

# Private Health Insurance Exchanges for Employers: Issues for Regulators and Public Policy

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## Executive Summary

The Affordable Care Act (ACA) has galvanized renewed attention to the long-standing idea of using insurance exchanges to implement superior forms of managed competition. In addition to the ACA's public exchanges for individuals, similarly-structured private exchanges have emerged that offer employer-sponsored coverage from competing insurers. There is expectation that these private multi-carrier exchanges could quickly become a new and established component of the health coverage landscape. If so, that development could pose new public policy and regulatory challenges. On the other hand, these private exchanges, so far, have grown slower than many forecasters projected, suggesting the possibility that they have encountered regulatory barriers or they could benefit from facilitative regulation.

This issue brief, based on in-depth expert interviews and an extensive literature review, evaluates the potential benefits and detriments of private exchanges in order to assess whether state and federal lawmakers and public policy actors should adopt a stance that is encouraging, neutral, or cautionary.

Considering first the potential concerns that private exchanges might pose, this evaluation failed to uncover any substantial evidence of serious threats to public policy. Private exchanges, so far, have not degraded employer sponsorship of health benefits, and informed experts believe this is not likely to happen. Instead, there is good reason to believe that private exchanges might enhance employers' willingness to continue offering health benefits.

Private exchanges also do not appear to threaten the ACA's regulatory structure. For the most part, they are not in direct competition with the small-employer component of the public exchanges, the Small Business Health Options Program (SHOP). Also, private exchanges are not being promoted as a way to circumvent or minimize the ACA's various regulatory requirements.

Views were more divided on whether useful regulatory measures could be taken to facilitate or promote private exchanges. The dominant view expressed was that private exchanges face no substantial regulatory barriers or uncertainties, and thus they are able to succeed in the market if they demonstrate their inherent economic value. Others, however, felt that adoption of private exchanges would accelerate if laws were to confer safe harbor to adopting employers from certain existing regulatory requirements.

The strongest accelerant would be if tax law were changed to allow workers to use pre-tax employer contributions to purchase individual insurance. Acknowledging that the government has reason to prevent "double-dipping" by using pre-tax dollars to purchase subsidized insurance, some exchange advocates argue with force that, now that the individual market has been fully reformed, government should not prohibit employers from facilitating pre-tax purchase of non-group coverage outside the public exchanges, where coverage is not otherwise subsidized. Others, however, disagree, fearing that these or other measures might create new problems, possibly doing more harm than good.

On balance, regulatory forbearance appears to be the wisest course of action at the present time. None of the potential concerns that one might conjure appears to have materialized as a real threat. Instead, private exchanges appear to hold real promise for improving choice and competition in the group insurance markets. Although lawmakers might consider facilitative measures, the best course of action might simply be to stand back and monitor how private exchanges develop within existing market conditions and regulatory pathways.

## Introduction

The ACA has galvanized renewed attention to the long-standing idea of using insurance exchanges to implement superior forms of managed competition (Abelson 2014; Carrns 2013; Enthoven 2014; Japsen 2013; Kapur et al. 2012; Sperling 2012). In addition to the ACA's public exchanges for individuals, similarly-structured private exchanges have emerged that offer employer-sponsored coverage from competing insurers. These newly emerging private exchanges – offered by major health benefits consulting firms such as Towers-Watson, Mercer, and Aon Hewitt, as well as by brokers

and start-up specialist firms – differ in several important ways from the similar structures that preceded them (Booz & Company 2012; Fronstin 2012; HR Policy Association 2013; Kapur et al. 2013; Margolis and Thompson 2013; Moody's Investors Service 2014). Many predecessor exchanges offered multiple products from only (or mainly) a single carrier. Others in the small-group market were designed to exploit regulatory loopholes (which, for the most part, no longer exist) (Hall, Wicks, and Lawlor 2001; Wicks and Hall 2000), or themselves were the victim of unfavorable market regulations (Curtis, Neuschler, and Forland 2001; Wicks and Hall 2000). Although the concept of a pri-

vate multi-carrier exchange has existed for decades (Enthoven 1978; McArdle 1995; Newhouse 1994), until recently it has had significant market presence only for retiree health benefits. Only in the past few years has there been widespread interest in, and availability of, multi-carrier exchanges for active workers of both large and small employers.<sup>1</sup>

The multi-carrier exchange concept was first widely discussed more than a decade ago (Battistella and Burchfield 1998; Baugh 2003; Changes in Health Care Financing and Organization 2002; Erb 2001; Fronstin 2001; Meyer and Tillman

