 42 U.S.C. § 300gg-12); ACA § 1201, 124 Stat. at 154–55 (adding § 2704 to the PHSA) (to be codified at 42 U.S.C. § 300gg-3) (preexisting conditions); ACA § 1201, 124 Stat. at 156 (adding § 2702 to the PHSA) (to be codified at 42 U.S.C. § 300gg-1) (guaranteed availability); ACA § 1201, 124 Stat. at 156 (adding § 2703 to the PHSA) (to be codified at 42 U.S.C. § 300gg-2) (guaranteed renewability); ACA § 1201, 124 Stat. at 156–60 (adding § 2705 to the PHSA) (to be codified at 42 U.S.C. § 300gg-4) (prohibiting discrimination).

Limited exceptions apply to insurers' obligations to accept new policyholders that are not relevant to this analysis. These include the prospect that an insurer is financially unstable and thus must stop accepting policyholders. See 42 U.S.C.S. § 300gg-1(d) (LexisNexis 2010) (application of financial capability limits).

[32] ACA § 1201, 124 Stat. at 155–56 (adding § 2701 to the PHSA) (to be codified at 42 U.S.C. § 300gg) (fair premiums). Note that premiums will only be allowed to vary by three times for age, id., which is likely to be less than current disparities based on age. See, e.g., Elizabeth Simantov et al., Market Failure? Individual Insurance Markets for Older Americans, 20 Health Aff. 139, 144–46 (2001) (finding that premiums for individuals age sixty were three to four times more expensive than premiums for individuals age twenty-five); Healthreform.gov, Strengthening the Health Insurance System: How Health Insurance Reform will Help America's Older and Senior Women 5, available at http://healthreform.gov/reports/seniorwomen/seniorwomenreport.pdf (stating that premiums for older women in the individual market are roughly four times greater than those in the group market).

[33] See Amitabh Chandra, Jonathan Gruber, & Robin McKnight, The Importance of the Individual Mandate—Evidence from Massachusetts, N.E.J.M. (Jan. 12, 2011), available at http://healthpolicyandreform.nejm.org/?p=13572&query=TOC.

quires that all individuals purchase health insurance coverage unless they "cannot afford coverage," meaning that the individual's "required contribution . . . for coverage . . . exceeds eight percent of such individual's household income . . . ."[34] In order to make coverage affordable for a larger number of individuals, ACA also provides refundable tax credits for individuals with income between one hundred percent and four hundred percent of the federal poverty level, as well as cost-sharing subsidies.[35]

2. ACA's Efforts to Limit Indirect Risk Classification in Individual Markets

ACA's prohibitions on direct risk classification methods are not sufficient to eliminate insurers' capacity to classify risks. Recognizing this, ACA supplements its prohibitions on direct risk classification with various measures that also prevent or limit indirect classification by insurers.[36]

a. Plan Design

First, and most importantly, ACA imposes various restrictions and requirements on the content of insurers' coverage in individual markets. These include prohibitions on annual and lifetime limits, as well as a mandate to cover preventive services in full with no cost sharing. The most significant of these coverage requirements is that all insurance issued on the individual market must cover "essential health benefits" ("EHBs").[37] This includes (1) coverage for

[34] ACA § 1501(b), 124 Stat. at 246–47 (to be codified at I.R.C. § 5000A). Individuals without coverage for a period of longer than three months face a penalty equal to the greater of $695 per individual per year (up to a maximum of three times that amount, $2085, per family) or 2.5% of household income. HCERA §1002(a)(2), Pub. L. No. 111-152, 124 Stat. 1029, 1032 (2010) (to be codified at I.R.C. § 5000A) (amending PPACA § 10106(b)(3), Pub. L. No. 111-148, 124 Stat. 119, 909 (2010) (amending PPACA § 1501(b), 124 Stat. at 246–47)).

[35] ACA § 1401, 124 Stat. at 213–20 (to be codified at I.R.C. § 36B); ACA § 1402, 124 Stat. at 220–24 (to be codified at 42 U.S.C. § 18071).

[36] The effectiveness of these attempts to limit indirect risk classification depends largely on how these measures are implemented. For one analysis of this issue, see Finan, supra note 15.

[37] ACA § 1201, 124 Stat. at 161 (adding § 2707 to the PHSA) (to be codified at 42 U.S.C. § 300gg-6) ("A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the es-

specific treatments and services, and (2) cost-sharing limits on such benefits.[38] ACA delegates to the Secretary of Health and Human Services ("HHS") the responsibility for defining the substantive coverage terms of EHBs but specifies that EHBs must include coverage for hospitalization, emergency services, prescription drugs, and laboratory services (among others).[39] The most significant guidance given to the Secretary in defining EHBs is a requirement that they be equal in scope to those offered by a "typical employer plan."[40] Thus, while ACA describes the basic contours of EHBs, it leaves substantial discretion to HHS about its particulars.

Although these coverage mandates for plans operating in the individual market can be defended in various ways, one of their key functions is to limit insurers' capacities to indirectly classify risks. By establishing mandatory coverage floors, these rules limit the capacity of insurers in individual markets to design their plans to appeal primarily to low-risk individuals.

b. Provider Networks and Exchanges

A second way in which ACA limits the prospect of indirect risk classification is through the establishment of insurance exchanges for the individual market.[41] An exchange is an entity that helps organize an underlying market and facilitate comparison shopping by

sential health benefits package required under section 1302(a) of the Patient Protection and Affordable Care Act.").

[38] See ACA § 1302, Pub. L. No. 111-148, 124 Stat. 119, 163–68 (2010) (to be codified at 42 U.S.C. § 18022). Out-of-pocket expenses (the amount that an individual must spend out-of-pocket on covered care, including co-payments, deductibles, etc.) must be limited to approximately $5950 for individual coverage and $11,900 for family coverage (in 2010 numbers). See id. § 1302(c), 124 Stat. at 165; I.R.C. § 223(c) (2006); Rev. Proc. 2009-29, 2009-22 I.R.B.

[39] See ACA § 1302(b), 124 Stat. at 163–64 (to be codified at 42 U.S.C. § 18022).

[40] For a lengthier discussion of essential health benefits, see Amy B. Monahan, Initial Thoughts on Essential Health Benefits, 1 N.Y.U. Rev. Emp. Benefits & Executive Compensation 1B1, 1B4–1B8 (2010).

[41] Starting in 2014, each state must establish such an exchange to facilitate the purchase of health insurance. ACA § 1321(b), 124 Stat. at 186 (to be codified at 42 U.S.C. § 18041). See generally Jost, supra note 15. State insurance exchanges will also organize the small group market in addition to the individual market. See ACA § 1311(b), 124 Stat. at 173.

buyers.[42] ACA requires each state to establish an exchange to be administered either by a government agency or non-profit corporation,[43] and it is expected that a substantial portion of the individual insurance market will operate on these exchanges.[44] In part, this is because they are designed to improve consumer shopping and help replicate various economies of scale found in large group markets. Additionally, and perhaps more importantly, individuals can only receive federal subsidies for coverage when they purchase coverage on an exchange.[45]

Individual insurance plans offered in state exchanges must meet additional criteria regarding plan design, which are encompassed in the requirement that they be "Qualified Health Plans."[46] Most importantly, qualified health plans must "ensure a sufficient choice of providers."[47] Like the limitations on benefit designs described above, this restriction on provider networks limits insurers' capacity to indirectly classify risks. For instance, it prevents insurers from developing a network of providers that are located predominantly in geographic areas with a comparatively young or healthy population, or from forming a network without any specialists, as both types of limited network would likely be considered to offer an inadequate choice of providers.

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[42] Timothy Jost, Health Insurance Exchanges: Legal Issues 3 (2009), available at http://www.law.georgetown.edu/oneillinstitute/national-health-law/legal-solutions-in-health-reform/Papers/Insurance_Exchanges.pdf.

[43] ACA § 1311(d)(1), 124 Stat. at 176 (to be codified at 42 U.S.C. § 18031). If a state does not choose to establish an exchange, the federal government is authorized to establish one for that state's residents. See ACA § 1321(c), 124 Stat. at 186–87 (to be codified at 42 U.S.C. § 18041).

[44] Memorandum from Richard S. Foster, Chief Actuary, Dep't of Health & Human Servs., Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as amended at 4 (Apr. 22, 2010), available at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf (estimating that 16 million individuals will be covered through exchanges).

[45] ACA § 1401, Pub. L. No. 111-148, 124 Stat. 119 (2010) (to be codified at I.R.C. § 36B); id. § 1402, 124 Stat. at 220–24 (to be codified at 42 U.S.C. § 18071). Exchanges are directed to work with the Department of Treasury to get the amount of the credit advanced and paid directly to the insurer, negating the need for the individual to pay and be reimbursed only when filing her tax return for the year. See ACA §§ 1411–12, 124 Stat. at 224–33 (to be codified at 42 U.S.C. §§ 18081–82).

[46] See ACA § 1301, 124 Stat. at 162–63 (to be codified at 42 U.S.C. § 18021).

[47] ACA § 1311(c)(1)(B), 124 Stat. at 174 (to be codified at 42 U.S.C. § 18031).

Additionally, officials are endowed with discretion in deciding which plans can be offered through an exchange.[48] While the basis on which exchange officials will exercise such direction is not yet clear, it is likely that one of the central factors they will evaluate is whether plans offered in the exchange are attempting to indirectly classify risks.[49] To the extent that regulators or exchange operators perceive this to be the case, they could ban a carrier from the exchange and thus substantially limit its capacity to compete in the individual market.

c. Risk Adjustment Mechanisms

A third approach that ACA employs to discourage indirect risk classification by insurers in individual markets is a trio of risk adjustment mechanisms. Two of these arrangements operate as temporary reinsurance programs for insurers in individual insurance markets.[50] Reinsurance essentially provides insurance for insurers.[51] First, ACA establishes a temporary reinsurance program that protects insurers in individual markets against the risk that their policyholders will disproportionately suffer from expensive conditions.[52] Second, ACA also reinsures insurers in both the individual and small group markets against the risk that their medical costs will be greater than 103% of expectations.[53] Both programs limit

[48] See ACA § 1301, 124 Stat. at 162–63 (to be codified at 42 U.S.C. § 18021) (defining a "qualified health plan" as a plan offered by a health insurance issuer that is "licensed and in good standing" and that complies with "such other requirements as an applicable Exchange may establish").

[49] See ACA § 1311(c)(1)(A), 124 Stat. at 174 (to be codified at 42 U.S.C. § 18031) (providing that the Secretary shall promulgate regulations to ensure that no qualified health plan will "employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs").

[50] See Mark A. Hall, The Three Types of Reinsurance Created by Federal Health Care Reform, 29 Health Aff. 1168, 1170–71 (2010). A third reinsurance program ends prior to 2014 and involves reinsurance for the expenses that employers incur in providing health benefits to early retirees. See id. at 1169.

[51] See generally Aviva Abramovsky, Reinsurance: The Silent Regulator?, 15 Conn. Ins. L.J. 345, 350 (2009).

[52] ACA § 1341, Pub. L. No. 111-148, 124 Stat. 119, 208–11 (2010) (to be codified at 42 U.S.C. § 18061).

[53] ACA § 1342, 124 Stat. at 211–12 (to be codified at 42 U.S.C. § 18062).

insurers' incentives to classify risks by blunting the possibility that the failure to indirectly classify risks will increase costs.[54]

In addition to these reinsurance programs, ACA establishes a prospective risk assessment mechanism. This program extends indefinitely and charges low actuarial risk plans a penalty while providing payments to high actuarial risk plans.[55] Unlike the two reinsurance programs, this risk assessment program not only mitigates the cost to insurers with high-risk policyholders, but it also reduces the benefits to insurers with low-risk policyholders. It therefore limits both the potential negative consequences of failing to engage in indirect risk classification and the potential gains to insurers that successfully use indirect risk classification to attract low-risk policyholders.

C. ACA's Reform of Group Markets and the Capacity of Employers to Dump

In contrast to insurers in the individual market, most employers engaged in relatively little risk classification prior to ACA. For this reason, ACA does little to alter the risk-classification landscape with respect to employers.[56] This Section first provides some background on the regulation of employer plans prior to ACA and then explores how ACA affects both direct and indirect forms of risk classification in this market. It shows that ACA largely affirms and extends preexisting federal laws preventing direct forms of risk classification in group markets, such as discrimination in premiums or cost sharing among different policyholders. But it also demonstrates that ACA leaves employers largely free to engage in various forms of indirect risk classification, particularly if they self-insure their health plans.

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[54] Hall acknowledges that the primary purpose of § 1341 is to blunt adverse selection, but suggests that the purpose of § 1342 is instead to limit actuarial uncertainty. Hall, supra note 50, at 1170–71. Both programs, however, simultaneously accomplish both goals, and identifying which goal is primary is a difficult exercise.

[55] ACA § 1343, 124 Stat. at 212–13 (to be codified at 42 U.S.C. § 18063).

[56] See Timothy Jost, How Does the Health Reform Legislation Affect Self-Insured Plans?, O'Neill Institute Legal Solutions in Health Reform Blog (Mar. 31, 2010, 5:24 PM), http://oneillhealthreform.wordpress.com/2010/03/31/how-does-the-health-reform-legislation-affect-self-insured-plans.

1. Regulation of Employer Plans Pre-ACA

Prior to ACA, employer-provided health plans were primarily governed by two federal laws, the Internal Revenue Code of 1986 ("I.R.C.") and the Employee Retirement Income Security Act of 1974 ("ERISA").[57] The I.R.C. provides important tax benefits to employer-provided coverage.[58] For example, it excludes from both federal income and payroll tax the cost of employer-provided health insurance coverage.[59] The I.R.C. also allows employers to establish cafeteria plans to allow employees to pay their share of health insurance premiums on a pre-tax basis.[60] As a result, it is possible to exclude from taxable income the entire amount of premiums in an employer-sponsored plan. In contrast, similar tax advantages are available for non-employer coverage only if an individual is self-employed.[61]

ERISA regulates many aspects of employer plan administration, reporting, disclosure, and remedies. However, it only lightly regulates the substance of group health plan coverage. At present, it contains just four such requirements: minimum hospital stays fol-

[57] Employer plans are also affected by various federal income tax regulations, some of which mirror provisions in ERISA. For example, the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") and the Consolidated Omnibus Budget Reconciliation Act ("COBRA") are contained in both statutes. Compare I.R.C. §§ 4980B(f), 9802 (2006), and 29 U.S.C. §§ 1161–65, 1182 (2006) (ERISA), with Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 222, 227, §§ 10001, 10002(a) (1986) (amending I.R.C. and ERISA, respectively), and Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, 1939, 2073, §§ 101(a), 401(a) (1996) (amending ERISA and I.R.C., respectively). Because the federal tax treatment does not directly affect use of risk classification, discussion of the tax code provisions that affect group health plans is largely omitted from this Article.

[58] It also regulates certain other aspects of plan terms and administration. For instance, the Code also imposes additional requirements on group health plans, such as the requirement to offer continuation coverage in the event that an employee loses her employer-provided health coverage as a result of a qualifying event. I.R.C. § 4980B(f).

[59] Id. at § 106. Most states follow the federal tax treatment and exempt such payments from state income tax as well. See Richard W. Genetelli, Tax Management Multistate Tax Portfolios, Personal Income Taxes: Alabama Through Michigan, 3010.01.B.2 (2002).

[60] See I.R.C. § 125.