2001; Nichols 2002; Reinhardt 2001; Trude and Ginsburg 2000), but the idea did not take hold then for several reasons. First, the idea was usually paired (under the umbrella of “consumer-driven health care”) with the also-new idea of offering high-deductible health plans coupled with health savings accounts. Employers realized they could easily offer these new plan designs through their existing single-carrier or self-insured structures, without also introducing the complications of a multi-carrier exchange structure (Pauly and Harrington 2013), and employers were reluctant to leave workers to the vagaries of the less-regulated markets of that time. Now, however, the ACA provides greater endorsement of the exchange idea and greater regulatory protections for workers who engage with the market directly. Also, the ACA has led large employers to take a fresh look at their health benefits strategies and options. In particular, private exchanges bolster movement toward a more “defined contribution” approach that gives workers a fixed amount of employer support that does not vary based on the plan selected. This “voucher” approach could help employers limit increases in their health benefits costs (and perhaps avoid the ACA’s new “Cadillac tax” on employers with especially generous plans), and also encourage workers to select more cost-effective coverage options.

Over the past decade, larger employers have tested these waters for their retirees, converting many of them to private exchanges rather than including them in the company health plan (Fronstin 2012). Thus, some employers now have more experience with and confidence in this concept compared to a decade ago. Private exchanges are not feasible unless insurers are willing to participate on favorable terms, but previously, insurers were very reluctant to compete for group business on a retail rather than wholesale basis, side-by-side with their competitors – in part because they feared adverse selection. Now, however, risk adjustment tools are more developed and better established, in both the Medicare Advantage market and

the new individual market exchanges (Hall 2011). Additionally, some insurers may see a potential to convert self-insured groups to more profitable fully-insured coverage. Finally, over the past decade, as high-speed Internet has proliferated and computing power has expanded exponentially, people have become generally more acclimated to the idea of computer-based exchange purchases for other types of products and services.

For all of these reasons, there is widespread belief that private multi-carrier exchanges could quickly become a new and established component of the health coverage landscape for active workers. According to various credible surveys, a quarter to a half of larger employers are at least considering using private exchanges and/or moving to a defined contribution approach to health benefits in the foreseeable future (Accenture 2013; Alvarado et al. 2014; Aon Hewitt 2012; Private Exchange Evaluation Collaborative 2013). Therefore, it is quite plausible that private exchanges will enroll tens of millions of workers and family members by the end of the decade.

Despite this pronounced interest, however, private exchanges have not taken off as quickly as many forecasters projected (Accenture 2015; Humer 2014; National Business Group on Health 2014; G. Scott 2014). The most credible sources estimate that no more than three million active workers (in contrast with retirees) are enrolled through private exchanges (Alvarado et al. 2014; Humer 2014).

The marked potential but muted growth of private multi-carrier exchanges raises two sets of important public policy issues, which lawmakers and regulators need to consider and potentially act on, or at least be aware of and informed about. First, the possible shift in a substantial portion of private coverage to new structures and entities raises potential public policy concerns regarding how private exchanges and their coverage should be regulated, and whether these exchanges pose new regulatory challenges. Second, the slower-than-

projected take-up of private exchanges points to the possibility that existing regulations may be hindering a favorable market development, or that measures might be taken that could facilitate this positive public policy innovation.

This issue brief evaluates the potential benefits and detriments of private exchanges in order to assess whether state and federal lawmakers and public policy actors should adopt a stance towards private exchanges that is encouraging, neutral, or cautionary. This analysis is based on in-depth research consisting of 42 expert interviews and an extensive review of the trade press and public policy literatures. Confidential interviews were conducted during 2015 (both in person and by phone), with a wide range of relevant sources, including: companies that operate private exchanges or their technology platforms (18); major insurers that are participating in them (4); benefits advisors and consultants (13); lawyers specializing in health benefits (8); and employer trade groups (5) whose members are both participating in exchanges and have decided not to do so.

## Potential Concerns Raised by Private Exchanges

### A. *Diminished Employer Sponsorship*

The most obvious implication of private exchanges under the ACA is whether they will facilitate employers maintaining coverage, or instead, will serve as a transition to dropping coverage. Dropping coverage might result if employers use private exchanges as a “glide path” to acclimate their workers to an exchange structure, so that eventually dropping group coverage and moving individuals to the public exchange feels less burdensome. On the other hand, private exchanges might encourage employers to maintain coverage by reducing costs, or at least making costs more predictable.