[61] See id. § 162(l)(1), (4) (indicating that self-employed individuals are eligible to deduct the cost of health insurance premiums from their taxable income and that the deduction may not be taken for self-employment tax purposes).

lowing childbirth, breast reconstruction following mastectomy, a mental health parity requirement,[62] and a limitation on the exclusion of preexisting conditions.[63] ERISA also incorporates the nondiscrimination provisions of the Health Insurance Portability and Accountability Act ("HIPAA"), which prohibit group health plans from discriminating on the basis of health factors with respect to eligibility, benefits, or premiums.[64]

In addition to this federal regulation, employers that purchase group insurance policies rather than self-insuring are also indirectly subject to state insurance regulation. Under ERISA, states are explicitly permitted to regulate the content of coverage that insurers offer to employers.[65] To date, states have exercised this authority regularly, enacting numerous coverage mandates requiring insurers to cover a wide variety of benefits.[66]

By contrast, ERISA forbids states from extending any of these insurance laws to employer plans that self-insure their employees' coverage.[67] At its most basic level, an employer self-insures a plan

[62] See 29 U.S.C. §§ 1185, 1185a, 1185b (minimum hospital stays, mental health parity, and reconstructive surgery, respectively) (2006).

[63] A plan may exclude coverage for a preexisting condition for a maximum of twelve months. Id. § 1181(a)(2). That maximum exclusion period is reduced by the amount of any prior creditable coverage the individual had. Id. § 1181(a)(3). For example, if an individual had coverage under an employer plan for twelve months and then switched employers and became covered under the new employer's plan without a break in coverage, the new employer's plan could not enforce any preexisting condition limitation for that employee.

[64] HIPAA, Pub. L. No. 104-191, 110 Stat. 1936, 1939, § 101 (1996) (codified at 29 U.S.C. § 1182). ERISA also contains a general nondiscrimination provision in § 510, but courts have held that an employer health plan does not violate § 510 merely by amending the terms of the plan in a way that has a disparate impact on employees with a particular condition or disability. See, e.g., McGann v. H & H Music Co., 946 F.2d 401, 404 (5th Cir. 1991).

[65] 29 U.S.C. § 1144(b)(2)(A). This is an extension of the McCarran-Ferguson Act, which affirms the primacy of the states in regulating insurance. Jonathan R. Macey & Geoffrey P. Miller, The McCarran-Ferguson Act of 1945: Reconceiving the Federal Role in Insurance Regulation, 68 N.Y.U. L. Rev. 13, 20–26 (1993).

[66] See generally Amy B. Monahan, Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform, 2007 U. Ill. L. Rev. 1361, 1363–64 (2007).

[67] 29 U.S.C. § 1144(b)(2)(B); see also Metro. Life Ins. Co. v. Massachusetts, 471 U.S. 724, 746–47 (1985); see generally Russell Korobkin, The Battle Over Self-Insured Health Plans, or "One Good Loophole Deserves Another," 5 Yale J. Health Pol'y L. & Ethics 89 (2005) (describing the evolution of the caselaw on self-insured health plans).

where it retains liability to pay plan benefits rather than transfer that risk to an insurance company. Historically, large employers have been much more likely to self-insure than small employers,[68] as the size of their workforce tends to ensure that employees' health care expenditures will be relatively steady over time, decreasing the need to shed risk to a third-party insurer.

Increasingly, however, mid-size and even small employers have opted to self-insure and purchase stop-loss insurance to protect themselves from the risk that their employees will experience unusually high claims in a given year.[69] Stop-loss insurance, a form of reinsurance, reimburses the employer once claims under the plan exceed a specified level either on an individual participant or plan-wide basis.[70] Self-insured plans do not lose their exemption from state insurance regulation when they purchase stop-loss insurance.[71] The end result is that nearly all employer plans are subject to the requirements of ERISA and HIPAA, but they are subject to state regulation only if the employer purchases a group insurance policy to fund benefits.

Prior to ACA, then, all employer plans were prohibited from engaging in direct risk classification because of HIPAA's prohibition on discrimination based on health status. Self-insured plans, however, did have the ability to engage in indirect risk classification through plan design. As will be discussed in more detail in Part III, though, few self-insured employers historically did so.

[68] See Kaiser Family Found. & Health Res. & Educ. Trust, Employer Health Benefits: 2010 Annual Survey 174, available at http://ehbs.kff.org/pdf/2010/8085.pdf (providing the percentage of employers that self-insured, by employer size, from 1999-2010).

[69] See Troy Paredes, Stop-Loss Insurance, State Regulation, and ERISA: Defining the Scope of Federal Preemption, 34 Harv. J. Legis. 233, 234–35 (1997). In 2009, among all workers covered by employer plans, fifty-seven percent were covered by self-insured plans. Kaiser Family Found. & Health Res. & Educ. Trust, supra note 13, at 157. The propensity of firms to self-insure varies with size. In firms with 5000 or more employees, eighty-eight percent of covered workers are enrolled in self-insured plans. Id. In firms with 3-199 employees, fifteen percent of covered employees are enrolled in self-insured plans. Id.

[70] Paredes, supra note 69, at 249–50.

[71] See, e.g., Am. Med. Sec., Inc. v. Bartlett, 111 F.3d 358, 364 (4th Cir. 1997).

2. ACA's Regulation of Direct Risk Classification in Group Markets

Although ACA extends some of the protections against direct risk classification in group markets that existed prior to reform, it largely leaves in place the pre-reform regime described above. For instance, ACA's guaranteed issue requirements and prohibition on rescissions apply to all employer plans, whether insured or self-insured, but its premium pricing restrictions apply only to the individual and small group markets.[72] This makes sense because HIPAA's existing requirements regarding premium setting are in fact stricter than ACA's, prohibiting premium setting based on all health-related factors, including age and tobacco use.[73] ACA does technically subject employers to its provisions prohibiting discrimination against enrollees based on health status, though this is largely duplicative of employers' responsibilities under HIPAA.[74] Similarly, while ACA eliminates the capacity of employers to use preexisting condition exclusions, this is much less of a shift for employer plans than for the individual market, as HIPAA already substantially limited the use of such clauses in employer plans. In the end, ACA changes little about the ability of employers to directly classify risk because such restrictions were already largely in place.

3. ACA's (Lack of) Regulation of Indirect Risk Classification in Group Markets

ACA does relatively little to address the prospect that employers, particularly those that are self-insured, will implement health insurance plans designed to disproportionately appeal to low-risk employees. Much to the contrary, ACA seems to assume that employers will continue to voluntarily offer relatively generous plans, as it directs the Secretary of HHS to define essential health bene-

[72] See ACA § 1001, Pub. L. No. 111-148, 124 Stat. 119, 131 (2010) (to be codified at 42 U.S.C. § 300gg-12) (adding § 2712 to the PHSA); ACA § 1201, Pub. L. No. 111-148, 124 Stat. 119, 155–56 (2010) (to be codified at 42 U.S.C. §§ 300gg–gg-1) (adding §§ 2701 and 2702 to the PHSA).

[73] See 29 U.S.C. § 1182 (2006).

[74] Compare ACA § 1201, 124 Stat. at 156–60 (to be codified at 42 U.S.C. § 300gg-4) (adding § 2705 to the PHSA), with 29 U.S.C. § 1182 (HIPAA).

fits so that they are no less generous than a typical employer plan.[75] This Subsection reviews the provisions of ACA that potentially implicate the capacity or willingness of employers to engage in indirect risk classification by designing plans that disproportionately appeal to low-risk employees. It demonstrates that self-insured employers face minimal legal impediments in implementing a plan designed to indirectly induce high-risk employees to opt out of ESI in favor of coverage on the individual market.

a. Plan Benefits

ACA's requirements regarding the substance of plan benefits vary based on whether the employer purchases insurance or self-insures. Group coverage for small employers is subject to the same requirement as individual insurance markets, and therefore such plans must offer essential health benefits.[76] By contrast, neither large group insurance plans nor self-insured employers are required by ACA to offer essential health benefits to their policyholders. Instead, these plans are subject to only a few specific requirements, each of which apply broadly to all insurance plans and group health plans. First, all employer plans must offer full coverage, with no cost sharing, for all preventive health services.[77] Second, employer plans must cover routine patient care costs of individuals participating in clinical trials.[78] Third, ACA sets overall limits on the maximum out-of-pocket spending a plan can require per participant per year, although these out-of-pocket annual limits apply only to the covered benefits that an employer plan provides.[79] Fourth, the statute restricts annual and lifetime caps on coverage,[80]

[75] For a lengthier discussion of essential health benefits, see Monahan, supra note 40, at 3–5.

[76] See supra Subsection I.B.2.a; ACA § 1201, 124 Stat. at 161 (to be codified at 42 U.S.C. § 300gg-6) (adding § 2707 to the PHSA).

[77] ACA § 1001, 124 Stat. at 131–32 (to be codified at 42 U.S.C. § 300gg-13) (adding § 2713 to the PHSA).

[78] ACA § 10103, Pub. L. No. 111-148, 124 Stat. 119, 892–96 (2010) (to be codified at 42 U.S.C. § 300gg-8) (adding § 2709 to the PHSA).

[79] ACA § 1201, 124 Stat. at 161 (to be codified at 42 U.S.C. § 300gg-6) (adding § 2707(b) to the PHSA). These limits are the same that are applicable to individual plans. See supra note 37.

[80] ACA § 10101, 124 Stat. at 883–84 (to be codified at 42 U.S.C. § 300gg-11) (adding § 2711 to the PHSA).

although it does not require employers to offer any particular benefits. Interestingly, these provisions prohibit large and self-insured employers from placing annual and lifetime caps on essential health benefits starting in 2014.[81] As a result, while large and self-insured employers need not offer essential health benefits at all, they cannot offer limited essential health benefits in conjunction with lifetime or annual limits.

Large employers who purchase a group insurance policy will, however, remain subject to state insurance regulation. The ability of such plans to design benefits in order to indirectly classify risks will consequently vary based on the flexibility of state regulation. Self-insured plans, on the other hand, will enjoy nearly complete freedom to design benefits to classify risk. To take an extreme example, a self-insured employer could implement a health plan that covers preventive services, the four coverages required by ERISA, routine patient care costs of individuals participating in clinical trials, *and nothing else.*

Alternatively, a self-insured plan could simply exclude coverage for specific high-cost conditions such as AIDS, diabetes, and hemophilia. While potentially an issue under the Americans with Disabilities Act ("ADA"), which prohibits discrimination with respect to disability,[82] employer health plans may employ a disability-based distinction provided that the plan provision is not being used as a "subterfuge" to intentionally violate the ADA.[83] A disability-based distinction is a "subterfuge" if it is not justified by the risks or costs associated with the disability.[84] For example, a plan may refute a claim of subterfuge by showing that the disparate treatment is justified by legitimate actuarial data or that the challenged provision "is necessary . . . to prevent the occurrence of an unacceptable change either in the coverage of the health insurance plan, or in the premiums charged . . . ."[85] This gives employers a tremendous amount of discretion in carving out entire categories of treatment,

[81] Id.

[82] 42 U.S.C. §§ 12101–213 (2006).

[83] Id. § 12201(c); EEOC Interim Guidance on Application of Americans with Disabilities Act of 1990 to Employer-Provided Health Insurance, No. 915.002, Subsection III.C.2.b–d (June 8, 1993), available at http://www.eeoc.gov/policy/docs/health.html.

[84] EEOC Interim Guidance, supra note 83.

[85] Id. at Subsection III.C.2.d.

even if doing so would create disability-based distinctions, provided that such treatments are in fact high-cost and will therefore create the needed actuarial data.[86] In the end, neither ACA nor other existing sources of law substantially restrict the ability of self-insured plans to engage in indirect risk classification through the design of plan benefits.

b. Provider Network

ACA leaves employers (whether insured or self-insured) largely free to design their provider networks however they see fit. It requires only that "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law."[87] This provision does "not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer."[88] Rather, it bars discrimination against licensed medical practitioners, such as chiropractors, acupuncturists, massage therapists, and midwives. At the extreme, employers are free to implement a health maintenance organization ("HMO")-style plan wherein enrollees are required to seek care only from employee-providers within the HMO.

c. Wellness Plans

Unlike insurers in the individual market, employers of all sizes are permitted under ACA to establish "wellness programs" for their enrollees.[89] Wellness programs create incentives for enrollees

[86] For an overview of how courts have interpreted the ADA coverage requirements as applied to health plans, see Timothy Frey, Your Insurance Does Not Cover That: Disability-Based Discrimination Where It Hurts the Most, 78 Geo. Wash. L. Rev. 636, 642–56 (2010); see also Samuel R. Bagenstos, The Future of Disability Law, 114 Yale L.J. 1, 27–32 (2004) (providing an overview and critique of how private health insurance fits into legal protections for the disabled).

[87] ACA § 1201, Pub. L. No. 111-148, 124 Stat. 119, 160 (2010) (to be codified at 42 U.S.C. § 300gg-5) (adding § 2706 to the PHSA).

[88] Id.

[89] ACA § 1201, 124 Stat. at 156–57 (to be codified at 42 U.S.C. § 300gg-4) (adding § 2705(j)(1)(A) to the PHSA) ("[A] program of health promotion or disease preven-

to take measures to promote health or prevent disease, usually by offering premium rebates, cost-sharing reductions, or financial perks.[90] Perhaps the most common example of such a program is one that pays a portion of an enrollee's gym membership if she visits the gym a specified number of times each month. Although designed to incentivize healthy living among policyholders, wellness programs provide employers with yet another risk classification tool because of their ability to lower costs for comparatively healthy enrollees.[91]

ACA permits two different types of wellness programs. First, it permits those not "based on an individual satisfying a standard that is related to a health status factor" and "made available to all similarly situated individuals."[92] Examples include gym membership reimbursement, diagnostic testing programs, and smoking cessation programs.[93] Second, it permits wellness programs "based on an individual satisfying a standard that is related to a health status factor," but only under much more stringent conditions.[94] These include the requirement that any reward "not exceed 30 percent of the cost of employee-only coverage under the plan" and that the program be "reasonably designed to promote health or prevent disease."[95] A program meets this latter requirement if it "has a reasonable chance of improving the health of, or preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease."[96] A reward for actually quitting smoking would be an example of this latter type of program.

tion (referred to in this subsection as a 'wellness program') shall be a program offered by an *employer* that is designed to promote health or prevent disease that meets the applicable requirements of this subsection." (emphasis added)).

[90] For a brief overview of wellness programs, see Wendy K. Mariner, Social Solidarity and Personal Responsibility in Health Reform, 14 Conn. Ins. L.J. 199, 214–17 (2008).

[91] See Harald Schmidt et al., Carrots, Sticks, and Health Care Reform—Problems with Wellness Incentives, 362 New Eng. J. Med. e3 (2010).

[92] ACA § 1201, 124 Stat. at 156–57 (to be codified at 42 U.S.C. § 300gg-4) (adding § 2705(j) to the PHSA).

[93] Id.

[94] Id.

[95] Id.

[96] Id.

d. Risk Adjustment Mechanisms

ACA largely excludes employers, especially those that are self-insured, from the risk-sharing arrangements described above that are designed to mute insurers' incentives to attract comparatively healthy risks.[97] First, and most importantly, self-insured employers are specifically exempt from participation in the permanent Prospective Risk Assessment mechanism, which charges low actuarial risk plans a penalty while providing payments to high actuarial risk plans.[98] In the long term, then, ACA provides no mechanism that would affect the financial benefits a self-insured employer might derive from dumping high-risk employees on the individual market or otherwise not insuring such individuals.

Second, both self-insured employers and employers who purchase insurance coverage in the large group market are also largely (but not entirely) unaffected by the two temporary reinsurance programs that ACA establishes in part to limit insurers' incentives to indirectly classify risk.[99] Under both programs, employers are ineligible to receive any reinsurance payments if their enrollees are disproportionately costly; indeed, both provisions are specifically labeled as reinsurance programs for "plans in individual and small group markets."[100] But in the case of the reinsurance program established in Section 1341 of ACA, which reinsures individual market insurers that have a disproportionate share of policyholders with high risk conditions, contributions must be made by "third party administrators on behalf of group health plans" in addition to other insurers.[101] Moreover, while ACA delegates to the HHS Secretary the authority to determine the amounts of these contributions, it provides that they "may be based on . . . the total costs of

[97] See supra Subsection I.B.2.

[98] ACA § 1343, Pub. L. No. 111-148, 124 Stat. 119, 212–13 (2010) (to be codified at 42 U.S.C. § 18063) (providing that "each State shall assess a charge on *health plans and health insurance issuers* (with respect to health insurance coverage) . . . if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that *are not self-insured group health plans* (which are subject to the provisions of the Employee Retirement Income Security Act of 1974)" (emphasis added)).

[99] See supra Subsection I.B.2.c.

[100] ACA §§ 1341–42, 124 Stat. at 208–12 (to be codified at 42 U.S.C. §§ 18061–62).

[101] ACA § 1341(b), 124 Stat. at 209–10 (to be codified at 42 U.S.C. § 18061).

providing benefits to enrollees in self-insured plans."[102] As such, it is possible—but by no means certain—that employers with relatively low-cost enrollees (including those that self-insure) would owe a larger contribution to this reinsurance program for the three years of its operation.

e. General Anti-Dumping Provisions

Although ACA creates and extends various rules prohibiting explicit forms of direct risk classification by employers, it does not supplement these rules with a broader standard prohibiting indirect risk classification. This is perhaps surprising, as ACA does contain precisely such a broad standard in its provisions governing the creation and operation of temporary high-risk pools.[103] These pools are temporary insurance programs designed to cover individuals with preexisting conditions or who have been uninsured for six months until 2014, when they can purchase coverage in the individual market without penalty for their high risk status.[104] ACA instructs the HHS Secretary to "establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status."[105] If either an insurer or an employer is found to have engaged in such dumping, it shall reimburse "the program . . . for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program."[106]

The statute is crystal-clear, however, that these generalized anti-dumping rules apply only to dumping on to high-risk pools, and not to potential dumping on to individual insurance markets or exchanges. First, these anti-dumping rules are contained in Section 1101 of ACA, which solely concerns temporary high-risk pools. Indeed, the provision is entitled "Immediate Access to Insurance for

[102] ACA § 1341(b)(3)(A), 124 Stat. at 210 (to be codified at 42 U.S.C. § 18061).
[103] ACA § 1101(e), Pub. L. No. 111-148, 124 Stat. 119, 142–43 (2010) (to be codified at 42 U.S.C. § 18001).
[104] ACA § 1101(a), (d), 124 Stat. at 141–42 (to be codified at 42 U.S.C. § 18001).
[105] ACA § 1101(e)(1), 124 Stat. at 142 (to be codified at 42 U.S.C. § 18001).
[106] ACA § 1101(e)(2).

Uninsured Individuals with a Preexisting Condition" and "in general" requires the HHS Secretary to "establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014."[107] Accordingly, all of the subsections of Section 1101, including the anti-dumping provisions, are limited to the temporary high-risk pools. Second, the anti-dumping provisions themselves contain remedial provisions that repeatedly describe "the program," a clear reference to the "temporary high risk health insurance pool program" introduced at the outset of the statutory provision.[108] In sum, there is no plausible reading of Section 1101 under which its anti-dumping provisions can be understood to extend to the prospect of employer dumping of high-risk employees on to the individual markets in 2014 and beyond.

II. EMPLOYER DUMPING STRATEGIES

As Part I makes clear, employers generally, and particularly those that self-insure, have substantial legal room under ACA to engage in indirect risk classification. In particular, they are largely free to design plan benefits, provider networks, and wellness programs so that their plans disproportionately appeal to relatively healthy employees but are unattractive to high-risk employees. Moreover, self-insured employers are not subject to the risk adjustment mechanisms that are designed to offset any potential financial gain that can be achieved through indirect risk classification. This Part explores how an employer would go about designing and implementing a targeted dumping strategy designed to induce low-risk employees to retain ESI but cause high-risk employees to opt out of ESI in favor of coverage through an exchange. Section A starts with general considerations, while Section B offers specific examples of how an employer might structure a plan designed to dump high-risk employees but retain low-risk employees.

[107] ACA § 1101(a), 124 Stat. at 141 (to be codified at 42 U.S.C. § 18001).
[108] Id.

A. General Considerations in Plan Design

1. Getting High-Risk Employees onto an Exchange

The core purpose of an employer dumping strategy is to cause high-risk employees to opt out of employer coverage and seek coverage on the individual insurance market, likely via an insurance exchange. Contrary to several different publicly available summaries of health care reform,[109] high-risk employees will indeed have the option of purchasing coverage in state-run exchanges. This is because ACA provides that any "qualified individual" may purchase coverage through an exchange.[110] A qualified individual, in turn, is "an individual who is seeking to enroll in a qualified health plan in the individual market offered through the Exchange and resides in the State that established the Exchange."[111] The only individuals who are explicitly excluded from the definition of quali-

[109] These summaries suggest or affirmatively proclaim that only individuals who do not have access to affordable employer coverage will be eligible to purchase coverage via an exchange. See, e.g., Foley & Lardner LLP, Will Proposed Health Insurance Exchanges Work and Be Affordable? 1 (Apr. 2010), available at http://www.foley.com/abc.aspx?Publication=7033 ("The Exchanges will initially be open only to individuals who work at companies no more than 100 employees or that do not provide insurance, the self-employed and unemployed, non-Medicare-covered retirees, and small businesses."); Kaiser Family Found., Explaining Health Care Reform: Questions About Health Insurance Exchanges 1 (Apr. 2010), available at http://www.kff.org/healthreform/upload/7908-02.pdf (stating that ACA "requires most individuals to have health insurance beginning in 2014. It authorizes entities known as American Health Benefit Exchanges, which states will establish by January 1, 2014, to make plans available to qualified individuals and employers. Qualified individuals include U.S. citizens and legal immigrants who are not incarcerated, and who do not have access to affordable employer coverage.").

The confusion of commentators appears to stem from several sources. First, under Massachusetts Health Care Reform coverage via the Connector, enrollment is indeed limited to those who do not have the option of affordable employer provided coverage. Mass. Gen. Laws ch. 176Q, § 1 (2006) (excluding from the definition of "eligible individual" anyone who is offered subsidized health insurance by an employer with more than fifty employees). Second, the bill that came out of the Senate Health, Education, Labor and Pensions Committee, which largely became the blueprint for PPACA, did exclude individuals with access to affordable employer coverage from eligibility for exchange-based coverage. Affordable Health Choices Act, S. 1679, 111th Cong. § 3116(a)(4)(A)–(B) (2009).

[110] ACA § 1311(d)(2)(A), Pub. L. No. 111-148, 124 Stat. 119, 176 (2010) (to be codified at 42 U.S.C. § 18031) ("An Exchange shall make available qualified health plans to qualified individuals and qualified employers.").

[111] ACA § 1312(f)(1), 124 Stat. at 183–84 (to be codified at 42 U.S.C. § 18032) (internal punctuation omitted).

fied individuals are those who are either incarcerated or not lawful residents of the country.[112] There are no such eligibility restrictions placed on employees with access to employer coverage.

Although coverage through an exchange will be available to high-risk employees, it will undoubtedly cost more to the employee than coverage under the employer's plan. First, by electing individual coverage, employees would ordinarily lose their employers' contribution to their health insurance premiums, which is often quite substantial.[113] At the same time, they would not be eligible for government subsidies through an exchange so long as their employers' plan was "affordable" and provided "minimum value."[114] Second, employees would ordinarily need to pay the premiums for coverage purchased through an exchange with after-tax dollars, even though their premiums for ESI can be paid with pre-tax dollars.[115] Third, ESI may continue to enjoy certain economies of scale relative to coverage on the individual market.[116] Finally, coverage on the individual market will be subject to various requirements that are not applicable to employer plans, resulting in a comparatively generous, and therefore expensive, plan.[117] As such, a major consideration in devising an effective employer dumping strategy is the extent to which the employer offsets these costs of electing coverage in the individual market, thereby making individual coverage a financially attractive option for high-risk employees. While some employers may not mind forcing their high-risk employees to choose between insufficient employer coverage or more expensive coverage on the exchange, others may be quite concerned about the labor market impacts of such a strategy.

[112] ACA § 1312(f), 124 Stat. at 183–84 (to be codified at 42 U.S.C. § 18032).

[113] On average in 2009, workers paid only seventeen percent of the cost of single coverage, and twenty-seven percent of the cost for family coverage. Kaiser Family Found., supra note 13, at 68. The majority of workers are employed by firms that contribute at least half of the premium cost. Id. at 81.

[114] ACA § 1401(a), 124 Stat. at 216–17 (adding § 36B(c)(1)(C) to the I.R.C.).

[115] In order to allow pre-tax payment of health insurance premiums, employers must establish a cafeteria plan pursuant to § 125 of the Internal Revenue Code. See Mark A. Hall & Amy B. Monahan, Using Tax Sheltered Cafeteria Plans to Pay for Individual Health Insurance, 43 Inquiry 252, 256 (2010).

[116] See infra Subsection III.A.2 (explaining that exchanges will largely reduce this historical benefit for ESI relative to individual markets).

[117] See infra Subsection III.A.2 (arguing that high risk employees will be willing to pay for this increased cost of coverage on the exchange).

2. The Complicated Desires of Low-Risk Employees

In order to be effective, an employer dumping strategy must avoid inducing substantial numbers of low-risk employees to opt for coverage through an exchange. After all, if the low-risk individuals leave along with the high-risk individuals, the employer plan will not improve its overall risk profile. Two interrelated concerns might cause low-risk employees to seek coverage through an exchange rather than the employer plan. First, low-risk employees may also be quite risk averse.[118] Second, low-risk employees may unexpectedly and quickly become high-risk employees if, for instance, they are diagnosed with a disease or are the victims of accidents. A low-risk but risk-averse individual will not want to enroll in a plan that does not adequately cover her needs in the event that she becomes high risk.

These concerns suggest that an effective employer dumping strategy must provide reliable coverage for any medical costs that are not foreseeable within a year's time of when they are incurred, such as an unexpected illness or accident. Under ACA, individuals are only eligible to purchase coverage through an exchange during a qualifying change in status (such as a change in employment or family status), or an annual open enrollment period.[119] As such, an individual who is enrolled in her employer's plan cannot, mid-year, simply elect to switch to exchange-provided coverage if she develops a health condition that enjoys better coverage in an exchange plan than in her employer's plan. Such an individual would have to wait until the next open enrollment period to switch to exchange coverage, which could be up to twelve months (or as little as one day). At the same time, however, risk-averse, low-risk employees who opt for an employer plan need not be concerned about their coverage in the event that they suddenly expect to incur large medical expenses in more than a year's time. This is because one year is the maximum period of time it would take an employee to

[118] See Siegelman, supra note 22, at 1264–74.

[119] ACA § 1311(c)(6), Pub. L. No. 111-148, 124 Stat. 119, 175 (2010) (to be codified at 42 U.S.C. § 18031) (referring to a change in status as a "special enrollment period").

acquire comprehensive coverage in an exchange at the same price as low-risk individuals, with no preexisting condition exclusions.[120]

3. The Individual and Employer "Mandates"

A final key consideration in designing an effective employer dumping strategy is ensuring that the plan successfully avoids tax penalties under the so-called individual and employer "mandates." First, individuals may owe a tax penalty under ACA if they do not possess "minimum essential coverage."[121] Surprisingly, though, ACA appears to define employer-provided coverage as automatically constituting minimum essential coverage for individuals, despite the minimal requirements applicable to such plans. In particular, Section 5000A(f) of the I.R.C., as added by ACA, provides that minimum essential coverage includes an "eligible employer-sponsored plan."[122] An "eligible employer-sponsored plan" is then defined in a way that appears to include all "group health plan[s]."[123] Federal regulations make clear that a "group health plan" includes self-insured employer plans.[124] In other words, even though self-insured employers enjoy near complete freedom in determining the composition of their plans, such coverage constitutes "minimum essential coverage" that satisfies the individual purchase mandate for covered employees.

Similarly, the employer mandate poses minimal obstacles to an employer's dumping strategy. Employers who offer a group health

[120] Assuming, of course, that their high risk does not stem from tobacco use. See supra note 32 and accompanying text.

[121] ACA § 1501(b), 124 Stat. at 244 (to be codified at I.R.C. § 5000A(a)–(b)).

[122] ACA § 1501(b), 124 Stat. at 248–49 (to be codified at I.R.C. § 5000A(f)).

[123] Id. (to be codified at I.R.C. § 5000A(f)(2)). The provision provides that "[t]he term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to an employee which is [either] a governmental plan . . . [or] any other plan or coverage offered in the small or large group market within a State." Id. Some commentators have raised the prospect that this definition does not automatically mean that a "group health plan" is an "eligible employer-sponsored plan" because parts (A) and (B) modify the term "group health plan" as well as "group health insurance coverage." See infra note 228. This prospect is discussed more fully infra Section III.B.

[124] Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,539 (June 17, 2010) ("The term 'group health plan' includes both insured and self-insured group health plans.").

plan only owe a penalty under ACA when their employees receive subsidized coverage through an exchange. But employees are not eligible for subsidies if they have the option of "affordable" employer-provided coverage that provides "minimum value."[125] An employer plan is unaffordable for this purpose only if the employee's required contribution for coverage exceeds 9.5% of her annual household income,[126] which the employer can easily control in setting employee premium contributions. And the term "minimum value" refers not to the scope of benefits offered, but to a requirement that the plan pay at least sixty percent of the costs of the benefits that are covered by the plan.[127] These thresholds are no more difficult for a plan to meet by virtue of the fact that it is designed to appeal primarily to low-risk employees and therefore has significant gaps in coverage for long-term conditions. As a result, an employer plan designed to dump high-risk employees would avoid any liability under the employer mandate so long as its coverage is "affordable" and provides "minimum value."

B. Specific Employer Dumping Strategies

In order to successfully dump high-risk employees, employers must design a plan that is unappealing to high-risk employees, but still appealing to low-risk employees. A major obstacle in accomplishing the former is the fact that high-risk employees who elect coverage in the individual market will face higher health insurance costs, particularly if they thereby lose their employers' contribution

[125] ACA § 1401(a), 124 Stat. at 216–17 (to be codified at I.R.C. § 36B(c)(2)(C)).

[126] HCERA § 1001(a)(2)(A), Pub. L. No. 111-152, 124 Stat. 1029, 1031 (2010) (amending PPACA § 1401(a), Pub. L. No. 111-148, 124 Stat. 119, 216–17 (to be codified at I.R.C. § 36B(c)(2)(C))). For example, if an employee earns $21,660 per year (currently this is 200% of the federal poverty level, see Delayed Update of the HHS Poverty Guidelines for the Remainder of 2010, 75 Fed. Reg. 45,628, 45,629 (Aug. 3, 2010)), but is eligible for employer-provided coverage, she could receive a premium tax credit only if the required contribution for her employer coverage exceeds $2058 per year (9.5% of her income).