Interviews provided no strong basis for concluding that one possibility – employers dropping versus keeping coverage – is substantially stronger than the other. Several informants noted that some of the most vis-

ible early adopters of private exchanges were large service sector or retail firms (Darden Restaurants, Walgreens, Sears), which face financial challenges in paying for comprehensive coverage. So far, none of these large early adopters has indicated any intent to drop employer sponsorship, however. Although some informants thought that it is quite possible that some employers, including medium or smaller-sized ones, could view exchanges in the “glide path” fashion noted above, this has not become a prominent pattern, and others thought that using exchanges as an “exit strategy” was only a weak motivation, or at most, only an option that some employers were preserving but had not yet embraced. The more common view expressed was that, if employers intended to drop coverage, they would just do so without feeling the need to acclimate employees through private exchanges. The decision of whether to move to an exchange and which exchange to select is sufficiently complex that, according to these informants, only employers committed to maintaining health benefits are likely to consider making this change.

In fact, many informants noted that most exchange enrollment, so far, is through large employers that have a strong commitment to maintaining employee benefits in order to attract and retain good talent and promote worker health and productivity. These employers see in exchanges the ability to enhance rather than degrade benefits by providing more options to workers, better information about those options, and additional supplemental insurance products (such as vision, dental, long-term care and the like). Other informants thought that smaller employers are attracted to the potential for private exchanges to simplify administration of the benefits they currently offer, and to assist with increasingly complex regulatory compliance.

Accordingly, it does not appear, so far, that private exchanges are likely to degrade employer sponsorship, and it is quite possible that private exchanges will enhance employers’ willingness to continue offering health benefits.

### **B. Impacts on Public Exchanges**

A second potential concern is whether private exchanges might take business away from the employer component of the public exchanges, or cause adverse selection against public exchanges. The ACA requires public exchanges to include a “SHOP” component for small employers. Currently, these SHOP exchanges cover employers with up to 50 full-time workers, but, states have the option of expanding SHOP exchanges to groups of 100, and, beginning in 2017, to even larger groups. If they were to do so, there would be direct competition between public and private exchanges for small and mid-sized employers.

Despite this potential rivalry, there is no indication from the interviews that public exchanges view their private counterparts as a threat, or vice versa. Most sources felt that these two similar exchange constructs are not in fact in head-to-head competition. Most private exchanges do not sell to groups with fewer than 100 workers, and those that do so generally do not offer workers choice among different carriers. Instead, smaller employers must pick a single insurer whose plans will be offered to its workers. That is because insurers are very reluctant to compete head-to-head in an exchange environment without a risk adjustment method that protects them from adverse selection – namely, receiving only or mostly the high-cost members of a group. The ACA provides this risk adjustment in the individual and small group market segments. Some private exchanges have implemented risk adjustment for large groups – sized several thousand and above. But, private exchanges find it difficult to establish an effective risk adjustment program for medium-sized groups. That is because risk adjustment in the private sector necessarily functions within separate groups, and not across groups, since employers with lower-risk workers have no reason to agree voluntarily to subsidize someone else’s higher-cost workforces. Only large employers have sufficient scale to make risk adjustment actuarially credible within a single group.

The ACA solves this “small numbers” problem by requiring risk adjustment across entire market segments (individual and small-group). In the realm that private exchanges function, however, there is no collective action solution; therefore, private exchanges that serve mid-sized groups cannot feasibly offer worker choice among different insurers. Instead, private exchanges in the “mid market” allow only employers to choose among insurers, picking a single carrier that then offers multiple benefit plans to workers, as in the normal, non-exchange market. This is a key difference from the public SHOP exchange in functional structure.

Because of this and other differences, no informant expected that public and private exchanges will be competing to any great extent for the same customers. Instead, they felt that the public SHOP exchange is a “niche” product that appeals to only a relatively few number of employers at the small end of the group size scale. And, they felt that, by and large, most employers will prefer a private version of an exchange because of generalized suspicion of government programs.

Consistent with these impressions, the public SHOP exchanges, so far, have not experienced substantial enrollment (Gabel et al. 2015; Haase, Chase, and Gaudetter 2015). It appears also that public exchanges are looking mainly to nongroup enrollment rather than to their SHOP components to bring in a critical mass of purchasers needed to make the exchanges financially self-sustaining. Therefore, no concern was detected in these interviews that private employer exchanges will pose a financial or operational threat to public exchanges. To the contrary, many market participants and observers felt that there are positive synergies between public and private exchanges, in that each might benefit from the other in various ways, such as by sharing information technology, or creating a greater critical mass for the construction of alternative provider networks or new entrants to insurance markets.

### C. *ACA Circumvention*

Additional sources of potential regulatory concern could arise if private exchanges became a mechanism for circumventing or exploiting the ACA's regulatory structure. This might happen, for instance, if private exchanges were used to offer "skinny" benefit plans that comply with the ACA's requirement of "minimum essential coverage" in only a narrow, technical way, but without actually offering comprehensive benefits.<sup>2</sup> Regardless of whether these skinny plans are legitimate, they are not substantially tied to the private exchange phenomenon. Informants said that a few exchanges might offer these skinny plans to employers that seek them, but most offer only comprehensive benefit plans, and no one thought that exchanges were being used as a way to promote skinny plans.

Another potential regulatory concern is the incentive the ACA creates for small employers to self-insure, perhaps inappropriately. Normally, only larger firms self-insure because of the financial risk entailed. But smaller employers might be enticed to also self-insure in order to avoid the ACA's prohibition of rating based on health risk and its requirement to cover a comprehensive set of benefits. Currently, these provisions apply only to groups up to 50, but states have the option to expand to groups up to 100. Groups this size might feasibly self-insure if they purchase "stop-loss" coverage that reinsures employers once claims reach a financial threshold. Normally, these thresholds are quite high for larger employers because more extensive stop-loss coverage would increase the cost of self-insuring. But, for smaller employers to self-insure, their stop-loss needs to be much more extensive, "attaching" at a much lower level, such as claims greater than \$25,000 or even \$10,000.

Many regulators view this low-attachment self-funding arrangement as circumvention because, functionally, it differs little from simply purchasing normal coverage with a high deductible (Jost and Hall 2014). Moreover, if small-firm self-

funding became more established, then it could cause adverse selection against the regulated market because self-insuring is more advantageous for younger, healthier groups, whereas older, sicker groups benefit more from continuing to purchase community-rated insurance. Finally, there is a past history of using self-funded purchasing pools that resemble exchanges to avoid state regulation of insurance solvency by claiming pre-emption under the Employee Retirement Income Security Act (ERISA) from state financial oversight. In prior decades, these unregulated Multiple Employer Welfare Arrangements (MEWAs) resulted in a number of bankruptcies or financial scandals (Hall, Wicks, and Lawlor 2001).

This investigation, however, discovered no evidence that the current private exchange movement is tied to inappropriate self-funding. First, none of the modern exchanges attempt to pool self-funding risk across different employers. Instead, the exchanges that offer self-funded coverage, which most do, keep each employer's risk pool separate, as is done outside of exchanges. Thus, there is no evidence of any potential for concerns related to the MEWA abuses of the past.

Some informants agreed that there is evidence of increased interest in self-funding by small employers. However, no one thought that this interest is tied to private exchanges, or that exchanges are being used to promote this idea. Instead, consistent reports were that only larger firms were using self-funding arrangements within exchanges. No one reported that exchanges are attempting to move smaller firms away from regulated insurance and into self-funding. To the contrary, some exchanges are attempting to convince employers to drop their self-funded arrangements in favor of purchasing insurer-underwritten coverage on exchanges – motivated by the view that, unless insurers bear the financial risk, they lack incentives to manage costs and promote health.

### D. *Reduced Employer Contributions*

Traditionally, employers have taken a "defined benefit" approach to health insurance, choosing a coverage package for which they pay a specified percentage of the premium. An alternative approach is known as "defined contribution"—giving employees a fixed amount, like a voucher, that exposes them to the full differential in costs or savings (at the margin) for selecting a more expensive or cheaper plan. A defined contribution approach to health benefits has been discussed for over a decade (Battistella and Burchfield 1998; Baugh 2003; Fronstin 2001; Trude and Ginsburg 2000), but this approach has not yet taken hold on a wide scale (Fronstin 2012). One reason is the absence, until now, of an exchange structure that facilitates employees shopping for their own insurance. Defined contribution can be (and has been) done without an exchange, and exchanges can be (and are being) done without defined contribution, but the two ideas fit well together and support each other.