[127] ACA § 1401(a), 124 Stat. at 217 (to be codified at I.R.C. § 36B(c)(2)(C)(ii)). To calculate this, one must subtract from the total cost of coverage the employee's "required contribution," which means "the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage." ACA § 1501(b), 124 Stat. at 247 (to be codified at I.R.C. § 5000A(e)(1)(B)(i)).

as well as the tax benefits of employer-provided coverage.[128] By contrast, to attract low-risk employees, the employer plan likely must provide reliable coverage for any risks that cannot be anticipated a year in advance.[129] Moreover, merely creating incentives that should produce sorting of high-risk and low-risk employees is not necessarily sufficient to accomplish this result—the employer must also convey reliable and understandable information to its employees about these incentives.

Meanwhile, the employer plan must also meet various legal requirements. As mentioned above, to avoid liability under the employer mandate, the employer's coverage must both be "affordable" and provide "minimum value."[130] And to comport with ACA's substantive requirements, the employer's plan must (i) avoid any explicit discrimination on the basis of health status,[131] (ii) provide full preventive benefits with no cost-sharing,[132] (iii) impose no annual or lifetime limits on any essential health benefits (although it need not offer essential health benefits at all),[133] and (iv) require cost sharing of no more than approximately $6000 for individuals and $12,000 for families.[134]

Clearly, an effective employer dumping strategy is not simple to construct. At the same time, though, this Section demonstrates various ways that motivated employers could thread this needle. In doing so, it focuses on self-insured plans, as an employer seeking to implement a dumping strategy would enjoy important benefits from self-insuring—including avoiding both state regulation and ACA's risk adjustment mechanisms.[135]

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[128] See supra Subsection II.A.1.
[129] See supra Subsection II.A.2.
[130] See supra Subsection II.A.3.
[131] See supra Subsection I.C.2.
[132] See supra note 77 and accompanying text.
[133] See supra note 81 and accompanying text.
[134] See supra notes 38 and 79 and accompanying text.
Additionally, the plan must (i) cover minimum hospital stays following child birth, (ii) breast reconstruction following a mastectomy, (iii) be consistent with mental health parity rules, and (iv) cover routine patient care costs of those participating in clinical trials. The first three requirements stem from ERISA, see supra notes 62–63 and accompanying text, and the fourth from ACA, see supra note 78 and accompanying text. See supra Section I.C.
[135] See supra Subsection I.B.3.

1. Addressing the Cost Differential

Many, though not all, employers considering dumping high-risk employees will want to limit the premium differential between ESI and coverage available on an exchange. As noted above, exchange coverage is almost certain to be more expensive than employer coverage because, among other reasons,[136] (1) employers, on average, pay the majority of employees' health insurance premiums[137] and (2) ESI, whether paid for by the employer, employee, or some combination, can be paid on a pre-tax basis.[138] Employers pursuing a dumping strategy have at least two independent reasons to limit (though not eliminate) this cost differential. First, they may be concerned about the labor market consequences of forcing their high-risk employees to incur these increased costs. Second, they may worry that high-risk employees will retain ESI simply because of the increased cost of coverage on an exchange. Such high-risk employees may generate disproportionately large costs for the employer notwithstanding the plan design.[139]

In order to offset the increased cost of coverage through an exchange, employers could offer employees who opt out of ESI a payment equaling the employers' ordinary contribution to employees' health insurance expenses. For example, if the employer typically contributes $5000 per year for each employee covered by the employer's plan, the employer would simply provide the employee with a direct payment of $5000 for use on an exchange. In fact, ACA already incorporates this concept, which it labels a "free

[136] See supra notes 115–16 and accompanying text (noting that economies of scale and regulation may also contribute to exchange coverage being more expensive than ESI). This issue is addressed infra Subsection III.A.2, which argues that exchanges will largely eliminate the economies of scale benefits of ESI and that the increased costs of regulation will not deter migration by high-risks because the benefits of this regulation will disproportionately benefit high-risk employees.

[137] See supra note 113.

[138] See I.R.C. §§ 106, 125 (2006). In addition, as noted earlier, employees will not be eligible for federal premium subsidies, even if their income would otherwise qualify them for a subsidy, because of the fact that affordable employer coverage is available to them. See supra note 114 and accompanying text.

[139] In addition, employers may be concerned that if high-risk employees remain in the employer-sponsored plan, the employees' work attendance or performance might suffer as the result of inadequately treated medical conditions.

choice voucher."[140] Indeed, ACA requires employers to offer such vouchers to employees when the employee's contribution to the employer-sponsored plan is between 8 and 9.8 percent of the employee's income for the taxable year and the employee would be eligible for subsidies through an exchange.[141] Employers seeking to dump high-risk employees could simply make such free choice vouchers available to all employees who opt to purchase coverage on an exchange rather than through their employer.[142]

An employer could ensure that these free choice vouchers would be tax free to employees by establishing a "health reimbursement arrangement" ("HRA").[143] The HRA would provide each participating employee with a set contribution each year, which the employee could then apply to the purchase of individual health insurance in an exchange. The amount an employee received under the HRA would be excluded from her taxable income provided that the arrangement is solely employer-funded, reimburses the employee for qualifying medical expenses, is not made available to an employee for any other purpose, and the employee could not elect at any time to receive a distribution of the amount in cash.[144] For purposes of an HRA, health insurance premiums are qualifying medical expenses.[145] An employer could even set up a debit card program related to the account so that the employees would not

[140] ACA § 10108, Pub. L. No. 111-148, 124 Stat. 119, 912 (2010) (to be codified at 42 U.S.C. § 18101). Note that the term "free choice voucher" is used in ACA to refer to a specific requirement that employers provide employees within certain income limits who face certain contribution requirements for an employer's plan with a "free choice voucher" to help fund exchange-based individual insurance purchases. Id. What we propose is not within the statute's provisions for "free choice vouchers," but follows the same general principles.

[141] Id.

[142] Ideally, employers looking to dump high-risk employees on to exchanges would offer supplemental payments only to high-risk employees for making this switch. Thus, an employer might offer the supplemental payment to any employee who incurred more than $50,000 in medical costs in the past year. However, this type of plan design would almost certainly violate HIPAA, as well as ACA's own nondiscrimination provisions. See supra note 74 and accompanying text.

[143] Under § 10108 of ACA, free choice vouchers to qualifying employees do not count as taxable income. ACA § 10108, 124 Stat. at 913 (adding § 139D to the I.R.C.). But the free choice vouchers described here would be paid to non-qualifying employees, and so would count as taxable income. As a result, the use of an HRA would be necessary to provide the amount tax-free to the employee.

[144] I.R.S. Notice 2002-45, 2002-28 I.R.B. 93.

[145] Id.

have to pay the premiums themselves and then seek reimbursement, in order to relieve any cash flow problems that might result from such an arrangement.[146] By utilizing an HRA, the employer could equalize the tax treatment of employer payments for group health plan participants and those who are being dumped.

Free choice vouchers provided through an HRA will mitigate, but not eliminate, the differential in cost between employer-provided coverage and coverage through an exchange. Employees who seek coverage on the individual market would still face a tax disadvantage because they could not pay their share of the premium with tax-free dollars.[147] An employer could potentially "gross up" such employees, however, in order to compensate them for the loss of tax benefits.[148] Unlike simply providing an HRA contribution that is equal to the amount the employer pays for employee coverage under the employer's plan, such gross-ups would produce entirely new costs to an employer when an employee opts for coverage through an exchange.[149] In many cases, though, a gross-up will not be necessary: most high-risk individuals will presumably be willing to incur an additional tax cost in order to acquire substantially more generous coverage.

One additional consideration is that premiums for coverage within an exchange may be higher than premiums for the em-

[146] See Rev. Rul. 2003-43, 2003-1 C.B. 935, 937.

[147] For example, if the employee's share of the premium is $1000 per year, and the employee faces a combined federal income, state income, and payroll tax rate of thirty percent, paying the premium on an after-tax basis would cost the employee $300 more per year than paying on a pre-tax basis through an employer's cafeteria plan. While an employer can, in some circumstances, establish a cafeteria plan under § 125 of the I.R.C. that allows employees to set aside pre-tax money to pay for individual health insurance policies, ACA specifically prohibits the pre-tax payment of the employee's portion of individual health insurance premiums in most instances. See ACA § 1515, Pub L. No. 111-148, 124 Stat. 119, 258 (2010) (to be codified at I.R.C. § 125(f)(3)) (excluding payments to exchange-participating health plans from the gross income exemption given to qualified benefits).

[148] The gross-up could be accomplished either by paying the employee additional cash compensation, or by increasing the amount of the contribution to the HRA, in an amount equal to the increased tax cost. Increasing the HRA contribution would be a cheaper option for the employer because it would be tax-free, but there might be problems under applicable nondiscrimination rules if the amount of the contributions were greater for higher-income employees.

[149] The actual cost to an employer would vary significantly based on the income levels of its employees.

ployer-provided plan precisely because the coverage in the exchange will be more generous. As above, an employer concerned that this cost difference will discourage migration by high-risk employees can cover this price differential between employer coverage and exchange coverage by increasing the size of its HRA contribution. But in many cases, incurring this cost may not be necessary to induce high-risk employees to opt for exchange coverage, assuming that an exchange plan is substantially more valuable to the high-risk employee than the employer plan. Moreover, making the employer's contribution to the HRA more generous than the employer's contribution to its own coverage carries with it the risk that low-risk employees will also opt to receive the HRA contribution and purchase individual policies.

In sum, employers can incorporate into their plans various measures that substantially mitigate the cost difference to employees of purchasing coverage in an exchange rather than purchasing employer-provided coverage. These efforts may come with an increased cost if the employer chooses to gross up the employee's premium payment or increase employer contributions. Employers who feel compelled to protect high-risk employees in this way will only find a dumping strategy attractive if these costs are outweighed by cost savings generated by targeted dumping. But if the plan design is successful at sorting risks, very significant cost savings from targeted dumping can be achieved.[150]

2. Benefit and Cost-Sharing Structure

An employer seeking to dump high-risk employees on to an insurance exchange must also carefully design its benefits and cost-sharing structures to appeal to low-risk employees but not to high-risk employees. To accomplish the former, the plan should provide generous benefits with no cost sharing for all medical expenses that a relatively healthy person might incur. ACA already requires full

[150] As an extreme example, take the statistic that three-quarters of all medical expenditures are incurred by individuals with chronic conditions. Catherine Hoffman et al., Persons with Chronic Conditions: Their Prevalence and Costs, 276 JAMA 1473, 1477 (1996). If an employer could successfully encourage all of its employees with chronic conditions to opt for coverage in the individual market instead of the group plan, the employer's group plan could theoretically reduce its costs by seventy-five percent. See infra Subsection III.A.2.c.

coverage for preventive services,[151] but an employer might also provide full coverage with no cost sharing for services such as dermatology visits, wellness screenings, sports medicine related treatments, and optometry expenses.

As discussed above, the more difficult, and more important, component of designing an employer dumping plan is to make the plan unattractive to high-risk insureds without scaring off low-risk, but risk-averse, policyholders. Recall that participants in an employer's plan may need to wait up to twelve months to switch into an individual plan in an exchange given the annual open enrollment period in exchanges.[152] As such, a plan design that provided inadequate coverage for acute episodes would likely cause low-risk, but risk-averse, individuals to opt for coverage in an exchange, especially if such coverage were subsidized by the employer as described above. Employers who either increase their contribution or gross up employee premium payments for those who participate in an exchange will need to minimize the number of non-high-risk employees who opt for exchange coverage in order to minimize those increased costs. As such, their plans must provide adequate coverage for acute health care expenses as well as for the initial stages of illnesses, but nonetheless provide quite limited care for large expenses that can be anticipated a year or more before they are incurred.

One way to meet these specifications is for the employer plan to include maximal levels of cost-sharing requirements for all medical services and drugs that are associated with chronic conditions.[153] Thus, the plan could require up to a $6000 deductible ($12,000 for families)[154] with respect to hospitalization, surgery, drugs used for chronic conditions, and durable medical equipment. The precise

[151] ACA § 1001, 124 Stat. at 131–32 (adding § 2713 to the PHSA) (to be codified at 42 U.S.C. § 300gg-13).

[152] ACA § 1311(c)(6), 124 Stat. at 175 (to be codified at 42 U.S.C. § 18031). Individuals who participate in their employer's medical plan through a cafeteria plan (i.e., individuals who pay premiums of a pre-tax basis) would not be permitted to drop employer coverage mid-year absent a qualifying change of status. Treas. Reg. § 1.125-4 (2010). Having to pay for the employer plan when it is no longer useful is, however, a less significant issue than potentially not being able to obtain coverage on the exchange.

[153] Recall that ACA does cap cost-sharing requirements even for self-insured plans. See supra note 79 and accompanying text.

[154] See supra note 134.

amount of the deductible would likely vary depending on the employee population's average income level. From the perspective of a high-risk individual, of course, these cost-sharing arrangements would be quite burdensome, particularly because they would be incurred year after year. At the same time, though, these cost-sharing arrangements can be designed so that they do not cause low-risk, but risk-averse, policyholders to opt for coverage in an exchange. This is because the maximum amount they would owe is capped, the likelihood of owing that amount is low (by assumption), and they will always be free to opt for coverage through an exchange in no more than a year if their risk level changes.

A second approach to designing an employer plan to produce dumping of high-risk employees is simply to exclude altogether care and drugs for conditions that can in most circumstances be readily anticipated. There are numerous illnesses and diseases wherein there is a substantial gap in time between diagnosis and the need for extensive medical treatment.[155] And the list of diseases that can be anticipated with a high degree of accuracy is only growing: for instance, recent reports preliminarily suggest that Alzheimer's can be predictably diagnosed well before its onset.[156]

Moreover, some genetic conditions, such as Huntington's disease, hemophilia, and cystic fibrosis, can be identified at the time of one's birth or shortly thereafter.[157] For these genetic diseases, there would be limited risk that individual employees would not expect a large likelihood of medical expenses, and so treatment

[155] This is true for many degenerative diseases, such as Huntington's disease. Carolyn Jacobs Chachkin, What Potent Blood: Non-Invasive Prenatal Genetic Diagnosis and the Transformation of Modern Prenatal Care, 33 Am. J.L. & Med. 9, 42–43 (2007).

[156] See Gina Kolata, In Spinal Test, Early Warning on Alzheimer's, N.Y. Times, Aug. 10, 2010, at A1.