Defined contribution holds the favorable prospect of educating workers about the true cost of trade-offs in insurance coverage and design; therefore, it might, for instance, make people less resistant to managed care or high deductible plans that do a better job of controlling costs (Reinke 2010; Sperling and Shapira 2011). Several major exchanges report that, in their initial experience, a half or more of exchange subscribers choose less generous coverage than they previously had, and only a quarter or fewer select more generous plans (Rickard 2014).

Defined contribution, however, might make it easier for employers to ratchet back from year to year the percentage of premiums they contribute to health insurance by setting a fixed contribution that does not keep up with medical cost inflation. This concern is acknowledged, to some extent, in literature discussing private exchanges (Young and Berkley 2014). However, capped or reduced employer contribution has not yet emerged as a

major phenomenon, perhaps because the new generation of private exchanges has existed only a few years. So far, although private exchanges have seen employees selecting lower-cost plans with greater patient cost-sharing, such as higher deductibles (Alvarado et al. 2014; Young and Berkley 2014), these adjustments in benefits have been chosen by workers in order to reduce their own contribution to the premium cost, rather than being imposed by employers as a way to reduce their expenses.

Although some exchanges encourage or require defined contribution, many continue to allow employers to pay for a percentage of benefits rather than a fixed amount. Informants noted that many of the larger employers initially adopting exchanges were reluctant to use a defined contribution approach because of concerns this could create among workers. Observers noted that these employers are ones that are heavily invested in employee benefits in order to attract and retain talented workers. Therefore, they are reluctant to make changes to their contribution structure that will be perceived as disadvantageous to workers.

Where defined contribution is used, there appears to be no concern about its disadvantaging older workers. In the community-rated portion of the market (individual and small-group coverage), insurers adjust their rates according to age, by a factor of three (that is, the oldest subscribers pay three times what the youngest adults pay). An employer that contributed a single flat amount to all workers, therefore, would obviously disadvantage older workers, but an employer that equalized what workers of different ages have to pay might be seen as unfairly contributing less to younger workers. This, plus other technical factors of defined contribution (such as determining which insurer's rates will set the employer-contribution benchmark), makes it difficult to resolve fairness issues when age-adjusted community rating is used.

So far, most private exchanges have avoided these problems simply by not selling to groups smaller than 50. For the larger groups, exchanges continue the existing market practice of using experience rating for each group, but pure community (or “composite”) rating for members within each group. In other words, each group's rate is based on its overall average cost per member (actual or projected) for that group's particular composition; but within each group, an insurer charges each person the same amount. Hence, premiums differ only according to choice of insurer, benefits, and family composition, as is normally done outside exchanges. Private exchanges confront the age-discrimination dilemma only if the exchanges sell to groups smaller than 50, which very few do. However, if community-rating requirements expand to groups of 100, which states have the option to do, then these age-fairness issues might become more of a concern. In addition, if private exchanges adopt different approaches to age-rated contributions than do the public SHOP exchanges, this could introduce market and regulatory complications that currently do not exist.

#### *E. Limited Provider Networks*

A final matter of potential regulatory concern is the adequacy of provider networks offered through private exchanges. One of the most notable immediate impacts of the public exchanges has been the formation of some provider networks that are much tighter or more focused than was common previously (McKinsey 2014). So far, these narrower networks are based primarily on how substantial a discount providers will agree to in their fee-for-service reimbursement. However, many observers believe that both public and private exchanges create a market environment in which narrower “high performance” networks can form that are based more on alternative compensation methods that better reward value and innovation in medical care delivery. Despite this potential, there is also possible concern that these narrower networks might not

provide adequate access to care across the full range of health care specialists, facilities, and services.

Informants acknowledged the potential that private exchanges offer for the establishment of narrow networks, but they reported that narrow networks, so far, are nowhere near as prevalent in the private exchanges as they are in the public exchanges. In the words of one expert observer, narrow networks, so far, are “much more aspirational than operational” in private exchanges. Although informants could point to some examples of alternative networks, they noted that most exchanges offer full-sized networks equivalent to what generally prevails in the employer group market, and that the smaller networks being offered are, for the most part, not dramatically different than conventional broad networks. These observers felt that, if provider networks start to narrow or become more performance based, this would not raise any regulatory concerns because employers that sponsor exchange-based plans would take care to avoid selecting exchanges or authorizing insurance plans that have inadequate networks in order to prevent employee dissatisfaction.

### **Barriers and Facilitation for Private Exchanges**

The previous section documents that private insurance exchanges for active workers do not currently pose any significant concerns for regulators or public policy. Shifting from the potential negatives to the potential positives, this section considers whether regulatory barriers that impede private exchanges might be removed or reduced, or whether other regulatory actions might help private exchanges succeed. Policy makers have reason to consider assisting private exchanges if they offer important improvements in market conditions that would give workers more and better choices in a manner that pressures insurers and health care providers to deliver better value. Despite the current sophis-

tication and clout of large employers, this market improvement might occur because offering workers individual choice among competing plans might allow them to better match their particular needs and preferences than having an employer pick a single carrier or only a few coverage options for an entire workforce (Hyman and Hall 2001; Maxwell and Temin 2002). Also, making the costs of insurance options more evident to workers might lead them to choose more cost-effective benefit designs or provider networks, prompting efficiency improvements in the delivery of care (Enthoven 2014).

#### A. Regulatory Barriers

The great majority of the market participants and observers interviewed said that there are no substantial regulatory barriers to the formation, spread, or adoption of private exchanges. Instead, most thought that private exchanges themselves, in their current form,<sup>3</sup> are not subject to any type of insurance or benefits regulation beyond those that already apply to the entities involved (insurers, brokers, employers). Many informants commented that private exchanges are simply an innovation in the way that conventional insurance arrangements are chosen and sold, using analogies such as an “Amazon” or “vending machine” for health insurance, offering “old wine in new bottles.” Because exchanges do not create any new or unique type of insurance or method of financing insurance, almost all sources felt that exchanges do not confront any major regulatory uncertainty.<sup>4</sup> Private exchanges offer the same kind of insurance plans that are in the regular market, and employers remain the plan sponsors.

Among the minority voices on this question, most pointed to regulatory issues that are not so much barriers as they are opportunities.<sup>5</sup> Informants felt that exchanges could and should serve as a vehicle to cut through parts of the existing regulatory thicket in a way that would facilitate their use. Interviews explored the following two

areas where facilitative legal reform might be considered: ERISA fiduciary duties, and tax treatment of employer contributions to individual (nongroup) insurance. The following sections discuss these and other ideas for potential government facilitation of private exchanges.

#### B. ERISA Compliance

The federal law known as ERISA imposes a number of “fiduciary duties” on employers that sponsor health benefits. Employers (or others acting on their behalf) must exercise reasonable care in selecting vendors for benefits administration, notifying employees about various aspects of their covered benefits, filing reports with the federal government, and ensuring compliance with various federal requirements that attach to employer-sponsored insurance. These fiduciary and other legal duties apply to employers that sponsor health coverage, regardless of whether employers provide or purchase coverage directly or through an exchange. Private exchanges, like other service providers, might contract to carry out some or all of these tasks, but employers remain ultimately responsible to see that these duties are met.

Some expert informants felt that private exchanges would be much more attractive to employers if using an exchange absolved employers from most ERISA fiduciary duties, or was treated as a safe harbor for compliance with these and other federal laws. These informants analogized to defined contribution arrangements for pension benefits, such as 401(k) plans. Under these arrangements, employers’ duties cease, for the most part, once they make their promised financial contributions (and comply with basic reporting requirements); employers do not retain any responsibility for how these contributions are invested or for deciding how retirement benefits are paid out. This limitation of employer responsibility is seen as one of the accelerants in employers’ shift from defined benefit to defined contribution retirement plans, but ERISA does not confer similar legal

protection for employers making defined contributions toward *health* benefits.

The majority of expert informants thought, however, that a change in ERISA fiduciary duties would not likely have much of an effect on employers’ interest in using exchanges, based on the following points. First, these fiduciary duties were not seen as being especially onerous. For the most part, they consist of administrative and record-keeping requirements that do not impose large potential liabilities and that are easily enough built into routine systems or contracted out to service providers. Unlike retirement pension obligations, health benefits do not entail long-term investments that must be managed and accounted for by the employer far into the future (PwC Health Research Institute 2014). Moreover, larger employers that sponsor health benefits would prefer to remain involved in benefits administration, and they have human resources staff to do so. Therefore, most are not seeking a turn-key exit solution. In addition, several informants questioned whether exchanges would be willing to assume employers’ fiduciary duties under ERISA. Some exchanges might, but others might balk at the legal exposure and resulting cost of liability protection.