[157] Chachkin, supra note 155. Neither the ADA nor the Genetic Information Nondiscrimination Act ("GINA") would prohibit such an exclusion. Under the ADA, such exclusions are permissible provided they are justified on the basis of cost, see supra notes 83–85 and accompanying text, and GINA imposes no requirements on health plans to cover genetically based diseases or illnesses. See Genetic Information Nondiscrimination Act, Pub. L. No. 110-223, 122 Stat. 881, 883, 888 (codified as amended at 29 U.S.C. § 1182(b) and 42 U.S.C. § 300gg-1(b)) (adding § 1182(b) to ERISA and adding § 300gg-1(b) to the PHSA) (mandating that a health plan may not adjust premiums or contributions on the basis of genetic information but making no coverage requirement for genetically based diseases).

and therapies for such conditions could be excluded from the employer's plan. There would be greater risk in excluding coverage for genetic diseases that might not become known until later in life. However, a plan could mitigate this risk by providing (but not requiring)[158] full coverage for genetic testing for such diseases, which would theoretically allow individuals to learn their status and switch to exchange-based coverage before treatment is necessary. Ultimately, though, given that there are many circumstances under which an individual may not know that she is a carrier of a gene for an excluded disease, careful thought would need to be given regarding exactly which genetic conditions to exclude and under what circumstances.[159]

Yet a third approach for an employer seeking to dump high-risk individuals while not scaring off risk-averse, low-risk individuals is to exclude coverage for care or drugs that can easily be postponed or that is usually only necessary in the later stages of chronic diseases or conditions. For instance, it might be possible to exclude coverage for certain organ transplants that are only necessary after a prolonged disease. Similarly, an employer plan might cover the diagnosis of chronic conditions such as autism but specifically exclude long-term treatment via behavioral therapy. Yet another example is that the plan might exclude gastric-bypass surgery and other forms of treatment that are considered only after a disease has significantly advanced.[160]

[158] Any such requirement would violate GINA. 42 U.S.C. § 2000ff-1(b) (2006).

[159] For example, a plan that excluded coverage for cystic fibrosis treatment might result in significant hardship for families that have a child unexpectedly born with cystic fibrosis. Because the cystic fibrosis gene is recessive, it is entirely possible that two individuals are unaware of their status as gene carriers and therefore are unaware of the risk to their children. See Cystic Fibrosis Foundation, Testing for Cystic Fibrosis, http://www.cff.org/AboutCF/Testing/ (last visited Oct. 26, 2010). A plan could potentially counteract this risk through coverage of genetic testing (in this case for potential parents), but it is an incomplete solution. In any event, the topic of genetics and insurance has produced a substantial literature. See, e.g., Susan Wolf & Jeffrey P. Kahn, Genetic Testing and the Future of Disability Insurance: Ethics, Law & Policy, Supplement, 35 J.L. Med. & Ethics 6 (Summer 2007). Our goal here is simply to raise the possibility that employers might exploit the time gap between diagnosis and medical treatment that accompanies some genetic conditions in designing a dumping strategy.

[160] See National Institutes of Health, The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults 38 (Oct. 2000), available at http://www.nhlbi.nih.gov/guidelines/obesity/prctgd_c.pdf.

Employers who are less sensitive to the labor market consequences of changing their health plan (that is, the potential that the employer will become less able to compete for desired employees) may be willing to employ a more aggressive dumping strategy. In particular, they may offer employees only the option of a health reimbursement arrangement funded with an amount equal to the employer's typical employee contribution to the group health plan and design their plans with larger gaps in coverage that may indeed scare away some risk-averse employees. For instance, such employers may refuse to cover various essential health benefits at all, such as hospitalization, non-preventive lab and blood work, or pharmacy costs. Taking this approach will likely cause many of their low-risk, but risk-averse, employees to opt out of employee coverage. But this prospect is much less troubling to an employer who chooses not to absorb any increased costs such as a higher employer contribution of premium gross-ups. And so long as the group of workers who migrate to an exchange are less healthy *on average* than those who do not, the employer will come out ahead if the labor market consequences of that decision are not significant.

Ultimately, motivated employers will enjoy tremendous discretion in seeking to develop a specific benefit plan that carves out expensive, long-term treatments and conditions without jeopardizing the financial security or health of low-risk individuals who unexpectedly develop medical needs during the year. Indeed, employers will have several years, copious data, and various sophisticated intermediaries studying this issue to help them develop such plans, if they so desire.

3. Limited Provider Networks

Another important facet of plan design that is available to an employer seeking to dump high-risk employees is its provider network. In contrast to the limitations placed on plan benefits and cost sharing, ACA imposes virtually no restrictions on an employer's network of providers.[161] Consequently, motivated employers will have substantial freedom to select providers who appeal to low-risk employees but not to high-risk employees. Once again, there are

[161] See supra Subsection I.C.3.b.

multiple different ways in which an employer could accomplish this. Perhaps the best option is for the employer to maintain a wide-open network of primary care doctors and other providers who do not specialize in treating those with chronic conditions. It might contract with providers with short wait times, attractive offices, and strong customer service, or even with concierge-type practices.[162] At the same time, it could maintain a tightly controlled network of providers when it comes to surgeons, oncologists, nephrologists, and other types of specialists. Irrespective of whether such a provider network would be beneficial in the abstract—and there is good reason to believe that it might be, given the imbalance of primary care doctors and specialists in this country[163]—it would help an employer generate indirect risk classification because choice among primary care doctors is comparatively valuable to low-risk employees, while choice among specialists is comparatively valuable to high-risk employees.

It is possible that risk-averse employees might be driven to purchase coverage in an exchange by a restricted network of specialist doctors, given the risk that they might become high-risk and need to wait up to twelve months to switch into an exchange plan. If so, the employer can simply place large cost-sharing requirements on provider visits outside of the network. However, because ACA imposes aggregate cost-sharing limits even on self-insured plans,[164] and cost-sharing limits may be an important facet of benefit design as described above, the employer instead simply might make it inconvenient and difficult to see out-of-network providers. For instance, it might require pre-approval from a primary care physician, or it might insist upon a referral from its own in-network specialist. It might also place a cap on the number of times a policyholder can permissibly see an out-of-network specialist.[165]

[162] Cf. Kevin Sack, Despite Recession, Personalized Health Care Remains in Demand, N.Y. Times, May 11, 2009, at A12 (discussing benefits of concierge medicine).

[163] Harry A. Sultz & Kristina M. Young, Health Care USA: Understanding Its Organization and Delivery 194 (6th ed. 2009).

[164] Supra note 77 and accompanying text.

[165] It is conceivable (but unlikely) that such a cap could be characterized as an aggregate or lifetime limit.

4. Wellness Programs

Employers seeking to induce high-risk employees to purchase coverage through an exchange will have various opportunities to exploit wellness programs to reduce the cost of coverage for low-risk employees (and, correspondingly, to increase it for high-risk employees).[166] Recall that ACA permits two types of employer wellness programs.[167] First, it permits all programs that are not tied to meeting a standard related to health status.[168] Although not specifically tied to health status, these types of programs may be disproportionately utilized by employees who are relatively low risk and thus help facilitate indirect risk classification. For instance, gym memberships are likely to be utilized more by relatively healthy employees. As a result, a wellness program that offers premium discounts for gym usage may disproportionately appeal to low-risk employees.

Second, ACA also permits, under more limited conditions, wellness programs that provide rewards for satisfying a standard that *is* related to health status.[169] The prospect that employers might exploit these types of programs to differentially benefit low-risk employees is self-evident. An employer might, for example, offer a wellness reward for obtaining a cholesterol level below average, or for maintaining a healthy weight. ACA does explicitly attempt to limit this risk, prohibiting the usage of wellness programs tied to health factors when they are "a subterfuge for discriminating based on a health status factor."[170] But this provision is unlikely to be effective, as it seems almost impossible to apply in practice. The core problem is that in order to incentivize healthy living, a wellness program must provide benefits only to those who are, in fact, healthier. Thus, while there is certainly a risk of liability under

[166] For a discussion of the role of wellness programs in health care reform, see generally Mariner, supra note 90.

[167] See supra Subsection I.C.3.c.

[168] ACA § 1201, Pub. L. No. 111-148, 124 Stat. 119, 156–57 (2010) (codified at 42 U.S.C. § 300gg-4) (adding § 2705(j) to the PHSA).

[169] ACA § 1201, 124 Stat. at 156–59 (codified at 42 U.S.C. § 300gg-4) (adding § 2705(j) to the PHSA).

[170] ACA § 1201, 124 Stat. at 158 (to be codified at 42 U.S.C. § 300gg-4) (adding § 2705 to the PHSA).

ACA to an employer that seeks to implement a wellness program based on health related status, this risk ultimately seems limited.

5. Employer-Provided Information and Employee "Free Choice"

All of the explicit design features described above can provide strong incentives for high-risk employees to opt for coverage in an exchange and for low-risk employees to stick with employer-sponsored coverage. But incentives are imperfect drivers of human behavior, especially when people have limited information about the circumstances that create these incentives or a limited capacity to make decisions on the basis of their self-interest.[171]

For these reasons, an employer dumping strategy is only likely to be successful if employees of dumping employers have good information and advice about the decision whether to retain employer-sponsored coverage or to opt for coverage in an exchange. The best way to accomplish this is to provide employees with the counsel of a learned intermediary incentivized to offer advice consistent with employees' best interests.[172]

Dumping employers are ideally suited to provide their employees with precisely such counsel. Most importantly, the incentives of dumping employers and their employees are aligned: both benefit when employees select employer-sponsored coverage if they are relatively healthy but select coverage on an exchange if they are less healthy. Second, employers typically already have extensive resources in place for informing their employees about their benefit options. Third, employees expect to make important benefits decisions when they begin employment, have the capacity to seek advice from similarly-situated co-workers, and often have time to devote to this choice when they begin a new job. Although this

[171] For general discussions of the problems that individuals may have making health care decisions consistent with their own self-interest, see Carl E. Schneider & Mark A. Hall, The Patient Life: Can Consumers Direct Health Care?, 35 Am. J.L. & Med. 7 (2009).

[172] See Daniel Schwarcz, Differential Compensation and the "Race to the Bottom" in Consumer Insurance Markets, 15 Conn. Ins. L.J. 723, 745–48 (2009) (emphasizing the importance of aligning the incentives of agents and the consumers they advise); Samuel Issacharoff, Disclosure, Agents, and Consumer Protection 4 (N.Y.U. Law & Econ. Research Paper Series, Working Paper No. 10–33, July 2010), available at http://ssrn.com/abstract=1640624 (discussing the important role that information intermediaries can play in overcoming market problems).

may be less true for current employees during open enrollment periods, employers seeking to dump high-risk employees could prioritize informing and counseling employees on a yearly basis, during each open enrollment period.

On top of this informational campaign, dumping employers could place subtle, informal pressure on their high-risk employees to avail themselves of the option to purchase coverage on an exchange. In particular, they could explain that the employee plan provides the best coverage around when it comes to routine care and episodic emergency care. At the same time, the employer could explain that the plan is not suitable for those with chronic or persistent conditions and, for that reason, it subsidizes the costs of purchasing individual coverage. Moreover, the employer might go so far as to explain to employees that it is in their collective self-interest for those with chronic or persistent conditions to opt for coverage through an exchange. Doing so does not cost high-risk employees substantially more that they would otherwise pay, provides them with more appropriate coverage, and helps keep costs low and salaries high.

None of this information, advising, and informal messaging would violate either ACA itself or pre-ACA law. In explaining the relative costs and benefits of employer provided coverage and coverage through the exchanges, the employer is not in any way discriminating among its employees. Rather, the employer is simply presenting employees with relevant information about an important choice. As a result, explaining the reasons behind the structure of the employer plan and the availability of the supplemental payment should not be legally problematic.

III. SCOPE, IMPLICATIONS, AND SOLUTIONS

Parts I and II laid out both the legality of employer dumping and the various strategies that employers might use to accomplish such dumping. This Part considers the implications of employer dumping as well as various potential solutions to the problem. Section A begins by considering the extent to which employers will ultimately find a targeted dumping strategy preferable to either dropping coverage altogether or maintaining relatively comprehensive coverage. Although predicting employer behavior is an inherently speculative enterprise, it argues that there is a substantial risk that

many employers will be drawn to some version of the dumping strategies described in Part II. It argues that such wide-spread employer dumping of high-risk employees could imperil the future of health care reform by undermining the sustainability of individual insurance markets and insurance exchanges.

Section B concludes by exploring both regulatory and statutory solutions to the problem of targeted employer dumping. It suggests that several regulatory approaches—including changing the regulations governing the ADA, revising administrative rulings on health reimbursement arrangements, or interpreting ACA to provide that self-insured plans do not automatically constitute "eligible employer plans"—could substantially limit the availability and attractiveness of an employer dumping strategy. Unfortunately, each of these approaches would likely have far wider implications that could not be cabined to the risk of employer dumping. By contrast, several relatively straightforward statutory changes could virtually eliminate the risk of employer dumping in a fairly targeted fashion.

A. Implications and the Magnitude of Employers' Incentives to Dump

Any amount of employer dumping of high-risk employees poses a public policy problem for health insurance reform. Employers who dump high-risk employees strike directly at the spirit of health care reform, which embraces social solidarity in the sharing of medical risks.[173] Irrespective of whether one sympathizes with this goal, it is clearly problematic to allow some people (dumping employers and their employees) to escape this obligation, while forcing the remainder of the population to contribute to social health care costs. Not only is employer dumping of high-risk employees fundamentally unfair, but it risks undermining the willingness of the general population to embrace the notion that all must contribute their fair share to paying for our country's sick population. Indeed, a robust literature suggests that people's willingness to cooperate with legal rules that require sacrifice crucially depends on the degree to which they perceive others to do the same.[174] In other

[173] See generally Mariner, supra note 90.

[174] See, e.g., Dan M. Kahan, What Do Alternative Sanctions Mean?, 63 U. Chi. L. Rev. 591, 604 (1996) ("Empirical studies show that the willingness of persons to obey

words, to the extent that some actors are perceived to "cheat" the system, others are less likely to play by the rules themselves.

Unfortunately, the risks associated with employer dumping of high-risk employees are not limited to unfairness or counterproductive norm-development. Much to the contrary, such employer dumping also jeopardizes the economic viability of health care reform writ large by threatening the individual insurance markets and exchanges that ACA establishes to organize these markets.[175] If employers dump a substantial number of disproportionately high-risk employees on to individual markets, then premiums for all policyholders will rise to reflect the worse-than-average risk pool. Such adverse selection would not only increase premiums, but would decrease coverage rates by making coverage unattractive to low-risk policyholders. Notably, it would also promote adverse selection for a less conventional reason: higher prices would exempt a greater number of people from the individual mandate.[176] This, in turn, would free these individuals to purchase comprehensive health insurance only once they became sick. Individuals would not bear the burden of the resulting rate increases alone: so too would the federal government, whose statutory obligations to subsidize health insurance premiums increase in lock step with increases in overall premiums.[177]

Such adverse selection on insurance exchanges is problematic even if one disputes the premise that employers and their low-risk employees ought to pay the health care costs of high-risk individuals. First, adverse selection does not simply move costs away from

various laws is endogenous to their beliefs about whether others view the law as worthy of obedience: if compliance is perceived to be widespread, persons generally desire to obey; but if they believe that disobedience is rampant, their commitment to following the law diminishes. Even a strong propensity to obey the law, in other words, can be undercut by a person's 'desire not to be suckered.'" (internal citations omitted)); Lawrence Lessig, Social Meaning and Social Norms, 144 U. Pa. L. Rev. 2181, 2185 (1996) ("At some point, when everyone else is violating a norm . . . obeying the norm makes one a 'chump.'").

[175] See supra Subsection I.B.2.b.

[176] ACA does not subject individuals to any penalties for failing to secure health insurance coverage if the individual's "required contribution . . . for coverage . . . exceeds 8 percent of such individual's household income." ACA § 1501, Pub. L. No. 111-148, 124 Stat. 119, 246–47 (2010) (to be codified at I.R.C. § 5000A).

[177] ACA §§ 1401–02, 124 Stat. at 213–24 (to be codified at I.R.C. § 36 and 42 U.S.C. §18071).

these parties. Instead, it reallocates these costs to other parties—the individuals who purchase coverage on exchanges.[178] This group is particularly likely to be low income in the aggregate, both because subsidies are available for low-income individuals in exchanges and because they will disproportionately not have the option of employer-sponsored coverage. Second, as described above, adverse selection on insurance exchanges threatens the exchanges' long-term viability. Even critics of reform are likely to support effective insurance exchanges, which are fundamentally aimed at promoting a more transparent marketplace for individuals to purchase insurance.