Nevertheless, many informants acknowledged that smaller employers that lack substantial in-house benefits staff often would prefer to “get out of the business” of sponsoring and administering health benefits altogether, if that could be done in a way that did not disadvantage workers. The main source of disadvantage, however, would be the tax treatment of employer contributions to nongroup insurance, discussed in the following section. If employers could make pre-tax contributions to individual insurance, then that alone might avoid the major ERISA and other federal responsibilities, since ERISA duties attach mainly to employer-sponsored group insurance.<sup>6</sup>



### C. *Taxation of Employer Contributions*

A major inducement for employer sponsorship of health insurance is that employers' contributions to premiums are not taxed as income to workers, and employees can deduct their own contributions to employer-sponsored group insurance.<sup>7</sup> This tax exclusion creates what, in effect, is a "discount" in the price of insurance equivalent to the worker's tax bracket, because it would otherwise cost that much more to purchase individual insurance with after-tax dollars. For a variety of legal and public policy reasons, this favored tax treatment has never been extended to the purchase of individual insurance.

In the past, one reason to maintain a clear border between tax-favored group insurance and non-favored individual insurance is that, prior to the ACA, individual insurance in most states was medically underwritten, meaning that insurers could turn down – or charge more to – people with elevated health risks or pre-existing conditions, or could exclude covering those conditions altogether. The ACA's insurance reforms eliminate this concern. Therefore, some employers initially have considered dropping group insurance in favor of creating a tax-sheltered "cafeteria plan" that allows workers to purchase their own insurance using pre-tax dollars. As explained above, doing this might allow employers to avoid most of ERISA's fiduciary responsibilities for employer sponsorship. This might also be a boon for private exchanges, which employers could use for help with administering such an arrangement and assisting workers in selecting individual plans.

A primary concern about this approach, however, is the potential for "double-dipping," by allowing lower-wage workers to both qualify for premium tax subsidies through the public exchanges and to shelter their own premium contributions from tax. Also, the exchanges might be flooded with unanticipated enrollees if smaller employers could this easily drop group coverage and shift their contributions to individual insurance. To prevent such a shift, the

Internal Revenue Service has ruled several times that favored tax treatment will not be given to premium contributions used to purchase individual (nongroup) insurance (Condeluci 2015). These rulings are based on technical reasoning that makes them applicable not only to subsidized insurance through the public exchanges, but also to full-price insurance outside the exchanges.<sup>8</sup> Acknowledging that the government has reason to prevent "double-dipping" by using pre-tax dollars to purchase subsidized insurance, some exchange advocates argue with force that, now that the individual market has been fully reformed, government should not prohibit employers from facilitating pre-tax purchase outside the public exchanges, where coverage is not otherwise subsidized.<sup>9</sup>

Views were sought about what effect such a change in tax law might have on employers' use of private exchanges. Many informants thought that smaller employers would "flock to" using private exchanges if favorable tax treatment were extended to nongroup insurance, and some thought this would be "a huge game changer" that could "revolutionize" insurance markets. They noted that smaller employers are the ones that are most interested in true defined contribution arrangements that eliminate employer sponsorship and management of health benefits while preserving tax-advantaged contributions.

Others were more skeptical about whether such a change in tax law would make a big difference. They felt that many employers want to maintain involvement with plan selection and administration out of concern that employees might choose inferior plans, affecting the welfare of both workers and the employer, which has an interest in promoting worker health and productivity. This viewpoint was more often expressed, however, by informants that dealt with large employers. Most people from this perspective nevertheless acknowledged the substantially different perspective held by many smaller employers.

If tax law were to allow pre-tax purchase of individual insurance, this would pose a number of other regulatory and public policy issues that would require further thought, according to various informants. One actuary noted that, because the individual market uses age-banded rating, moving from group to individual coverage would have differential impacts on workers of different ages; employers could vary contributions to offset that difference, but doing that itself might raise fairness concerns.

Several informants also noted that, although the individual market now offers distinctly narrower networks with deeper price discounts than in the group market, these network discounts would probably change if a major portion of enrollment shifted from group to nongroup products. Then, some observers thought that providers would be much less willing to give the kind of discounts they agreed to for enrollment of previously uninsured people through the public exchanges. Also, one expert analyst noted that insurers in the individual market tend to take a shorter-term view of delivery system innovations than do large group plans because, historically, there has been a lot more enrollment turnover in the individual than in the group market. This greater turnover gives individual-market insurers much less incentive than large employers to invest in innovations that produce longer-term health benefits.<sup>10</sup>

### D. *Additional Regulatory Facilitation*

ERISA and tax law are the two primary areas in which some informants felt that regulatory policy might be changed in a way that facilitates employer adoption of private exchanges. Some additional areas for potential facilitation were also mentioned occasionally. One person wished that private exchanges could serve as a structure to sell insurance across state lines. Another topic, mentioned more frequently, is the ACA's "Cadillac tax," which will affect employers sponsoring especially generous coverage, starting in 2018. Several informants noted that inter-

pretation and application of the Cadillac tax is complex, especially for employers that package different supplemental health benefits, such as wellness programs. Thus, several informants thought that exchange adoption would be encouraged if doing so served as a safe harbor for remaining below the Cadillac tax threshold.