These risks are different in kind than those associated with the risk that employers will drop coverage altogether. Most importantly, even if a large number of employers dropped coverage altogether, this would not undermine the sustainability of exchanges or the individual market more generally, as employers have heterogeneous populations with respect to health risks. As a result, an employer who dropped coverage altogether would dump employees of all risk levels into the individual market, which would not skew the risk profile of the individual market. Second, large employers who dropped coverage entirely would potentially owe tax penalties under the "employer mandate,"[179] meaning that it is not likely that they would undermine social norms consistent with compliance with health care reform.

The magnitude of both the norm development and adverse selection threats depends entirely on the prevalence of targeted employer dumping of high-risk employees. If only a few relatively small employers utilize this dumping strategy, then the amount of adverse selection that will result will likely be trivial. And while sporadic dumping by a few small employers might impact the attitude of some regarding health care reform, it would be unlikely to dramatically influence the willingness of the population at large to comply with the individual mandate. By contrast, if a dumping strategy becomes prevalent among large employers, then the resulting adverse selection would be catastrophic. The remainder of

[178] The costs associated with dumping are also indirectly reallocated to the federal government, which must pay a greater amount in premium tax credits as premiums rise.

[179] See supra Subsection II.A.3.

this Section therefore analyzes how prevalent dumping of high-risk employees is likely to be among employers and which employers are most likely to be attracted to such a strategy. Although predicting the future is always a dangerous enterprise, this Section argues that there is a real risk that employers generally, and large employers in particular, are likely to find a dumping strategy appealing in 2014.

1. Employers' Pre-ACA Incentive to Offer Generous Coverage

Historically, employers have had strong incentives to design robust health insurance plans that provide generous coverage to all of their employees. In large part, this is because ESI has traditionally enjoyed several economic advantages over individual insurance coverage. First, employers hire employees for reasons unrelated to health insurance, so the insured group tends to enjoy a near community-level risk profile. In other words, employees' health risks generally mirror the community at large, especially for large employers, creating a natural risk-pooling mechanism. Second, because of the administrative efficiencies associated with group purchase, administrative costs have historically been substantially lower for ESI than coverage available in individual markets.[180] As with the benefits associated with risk pooling, large employers disproportionately benefit from such economies of scale. Third, from an employee's perspective, the employer also provides valuable "informational intermediation" by performing the health insurance search and aggregation functions, reducing the health insurance decision-making costs that employees face.[181]

As described earlier, the federal tax code further reinforced the tendency of employers to offer generous coverage.[182] Both employer and employee contributions toward ESI can be excluded

[180] Estimates suggest that group plans spend less than ten percent of premiums on administrative costs, while such costs are equal to thirty to forty percent of premiums in the individual market. Mark Pauly et al., Individual Versus Job-Based Health Insurance: Weighing the Pros and Cons, 18 Health Aff. 28, 33–34 (1999); Mark V. Pauly & Len M. Nichols, The Nongroup Health Insurance Market: Short on Facts, Long on Opinions and Policy Disputes, Health Aff. – *Web Exclusive* W325, W326 (Oct. 23, 2002), http://content.healthaffairs.org/cgi/reprint/hlthaff.w2.325v1.

[181] See David A. Hyman & Mark Hall, Two Cheers for Employment-Based Health Insurance, 2 Yale J. Health Pol'y L. & Ethics 23, 30 (2001).

[182] See supra Subsection I.C.1.

from federal income and payroll taxes. The tax exemption makes such benefits more valuable than an equal amount of cash compensation (which of course is taxable), and this has led employers to offer plans with generous benefits and low out-of-pocket payments.[183] As a result, ESI effectively enjoys a federal subsidy, which is not generally available for individual insurance purchases.[184] By lowering the cost of coverage, this subsidy also encourages low-risk individuals to accept coverage in group plans that they might otherwise find too generous relative to its price. The subsidy thus helps to ensure that such plans do not suffer from adverse selection. Additionally, this subsidy often leads employers to contribute significantly to the cost of coverage, as doing so essentially constitutes a vehicle for paying salary that is not taxable.[185] This further encourages low-risk employees to join employer plans.

These economic and tax benefits of ESI contrast sharply with the coverage that has historically been available to employees who purchase coverage in the individual market. Indeed, one of the primary motivations for federal health care reform was the near-consensus view that individual health insurance markets have traditionally been dysfunctional. Not only did these markets typically fail to offer affordable protection to those with poor health history or risks, but they subjected even healthy individuals to significant risks associated with unanticipated coverage restrictions, rescissions, non-renewals, large rate increases, and preexisting condition exclusions.[186] In other words, without the option of comprehensive ESI, high-risk employees historically found coverage to be largely unavailable or exorbitantly priced, and even low-risk employees were subject to substantial risk.

For these reasons, employers who offered limited coverage in the pre-ACA world would risk experiencing substantial labor mar-

[183] See Amy B. Monahan, The Promise and Peril of Ownership Society Health Care Policy, 80 Tul. L. Rev. 777, 785 (2006).

[184] Only self-employed individuals may deduct the cost of individual health insurance purchases. See I.R.C. § 162(l) (2006).

[185] On average, workers pay only seventeen percent of the cost of single coverage, and twenty-seven percent of the cost for family coverage. Kaiser Family Found., supra note 13, at 68. The majority of workers are employed by firms that contribute at least half of the premium cost. Id. at 81.

[186] See Abraham & Schwarcz, supra note 5, at 10–26.

ket costs.[187] First, a plan with limited coverage would expose all employees to substantial risks associated with the prospect of becoming sick in the future. In the pre-ACA world, once a person became sick, his options for coverage changed dramatically. Second, the employees who are most likely to be high risk are also likely to be disproportionately senior—precisely those that may be most valuable to an organization. In competing for senior talent, employers would be unlikely to take action that puts them at a disadvantage compared to their competitors. Consistent with these arguments, there is little indication that employers are currently, or have in the past, designed their plans to discourage enrollment by high-risk employees.[188]

2. Employers' Incentive to Dump in the Post-ACA World

Starting in 2014, when most of ACA's key provisions become effective, employers' incentives will shift dramatically. Many employers in the post-ACA world are likely to have an incentive to dump high-risk employees in the ways described in Part II. As Subsections a and b show, such targeted dumping would not negatively

[187] Of course, policyholders often have difficulty assessing the quality of their coverage. See generally Daniel Schwarcz, Regulating Insurance Sales or Selling Insurance Regulation?: Against Regulatory Competition in Insurance, 94 Minn. L. Rev. 1707, 1733–38 (2010); Daniel Schwarcz, A Products Liability Theory for the Judicial Regulation of Insurance Policies, 48 Wm. & Mary L. Rev. 1389, 1412–21 (2007). But employees may enjoy various comparative advantages in assessing the quality of their employer-provided coverage over policyholders in individual markets. In particular, they interact with other policyholders (i.e., co-workers) on a consistent basis and therefore may often be quite familiar with those policyholders' insurance experiences. However, such advantages may be undercut somewhat by frequent carrier and plan design changes made by employers. Moreover, there are potentially significant market problems even with respect to employer provided insurance. See generally Russell Korobkin, The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure, 85 Cornell L. Rev. 1, 27–62 (1999).

[188] Most evidence indicates that employers do sometimes adopt plan designs that force high-risk employees to pay more for health care on an out-of-pocket basis, but we were unable to locate any studies indicating that plans were designed to discourage enrollment by high-risk employees. See, e.g., Elizabeth Pendo, Working Sick: Lessons of Chronic Illness for Health Care Reform, 9 Yale J. Health Pol'y L. & Ethics 453, 456–59 (2009) (describing the research on employer plans and the increased costs that enrollees with chronic conditions in such plans face). The lack of evidence of the discouragement of enrollment of high-risk employees is unsurprising, given the traditional unavailability of individual health insurance for high-risk individuals.

affect the coverage/cost mix of either low-risk or high-risk employees, and might even improve it. At the same time, as Subsection c demonstrates, employers could substantially decrease their health insurance costs by implementing a targeted dumping strategy.

a. Targeted Dumping and Low-Risk Employees

A dumping strategy consistent with the parameters described in Part II would not negatively affect either the cost or scope of coverage for low-risk employees, who would retain ESI. Rather, such employees would experience both lower premiums and more extensive coverage for the types of services they routinely utilize, such as preventive, wellness, and health maintenance care. By design, they would not be subject to substantial risk: most, if not all, unanticipated medical costs would be covered. To the extent that such medical costs rendered them a high-risk rather than a low-risk employee, they would be covered (though perhaps with higher cost-sharing) until the next annual open enrollment period, when they could switch to coverage on their state insurance exchange.

b. Targeted Dumping and High-Risk Employees

More controversially, high-risk employees would also not be worse off if their employer chose to embrace a dumping strategy. As described above, coverage through an exchange will undoubtedly cost more to high-risk employees than coverage under a typical employer's plan, for at least three reasons: (1) greater administrative inefficiencies, (2) less favorable tax treatment for the employee's contribution to coverage, and (3) broader, more generous coverage under the exchange plan.[189] Nevertheless, some of these cost increases are likely to be minor and all of them can be managed by an employer.

Starting with the first cost driver, greater administrative inefficiencies, the comparative increase in premiums for exchange-based plans relative to employer plans will likely be minimal starting in 2014. This is because many of the historical economic advantages enjoyed by ESI—including informational, administrative, and risk-

[189] See supra Subsection II.A.1. It is also possible that the risk pool within an exchange will be worse than a typical employer's risk pool, which would also contribute to increased cost for exchange-based coverage.

pooling benefits—will be at least partially replicated on exchanges starting in 2014.[190]

The second cost driver is less favorable tax treatment for the employee's contribution to coverage. As previously explained, employees electing coverage on an exchange would be unable to pay their share of premiums on a pre-tax basis.[191] This has the potential to make such coverage significantly more expensive than even ESI with equal premiums. However, the actual magnitude of this penalty depends on both the size of the employee's contribution and the employee's marginal tax rate. For example, an employee with a $2000 contribution for family coverage, whose federal and state combined income and payroll tax rate is forty percent, would face an increased cost of $800 solely because she is paying for coverage on the exchange. On the other hand, an employee with a $500 contribution for single coverage, who has no federal and state income tax liability, but an eight percent payroll tax rate, would face a penalty of only $40. One factor that makes this increased cost slightly less troubling is that it is by its nature progressive. Because federal tax rates are themselves progressive (imposing higher rates on higher levels of income), higher-income individuals are likely to face higher tax costs than their lower-income counterparts. As with other increased costs, to the extent that this tax penalty discourages high-risk employees from switching to exchange coverage, an employer could simply increase the compensation of migrating employees, as described above.[192]

Recall that the final cost driver is the generosity of exchange-based coverage compared to ESI. While this may significantly increase comparative costs, it comes with a corresponding benefit to the high-risk employee. The coverage costs more because it is offering greater protection. This trade-off should be desirable for

[190] Indeed, this is the central goal of insurance exchanges. See Jost, supra note 14, at 1.

[191] With ESI, employers can establish a cafeteria plan under § 125 of the I.R.C. to allow employees to pay for coverage on a pre-tax basis. See supra note 60 and accompanying text. ACA specifically disallows the use of cafeteria plans to pay for exchange-based coverage, unless the individual's employer offers a group plan through the exchange. ACA § 1515, Pub. L. No. 111-148, 124 Stat. 119, 158 (2010) (to be codified at I.R.C. § 125).

[192] See supra Subsection II.B.1.

most high-risk employees, who will disproportionately benefit from greater coverage.

Exchange-based coverage offers an additional benefit as well: choice. An employee who was being dumped would be able to select among a wide range of generous plans in her state insurance exchange at precisely the time when that choice is most valuable. Like all insurance starting in 2014, these plans will not include any preexisting condition exclusions or annual or lifetime caps, and will be tightly regulated to ensure that they provide essential health benefits and a robust provider network.[193] Although much uncertainty remains about the specific features of EHBs and exchange governance, these plan requirements are likely to be disproportionately valuable to high-risk individuals. Moreover, at least some plans in the exchange will presumably offer "platinum" level coverage, which must provide "benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan."[194] Even if insurers fail to offer platinum level coverage, they are required to offer at least one "gold" level plan, providing benefits at the eighty percent level, if they want to participate in an exchange.[195] Additionally, some plans available through the exchange may have a reputation—made accessible through the various transparency provisions applicable to exchanges[196]—for providing particularly good care for the specific ailment or condition applicable to the high-risk employee.

Despite these benefits and employer cost mitigation, it may be that low-income, high-risk employees will be unwilling or unable to bear any significant cost increase and will therefore fail to opt-out of ESI. In order to combat this risk, the employer may want to make its contributions to HRAs tiered based on income level. For

[193] See supra Subsection I.B.2.

[194] ACA § 1302(d)(1)(D), 124 Stat. at 167 (to be codified at 42 U.S.C. § 18022). While platinum level coverage is permitted to be offered within the exchange, an insurer is not required to offer such coverage in order to participate in the exchange. See ACA § 1301(a)(1)(C), 124 Stat. at 162–63 (to be codified at 42 U.S.C. § 18021) (providing that in order for a plan to be a "qualified health plan" the insurer issuing the plan must agree to offer at least one silver level plan and one gold level plan; there is no requirement that insurers offer platinum level coverage in order to participate in the exchange). ACA § 1302(d), 124 Stat. at 167 (to be codified at 42 U.S.C. § 18022) defines gold coverage.

[195] ACA § 1301(a)(1)(C), 124 Stat. at 162–63 (to be codified at 42 U.S.C. § 18021).

[196] See ACA § 1311(c), 124 Stat. at 174–75 (to be codified at 42 U.S.C. § 18031).

example, if the employer contributed $500 to the HRA of high-income employees, it might contribute $1000 to moderate-income employees, and $1500 to low income employees.[197] This would recognize that individuals' ability to bear increased costs varies with income level and should help alleviate problems with low-income individuals being unwilling to switch to exchange-based coverage.[198] In the end, then, while costs may in fact be higher for high-risk employees, some of these costs come with corresponding benefits, others can be reduced or eliminated by an employer, and these costs vary based on income level. As a result, high-risk employees should be no worse off, and indeed are likely to be better off, under a targeted dumping strategy.

B. Targeted Dumping and Employers

Employers that design their plans to induce dumping of high-risk employees would also benefit. Such employers would experience decreased health insurance costs. The costs of funding their employees' health insurance should decrease dramatically to the extent that high-risk employees opt out of employer-provided coverage. Indeed, it is well-known that a substantial percentage of health care costs are attributable to a small fraction of the insured population: two percent of the American population is responsible for thirty-eight percent of medical expenditures,[199] and ten percent of the population account for sixty-nine percent of its medical costs.[200] While some of these expenses are the result of sudden and accidental events that are not predictable ex ante, many are not: indeed, "60–75 percent of health expenditures are associated with people [suffering from] chronic [medical] conditions."[201] These numbers

[197] The I.R.C. is concerned only with discrimination *in favor of* highly compensated employees. See I.R.C. § 105(h) (2006). There is no prohibition on discrimination in favor of non-highly compensated employees.

[198] See Reed Abelson, Shifting Health Costs, N.Y. Times, Nov. 10, 2010, at B1.