Despite this list of possible ways in which state and federal lawmakers might consider being helpful, the dominant view from multiple perspectives was that the government should stand back and allow private exchanges to develop on their own, without special assistance. Most participants would much prefer that regulators not attempt to help private exchanges, out of the concern that doing so could end up being more of a hindrance than a help.

## Conclusion

Seldom in the history of health care public policy has a major development in health care finance failed to prompt a major regulatory response. The initial growth of health insurance prompted state regulation of covered benefits. The spread of employer-sponsored health insurance yielded ERISA. The managed care revolution sparked a regulatory backlash against restrictive coverage. And, the ACA's creation of public health insurance exchanges carried with it a host of regulatory requirements for "qualified health plans" that participate in public exchanges.

Private insurance exchanges have not yet achieved the same level of significance, but some analysts predict they will; if so, it would be surprising if private exchanges did not merit some attention from regulators. This extensive investigation indicates, however, that private exchanges appear to be an exceptional case where regulatory forbearance is the wisest course of action. None of the potential concerns that one might conjure for private exchanges appears to have materialized or to be a real threat. Currently, private exchanges are not a pathway for employers to drop or radically reduce coverage. They are not being offered as a way to circumvent or

exploit other federal or state regulatory standards. And, they do not pose a threat to the public exchanges.

Instead, private exchanges appear to hold real promise for improving choice and competition in the group insurance markets. The promise is sufficiently attractive that, in fact, lawmakers might consider measures that facilitate creation and adoption of private exchanges, such as changes to ERISA and to the tax treatment of individual insurance. These or other measures themselves might create new problems, however, and so care would need to be taken to avoid doing more harm than good. On balance, the best course of action at the moment appears to be simply standing back to monitor how private exchanges develop within existing market conditions and regulatory pathways.

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## Endnotes

1. For more detailed descriptions of various models, see (Alvarado et al. 2014; PwC Health Research Institute 2014).
2. This possibility arises because the ACA specifies a full set of “essential health benefits” only for individual and small-group coverage. For larger group coverage, the ACA requires only that employers offer “minimum essential coverage,” defined as insurance that pays for at least 60 percent of the covered benefits. However, because the “denominator” of covered benefits is not defined or specified, some brokers and benefits consultants believe it is possible to meet this “minimum essential” standard simply by offering 60-percent coverage for only physician visits, or even for just primary care or preventive

care. Regulators have cast some doubt on this interpretation, however, by proposing a requirement that employers provide “substantial” coverage of at least physician and hospital services. Nevertheless, the issue is still being debated.

3. One expert analyst noted that private exchanges are still very early in their development, and so “next generation” versions could encounter more substantial regulatory barriers. For instance, he pointed to regulatory uncertainty that would attach to exchanges that, themselves, took on some financial inducement to promote population health.
4. There is a dissenting view on this, however. Some benefits lawyers would like legal clarification on a number of important points (V. Scott 2014).
5. As one exception, an observer familiar with unionized workforces and government employers noted that these types of employers often are restricted by collective bargaining agreements or public sector rules from freely moving to a private exchange structure. This person felt that, for these employers, legislation that freed them from these commitments to existing insurance arrangements could facilitate exchange adoption, at least to some degree.
6. There are some minor ERISA requirements in setting up a simple “cafeteria plan” through which workers can earmark a portion of their wages to pay for medical expenses.
7. Employers also benefit a modest amount by exempting such contributions from payroll taxes.
8. The IRS reasoned that the accounts used to earmark compensation for the purchase of insurance themselves constitute employer-sponsored “group health plans,” under both the ACA and the tax code.
9. (Nelson 2015). Rep. Charles Boustany Jr. has introduced a bill (H.R. 2911) that would change tax law to allow small employers to make pre-tax contributions to workers’ purchase of individual (nongroup) insurance.
10. Potentially, this difference could disappear, however, if individual coverage were portable across different employment arrangements.