[199] Thomas Rice, The Economics of Health Reconsidered 127 (2d ed. 2003).

[200] Karen Davis, Consumer-Directed Health Care: Will It Improve Health System Performance?, 39 Health Servs. Res. 1219, 1223 (2004) ("At the other end of the spectrum, . . . 50 percent of individuals account for only three percent of health care outlays, all with expenditures under $350 in 1997."); see also Korobkin, supra note 187, at 41–42.

[201] Alain C. Enthoven, Employment-Based Health Insurance Is Failing: Now What?, Health Aff. - *Web Exclusive* W3-237, W3-328 (May 28, 2003), http://content.health

suggest that even if employer dumping works imperfectly, with some high-risk employees retaining coverage and some low-risk employees purchasing coverage in an exchange, an employer can nevertheless generate substantial cost savings from a dumping strategy.

Additionally, an employer dumping strategy should independently decrease the costs of providing health care to employees because it will contain more gaps in coverage than traditional employer plans.[202] As described above, a key feature of dumping strategies is that they provide relatively limited coverage for those with long-term chronic conditions in order to induce high risks to opt into the individual market.[203] Although the employer plan will likely need to be abnormally generous in other respects in order to retain low-risk individuals, the extent to which chronic conditions drive health care costs makes it clear that the cost savings from gaps in coverage will outweigh the increased costs of generous coverage for low risks.

The savings that a dumping strategy can generate should benefit not only employers who dump high-risk employees but also the employees themselves. All employees could benefit from the decreased costs to employers in health care expenses if the employer chose to pass along some of these savings in the form of higher salaries. Whether dumping employers would do that is unclear. Most economists agree that health care costs are simply part of

affairs.org/cgi/reprint/hlthaff.w3.237v1 (the figures cited include expenditures of those covered by both public and private insurance; as a result, those who are employed and have chronic conditions may have lower levels of health expenditures than those who are unable to work); see also Gerard Anderson & Jane Horvath, The Growing Burden of Chronic Disease in America, 119 Pub. Health Rep. 263, 264 (2004) ("Analysis of the 1998 [medical expenditure] data shows that almost four in five health care dollars (78%) are spent on behalf of people with chronic conditions. People with chronic conditions are the heaviest utilizers of medical care: 96% of home health, 88% of prescriptions, 72% of physician visits, and 76% of inpatient hospital stays are attributed to people with chronic conditions . . . . Most of the utilization is by people with two or more chronic conditions: 80% of home health, 67% of prescriptions, 48% of physician visits, and 56% of inpatient stays."); Catherine Hoffman et al., Persons with Chronic Conditions: Their Prevalence and Costs, 276 JAMA 1473, 1477 (1996) (finding that individuals with chronic conditions accounted for three-quarters of all medical expenditures in 1987).

[202] See supra Subsection II.B.2.

[203] See supra Part II.

employees' total compensation.[204] Decreased health insurance costs may consequently tend to translate into increased salaries. At the same time, though, decreased costs from health insurance may not affect perceived employee compensation, meaning that employers might be free to retain these savings.

These benefits of targeted dumping of high-risk employees are likely to make it a more attractive option for many employers than opting to simply get out of the health care business entirely.[205] The primary benefits of dumping coverage entirely are the decreased costs for employers and the fact that employees with household incomes equal to or less than 400 percent of the federal poverty limit would become eligible for refundable premium tax credits. However, for many employers and employees, a targeted dumping strategy will produce greater benefits than the employer dropping coverage altogether. First, employers with fifty or more employees who dropped coverage altogether might owe a substantial tax as a result of the employer mandate.[206] By contrast, as described above, employers who dump high-risk employees can entirely avoid any tax penalty as a result so long as their coverage is "affordable" for all employees and provides "minimum value."[207] Second, unlike

[204] See Lawrence Summers, Some Simple Economics of Mandated Health Benefits, Am. Econ. Rev., May 1989, at 177, 181–82.

[205] Cf. Hyman, supra note 5, at 1A11–1A17 (discussing why ACA may cause some employers to consider dropping group coverage entirely).

[206] See ACA § 1513, Pub. L. No. 111-148, 124 Stat. 119, 253–56 (2010) (to be codified at I.R.C. § 4980H). Employers who offer a group health plan and have at least one full-time employee who receives a premium tax credit would pay the lesser of $3000 for each employee receiving a premium credit or $2000 for each full-time employee, excluding the first thirty employees from the assessment. HCERA § 1003, Pub. L. No. 111-152, 124 Stat. 1029, 1033 (2010) (amending PPACA § 10106(e), Pub. L. No. 111-148 124 Stat. 119, 910 (2010) (amending PPACA § 1513, 124 Stat. at 253–56 (to be codified at I.R.C. § 4980H))). For example, if an employer with sixty employees offers coverage, but five employees are eligible for and receive a premium tax credit through the exchange, the employer would face a fee of $15,000 (the lesser of (1) the number of employees receiving the credit multiplied by $3000 and (2) the number of employees minus thirty, multiplied by $2000). A separate formula applies when an employer does not offer coverage and has at least one full-time employee who receives a premium tax credit. In that case, the employer faces a fee of $2000 per full-time employee, excluding the first thirty employees from the assessment. Id. For example, if the employer has seventy full-time employees, its penalty would be calculated by subtracting thirty from seventy, and multiplying the resulting forty by $2000, for a total of $80,000 per year.

[207] See supra Subsection II.A.3.

dropping coverage altogether, dumping effectively allows employers to increase both the compensation of its employees and its own profits at the expense of the public at large.[208]

Nor is the attractiveness of a dumping strategy likely to substantially diminish over time. Widespread and persistent dumping might well cause substantial adverse selection in the individual markets. This, in turn, might cause employers who dump to suffer some of the same labor market repercussions that existed prior to ACA. But employers would still be likely to reap a financial benefit by dumping high-risk employees onto exchanges unless those exchanges became so swamped by adverse selection that they collapsed. This is because so long as there is a minimum level of participation in the individual market by low- and average-risk individuals, high-risk employees will be cross-subsidized by policyholders in the exchanges rather than other, less risky employees.[209] Such minimal participation by low-risk individuals is likely to persist, given that the individual market will be subsidized through the exchanges for those with household incomes below 400 percent of the federal poverty limit.[210]

To be sure, a dumping strategy may also carry with it various costs. First, an employer who dumped its high-risk employees onto an exchange might risk reputational harm from media scrutiny. After all, it is not uncommon for companies, particularly large companies, to receive negative press regarding sub-standard health insurance practices.[211] An employer who pursued a dumping strategy could be characterized as avoiding its "fair share" and harming the general public by dumping its high-risk employees for others to cross-subsidize. Second, an employer that dumped its high-risk employees may risk generating negative employee sentiment. This

[208] This gain results from the fact that employers that engage in targeted dumping are able to shift most of the costs associated with high-risk employees' health care onto the individuals who purchase coverage on an exchange

[209] Assume, for example, that a high-risk individual has projected annual medical expenditures of $20,000. As long as the premiums in the individual market are below $20,000 (which they should be with decent participation levels by non-high-risk individuals), the employer stands to gain by dumping even if the employer pays the full cost associated with exchange coverage.

[210] See supra note 35 and accompanying text.

[211] See, e.g., Michael Barbaro, Wal-Mart's Detractors Come in from the Cold, N.Y. Times, June 5, 2008, at C1.

may be particularly likely if some high-risk employees do not opt for coverage on an exchange and are then denied coverage under the employer plan. Even if employees do sort themselves appropriately, they may view their employer's efforts to shuttle high-risk employees into the individual market as an indication that their employer does not "care" about the health burdens of its employees.[212] Finally, an employer that embraced a dumping strategy would need to incur various administrative expenses as a result. These include the costs of setting up a self-insured plan, purchasing stop-loss insurance, administering HRA payments for high-risk employees, and monitoring the effectiveness of the dumping strategy.

Some of these costs could be managed by a firm that opted to dump high-risk employees. In particular, such employers need not be explicit about their strategy, and can frame their employer health program as one that embraces "free choice."[213] Indeed, in many ways this characterization is apt: the essence of an employer dumping strategy is to facilitate choice among employees, and then manipulate the options so that those employees segregate themselves into low-risk and high-risk pools. For this reason, it is not at all clear that an employer who embraced a dumping strategy could easily be vilified in the press or among employees. At the very least, it seems likely that an employer who dropped coverage altogether would be a much easier target of both public outrage and employee dissatisfaction than an employer that cleverly but covertly embraced a dumping strategy.

Different employers will obviously weigh these costs differently. Many small employers, for instance, are likely to find the administrative costs of implementing a dumping strategy to be substantial.

[212] There is evidence that many employers provide health care coverage because "[i]t is the right thing to do." See, e.g, Paul Fronstin & Ruth Helman, Small Employers and Health Benefits: Findings from the 2002 Small Employer Health Benefits Survey 7 (Employee Benefit Research Inst., EBRI Issue Brief No. 253 (Jan. 2003), (finding that seventy-seven percent of small employers surveyed in 2002 reported "it is the right thing to do" as a major reason for offering a health plan). At the same time, employers routinely make changes that negatively impact employee health care coverage. See, e.g., Kaiser Family Found., supra note 13, at 186 (listing various changes surveyed employers would consider making to their health plan in the next year; for example, forty percent of respondents indicated that they were somewhat likely or very likely to increase the amount employees pay for copays or coinsurance).

[213] See supra Subsection II.B.5.

At the same time, the benefits of dumping may be reduced for small employers. Such employers are exempt from the employer mandate (if they have fewer than fifty employees). Additionally, a small employer's pool of employees may not be large or diverse enough to make the benefits of a dumping strategy compelling. For example, if a small employer has twenty-five employees, all of whom are in excellent health with no known risk factors, dumping would offer no benefit. Alternatively, an employer with forty employees, four of whom are high risk, may have difficulty designing a dumping strategy that effectively targets those four high-risk employees.

Large employers, by contrast, are relatively likely to be drawn to a dumping strategy. Most large employers already self-insure their group health plans,[214] and therefore would not face start-up costs that are as high as non-self-insuring employers. Additionally, large employers should have an easier time successfully segregating low from high risks due to the size of their risk pool. These employers also face the greatest potential penalty under the employer mandate if they were to simply drop employer coverage.[215]

Employers with a large number of relatively unskilled employees are also comparatively likely to be drawn to a dumping strategy. Although a properly designed dumping strategy would not appreciably harm employees, it might be perceived to do so. Employers with unskilled labor are less likely to be concerned about this prospect from a labor market perspective. As described above, such employers might even be drawn to aggressive dumping strategies that transferred costs on to high-risk employees but generated enhanced cost savings.[216] A large employer could implement a dumping strategy while shielding its cadre of skilled labor from any perceived downsides of a dumping strategy. For instance, it could retain a generous employer plan that was available only to headquarters staff. Doing so would potentially create problems under

[214] Kaiser Family Found., supra note 13, at 157 (compiling data by firm size for the percentage of covered workers in partially or completely self-funded plans).

[215] The penalty is $2000 per employee, except that the first thirty employees do not incur a penalty. See supra note 206. Therefore, while an employee with one hundred employees would only face a penalty of $140,000, an employer with 100,000 employees would face a penalty of $199.9 million.

[216] See supra Subsection II.B.1.

provisions of the I.R.C. that discourage discrimination in favor of highly compensated employees.[217] However, differing eligibility provisions are permissible so long as they are based on nondiscriminatory criteria. Distinctions based on geographic location would generally be considered nondiscriminatory,[218] but it is unknown whether the outcome would be different where the geographic differences distinguish between corporate and retail-level employees.[219] Alternatively, an employer could make all plan options available to all employees, but set premium levels for the options in a way that makes it cost-prohibitive for a low wage employee to elect coverage under the generous plan.

If a small number of employers successfully dumped their high-risk employees onto exchanges, it is possible that many other employers would follow suit. Some of the specific details of a dumping strategy—such as precisely how large the HRA contribution must be, or exactly which types of coverage can be safely eliminated without harming low-risk employees—may take time to work out. Employers who follow the lead of others may enjoy decreased costs in experimenting with these variables simply by mimicking the efforts of others.[220] Moreover, the reputational and labor market consequences of dumping high-risk employees are likely to diminish to the degree that such a strategy becomes widespread. As

[217] See I.R.C. § 105(h) (2006). This previously applied only to self-insured plans, but was extended to all employer plans by ACA. ACA § 10101(d), Pub. L. No. 111-148, 124 Stat. 119, 884–85 (2010) (amending ACA § 1001, 124 Stat. 119, 130–38 (2010) (adding § 2716 to the PHSA) (to be codified at 42 U.S.C. § 300gg-16)). If a self-insured plan discriminates in favor of such employees, the highly compensated employee must include the value of coverage in her taxable income. I.R.C. § 105(h).

[218] Treas. Reg. 1.105-11(c)(2)(ii) (2010) provides that a plan satisfies the nondiscrimination requirements with respect to eligibility where eligibility is based on a classification that the Service determines, based upon the facts and circumstances of each case, are nondiscriminatory. Assuming that a company's highly and non-highly compensated employees are distributed reasonably equally across geographic locations, setting different eligibility provisions based on employee location seems permissible under I.R.C. § 105(h).

[219] The Internal Revenue Service will not issue rulings regarding whether specific eligibility criteria are nondiscriminatory, and therefore there is very little information regarding which criteria are permissible and which are not. See Rev. Proc. 2010-3, 2010-1 I.R.B. 111.

[220] See, e.g., Cass R. Sunstein, Deliberative Trouble? Why Groups Go to Extremes, 110 Yale L.J. 71, 77–78 (2000) ("People frequently think and do what they think and do because of what they think relevant others think and do.").

more and more employers follow the dumping trend, a critical mass may be reached where the employer norm "tips" in favor of dumping.[221]

Dumping by a few employers could produce a cascade effect for an additional reason. High-risk employees of a dumping employer may elect not to purchase coverage on an exchange, but instead to sign up for coverage through a spouse's employer. This, in turn, could force the hand of non-dumping employers, who would themselves be subject to increased costs due to adverse selection from the spouses of dumping employers. Unless the non-dumping employer mimicked the dumping employer's strategy, it would need to bear the increased costs of the dumping employer's high-risk employees.

C. Solutions

Given the possibility that employers could structure plans to encourage high-risk employees to opt for individual coverage, and the serious consequences such strategies could have for health care reform generally, it is imperative for lawmakers to preemptively respond to the prospect of employer dumping. Although the most effective responses to the problem are statutory, several regulatory efforts may at least mitigate its scale. Notably, all of these solutions, to one extent or another, increase the prospect that employers will drop coverage altogether, as they deprive employers of the option to selectively dump high-risk employees. But as explained above, the consequences of such employer decisions to drop coverage entirely are much less troubling than the prospect of employer dumping of high-risk employees.[222] Moreover, at least some (and probably many) employers that would otherwise be attracted to a dumping strategy would presumably choose to retain generous employer coverage if the dumping option were foreclosed.[223]

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[221] See id. at 82.

[222] See supra Section III.A.

[223] In the event that the dumping strategy were foreclosed, then the question of how employers would respond would simply implicate the familiar debate about whether employers will dump coverage. See supra notes 4–5 and accompanying text (noting this debate).

1. Regulatory Solutions

ACA delegates substantial discretion to various agencies, most notably HHS, to interpret and enforce its provisions. Given the substantial stake and responsibility that federal agencies have in implementing health care reform effectively, they are in an ideal position to counteract the prospect of employer dumping of high-risk employees. Unfortunately, the best options for limiting the risk of dumping are likely "manifestly contrary to the statute."[224] Nonetheless, regulators may have some discretion to, at the very least, make employer dumping less economically attractive.

One potential way for regulators to limit the desirability of employer dumping is to issue regulations specifying that self-insured plans do not automatically constitute "eligible employer plans" that satisfy the individual mandate. Recall that the statute appears to contemplate the opposite result, providing both that (i) "eligible employer-sponsored coverage" constitutes "minimum essential coverage" and that (ii) "eligible employer-sponsored coverage" includes a "group health plan."[225] And both interim regulations, as well as the statute itself, make absolutely clear that a group health plan includes a self-insured employer plan.[226]

[224] Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843–44 (1984). The next Subsection describes various statutory fixes that would clearly prohibit employer dumping. But each of these appear to be beyond the authority of regulators. For example, one possible way to prevent dumping would be to subject self-insured plans to the requirement to provide essential health benefits. Yet the statute is clear that the term "health plan" will not, except as specifically provided, include self-insured plans, ACA § 1301(b)(1)(B), Pub. L. No. 111-148, 124 Stat. 119, 163 (2010) (to be codified at 42 U.S.C. § 18021), and is similarly clear that "health insurance issuer" does not apply to such plans. ACA § 1001, 124 Stat. at 130–38 (adding § 2715(d)(3)(A) to the PHSA) (to be codified at 42 U.S.C. § 300gg-15) (defining a health insurance issuer to include "a group health plan that is not a self-insured plan"). The statute is similarly clear with respect to each of the other statutory solutions discussed below.

[225] See supra Subsection II.A.3 (explaining ACA § 1501(b), 124 Stat. at 244–49 (to be codified at I.R.C. § 5000A)).

[226] See ACA § 1301(b)(3), 124 Stat. at 163 (to be codified at 42 U.S.C. § 18021) (stating that "group health plan" has the meaning given to it under § 2791(a) of the PHSA, 42 U.S.C. § 300gg-91(a)(1) (2006), which in turn uses the definition of group health plan used in ERISA § 3(1), 29 U.S.C. § 1002(1) (2006), which clearly contemplates both insured and self-insured plans); Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,539 (June 17, 2010).

However, the statute actually employs the following definition:

> The term 'eligible employer-sponsored plan' means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is— (A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or (B) any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan described in paragraph (1)(D) offered in a group market.[227]

In contrast to the interpretation above, this provision can be construed such that requirements (A) and (B) modify the term "group health plan," as well as the term "group health insurance coverage."[228] Under that construction, self-insured plans would never constitute an "eligible employer sponsored plan" and would therefore never satisfy an individual's obligation under the so-called individual mandate. This is because ACA defines the small and large group markets in a way that clearly excludes self-insured plans.[229]

Because this interpretation is textually plausible, a court might be willing to defer to regulatory guidance on this issue.[230] What is less clear is whether a court would allow HHS to use the ambiguity in the statute to present a third interpretation of the provision that is a compromise of the two extreme interpretations.[231] One such

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[227] ACA § 1501(b), 124 Stat. at 248–49 (to be codified at I.R.C. § 5000A(f)(2)).

[228] See Shearman & Sterling LLP, Self-Insured Medical Plans After Health Reform, Client Publication (Apr. 29, 2010); Church Alliance, Comments on Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the PPACA 4 (Aug. 10, 2010).

[229] See ACA § 1301(b)(2), 124 Stat. at 163 (to be codified at 42 U.S.C. § 18021) (stating that a "health insurance issuer" has the meaning given to it in § 2791(b) of the PHSA). The PHSA defines a "health insurance issuer" as follows: "[A]n insurance company, insurance service, or insurance organization . . . which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144(b)(2))). Such term does not include a group health plan." 42 U.S.C. § 300gg-91(b)(2) (2006).

[230] Chevron U.S.A. Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843–44 (1984).

[231] The scope of what reviewing courts consider to be permissible under *Chevron* Step II (that is, whether the agency's interpretation of a statute is reasonable) is a subject of much scholarly debate. See, e.g., Michael Herz, Deference Running Riot:

compromise would be to define a group health plan (and thus a self-insured plan) as constituting an "eligible employer-sponsored health plan" only if it is not designed to produce dumping of high-risk employees. Under this reading, an employer that attempted to dump its high-risk employees would find that its low-risk employees would not be in compliance with the individual mandate. This, in turn, would largely undermine the employer's capacity to dump high-risk employees by changing the labor market impact of any such strategy.

A second conceivable regulatory strategy would require the Internal Revenue Service to amend its rulings on health reimbursement arrangements to provide that the payment of insurance premiums is not an eligible expense. There is likely sufficient ambiguity in the relevant statutory provision to allow such an interpretation.[232] The Service could, for example, issue a new ruling stating that arrangements whereby an employer merely reimburses an employee for individually purchased health insurance does not constitute "employer-provided coverage under an accident or health plan." The downside of this approach is that it would affect not only dumping situations, but also other situations where an employer has simply chosen not to sponsor a group plan and instead subsidizes the purchase of individual policies. However, once ACA's reforms become effective in 2014, these non-dumping uses of HRAs will be much less significant. Currently, employers that utilize HRAs are often small employers for whom the cost of sponsoring a group health plan is prohibitive. Nevertheless, they would like to make a tax advantaged contribution to their employees' health care expenses, and an HRA allows them to do so. Once ACA's reforms become effective, those small employers can sim-

Separating Interpretation and Lawmaking Under *Chevron*, 6 Admin. L.J. Am. U. 187 (1992); Thomas W. Merrill, Textualism and the Future of the *Chevron* Doctrine, 72 Wash. U. L.Q. 351 (1994); Mark Seidenfeld, A Syncopated *Chevron*: Emphasizing Reasoned Decisionmaking in Reviewing Agency Interpretations of Statutes, 73 Tex. L. Rev. 83 (1994).

[232] The Internal Revenue Code provides an exclusion from gross income for "employer-provided coverage under an accident or health plan." I.R.C. § 106(a) (2006). The statute does not, however, define the relevant term. Id. Regulations simply specify that the reimbursement can be made through "insurance or otherwise" and that the employer can fund the arrangement either by paying premiums or by contributing to a separate trust or fund. Treas. Reg. 1.106-1 (2010).

ply elect to make exchange-based coverage available to their employees, and ACA contains provisions that allow payments for such coverage to be made on a pre-tax basis. Therefore, amending IRS guidance to prohibit the use of an HRA to reimburse individual insurance purchases may be a viable policy solution. If successful, it would eliminate the ability of employers to offer contributions toward individual insurance coverage on a tax-advantaged basis and therefore increase the costs associated with a dumping strategy.[233]

Yet a third potential regulatory strategy would be for the EEOC to issue new guidance surrounding disability-based distinctions in health plans that are designed to accomplish employer dumping. Recall that disability-based distinctions run afoul of the ADA only if they are a "subterfuge" to intentionally violate the ADA, which is in turn defined to mean that it is not justified by the costs associated with the disability.[234] The EEOC could further define a "subterfuge" to encompass schemes that attempt to dump those with specified disabilities onto individual insurance markets. Of course, doing this could have broad implications for all employer-based health plans, even those that are not actively pursuing dumping strategies.[235] Moreover, this regulatory solution would merely limit one element of a motivated employer's dumping strategy: it would not solve the underlying problem.

A fourth, and relatively modest, regulatory response, alluded to earlier,[236] is to ensure that the premiums paid by third party administrators to reinsurance programs reflect any employer dumping. Recall that one of the temporary reinsurance programs established by ACA allows HHS to determine how much third party administrators must pay, on behalf of group health plans, for reinsurance of individuals in the individual market.[237] HHS is free to set these premiums substantially higher for employers that engage in dumping, as measured by the number of employees who acquire cover-

[233] See supra Subsection II.B.1.

[234] See supra Subsection I.C.3.a.

[235] Discussion of whether an employer's ability to make disability-based distinctions within its health plan should be further restricted is beyond the scope of this article, but Bagenstos, supra note 86, at 27–32, discusses some of the issues involved.

[236] See supra Subsection I.C.3.d.

[237] Id.

age on an exchange. Unfortunately, this is obviously a limited solution, both because the underlying reinsurance program ends after three years and because it is unlikely that an increase in such premiums would offset the potential benefits of employer dumping.

One final regulatory action would be to proactively monitor insurance exchanges for employer dumping. In particular, insurance exchanges should ask whether enrollees have the option of employer-sponsored coverage, even if they are not seeking subsidies. Gathering data on this question would hardly be difficult, both because usage of exchanges will presumably require individuals to sign up and answer questions and because exchanges will need to verify that individuals who do receive subsidies do not have the option of affordable employer-sponsored coverage that provides minimum value.[238] The exchanges could then study the risk profiles of those who were eligible for employer-provided coverage but nevertheless chose exchange-provided coverage. While this information gathering would not, by itself, solve the problem of employer dumping, it would provide the data necessary to support legislative action if the effect of employer dumping of high-risk employees is significant.

2. Statutory Solutions

There are various potential statutory solutions to the problem of employer dumping. The advantages and disadvantages of each are discussed briefly below.

a. Prohibit Employees with Access to Affordable Coverage from Enrolling in an Exchange or Other Individual Coverage

Perhaps the simplest solution to the problem of employer dumping is to make employees with access to affordable employer-provided coverage ineligible for coverage on an exchange. Indeed, such a provision was apparently included in earlier versions of ACA.[239] Moreover, this is the operative rule in Massachusetts's ver-

[238] See supra note 125 and accompanying text.
[239] See supra note 109.

sion of health care reform.[240] Making coverage through the exchanges unavailable to employees with the option of affordable employer coverage would largely eliminate the incentive that employers would have to dump high-risk employees, as they would not have many viable alternatives to employer coverage. As a result, labor market forces would likely dissuade employers from adopting this strategy, just as they have in the past.

The one limitation of this option is that ACA does preserve the possibility of an individual insurance market outside state-run exchanges. It is therefore possible that employers might still seek to dump high-risk employees onto non-exchange individual markets, which are subject to nearly all of ACA's prohibitions on direct and indirect risk classification. To address this problem, ACA could be amended to provide that individuals with access to affordable employer-provided coverage cannot purchase individual coverage at all, whether within or outside an exchange. Of course, these solutions interfere with an individual's choice of health insurance. Setting aside the potential problem of employer dumping, there may be very good reasons why an individual might prefer individual coverage to that offered by her employer, and we should be reluctant to interfere with that choice.

b. Impose Limited Preexisting Condition Limitations

Another potential solution to the employer-dumping problem is to amend ACA to reintroduce the ability of insurers to impose preexisting condition limitations for individuals with access to employer-provided coverage. This option would permit insurance companies in individual markets to deny coverage for preexisting conditions where the individual had access to affordable employer-provided coverage, but would continue to prohibit all other types of preexisting condition exclusions. For example, if an employee with a chronic condition such as diabetes was offered affordable employer coverage and nevertheless sought coverage in the individual market, insurers in the individual market would be permitted to exclude coverage for the treatment of diabetes. This solution

[240] See An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts 77 § 45 (codified as amended in scattered sections of the Massachusetts General Laws).

once again takes away the viable coverage alternative for high-risk employees and should eliminate the primary motivation for employer dumping. It has the added advantage of continuing to preserve individual choice in most circumstances. However, the primary risk of this approach is that it would complicate the absolute ban on preexisting condition exclusions in ACA and potentially allow insurers to impose these restrictions even where there was no credible evidence of employer dumping. It could also leave an individual without effective coverage for an existing medical condition—if an employer's plan excluded coverage for diabetes, employees with diabetes would not be able to elect insurance on an exchange that covered their condition.

c. Enact an Anti-Dumping Provision Applicable to Employers Dumping into the Individual Market

As described above, ACA already contains broad anti-dumping standards applicable to employers who dump high-risk individuals into certain high-risk pools.[241] These rules could be extended to apply to employer dumping into the individual market. The difficulty in this approach would lie in crafting a rule that was both clear and certain. ACA's current anti-dumping rules for high-risk pools prohibit the use of monetary or other financial incentives for disenrolling in employer coverage,[242] but delegate to the HHS Secretary the responsibility for developing and enforcing this provision.[243] Depending on its content, a similar rule might be unattractive in the broader context of potential dumping into the individual market. For instance, there may be legitimate reasons for employers to offer free choice vouchers to all their employees. Moreover, any rule that was contingent on the risk profiles of those individuals who enrolled in individual plans instead of the employer plan might unfairly penalize employers who lacked a motive to dump.

[241] See supra Subsection I.C.3.e.

[242] Supra note 103 and accompanying text

[243] See ACA § 1101(e)(1), Pub. L. No. 111-148, 124 Stat. 119, 142 (2010) (to be codified at 42 U.S.C. § 18001).

d. Enact Broader Employer Penalties

The employer penalty provisions in ACA are relatively weak. Most important for present purposes, they only result in a monetary penalty where an employee receives a premium tax credit through an exchange. It is for this reason that an employer can dump its high-risk employees on to an exchange without risking the prospect of paying increased taxes as a result. Enacting broader employer penalties could help to discourage employer dumping. For example, making the penalty apply to *any* employee who receives coverage through an exchange, regardless of whether he or she receives subsidies, would significantly change an employer's calculus regarding dumping high-risk employees. Under such a system, an employer would have a direct incentive to ensure that all employees elected coverage under the employer plan. But the penalty would also have to be sufficiently high per employee to outweigh any financial benefit that may continue to accrue to an employer as a result of dumping a high-risk individual. For example, if individuals with diabetes cost the plan on average $15,000 per year in medical costs, paying a $5000 penalty plus a $2000 "supplemental" payment to the individual to subsidize exchange-based coverage may remain attractive. The advantage of amending the employer penalty is that it still preserves individual choice, while changing an employer's incentive to dump. The difficulty of this approach would lie in determining the optimal employer penalty amount and the precise circumstances in which it should apply.

e. Require All Employer Plans to Offer Essential Health Benefits

The potential for employer dumping depends in large part on the ability of self-insured plans to cover a limited range of benefits and to vary cost-sharing requirements for different types of benefits. Taking away these freedoms for self-insured plans by forcing them to cover essential health benefits in the same manner as insured plans would thus reduce the prospect of employer dumping.[244] After all, a self-insured plan that must cover essential health benefits on the same terms as all other insured plans no longer has

[244] Doing so would have additional benefits as well. For a detailed discussion of the arguments in favor of removing the disparate treatment of self-insured plans, see Monahan, supra note 66.

the same ability to discourage enrollment by high-risk employees. Although the plan could still employ other strategies to achieve this result—such as utilizing a limited provider network—it is unclear how effective such a strategy would be on its own at effectively separating high-risk and low-risk employees. Of course, the biggest downside of this approach is that, more so than any of the other proposals outlined above, it would likely increase the possibility that employers would choose to abandon providing any coverage at all.

CONCLUSION

The primary goal of ACA is to increase dramatically the number of individuals who have health insurance coverage, while preserving the existing system of employment-based coverage for the nonelderly. Achieving this goal is anything but simple, as illustrated in the complex, over 2000-page legislation that puts such change in motion. This Article has identified an important, unintended, and as-yet unnoticed effect of ACA: that employers will, for the first time, have both an incentive and the ability to design their plans to discourage enrollment by high-risk employees. By doing so, employers can benefit themselves and their employees while individual purchasers and the federal government suffer the consequences. If health care reform is to have its intended effect, Congress and regulators must act quickly to eliminate the potential for employer dumping of high-risk employees.