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SELF-INSURANCE AND HEALTH BENEFITS: AN AFFORDABLE OPTION FOR SMALL BUSINESS?

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH AND TECHNOLOGY

OF THE

COMMITTEE ON SMALL BUSINESS
UNITED STATES
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

HEARING HELD
NOVEMBER 14, 2013

Small Business Committee Document Number 113–042
Available via the GPO Website: www.fdsys.gov

U.S. GOVERNMENT PRINTING OFFICE
85–594 WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
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SELF-INSURANCE AND HEALTH BENEFITS: AN AFFORDABLE OPTION FOR SMALL BUSINESS?

THURSDAY, NOVEMBER 14, 2013

HOUSE OF REPRESENTATIVES,
COMMITTEE ON SMALL BUSINESS,
SUBCOMMITTEE ON HEALTH AND TECHNOLOGY,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 2360, Rayburn House Office Building. Hon. Chris Collins [chairman of the subcommittee] presiding.

Present: Representatives Collins, Coffman, Luetkemeyer, Huelskamp, Hahn, and Schrader.

Chairman COLLINS. Good morning. I want to thank everyone for being with us today, and we want to take a look, I think it is very appropriate, at the trend of smaller companies now exploring self-insurance as a very viable option to provide their employees with healthcare coverage. I appreciate all of our witnesses taking time out of their business schedules to be with us today.

Just last week, President Obama apologized to the 4.8 million Americans who had their insurance policies canceled since this healthcare act was enacted. This includes 137,000 people in my area of Western New York. And while I appreciate the president's apology, these cancelations represent just one of the many broken promises and severe problems plaguing the rollout of his signature legislation.

The list of issues with this implementation is staggering—the bumbling of the healthcare.gov website; the 30-hour per week definition of full-time employment; the medical device tax; the health insurance tax; the cancelation of policies; and of large concern to those of us who serve on this Committee, small businesses facing significant increases in the cost of their healthcare plans, upwards of 55–60 percent in some cases.

These are not issues that the president and the administration will be able to resolve anytime soon. So as the confusion continues, small businesses and the people they employ continue to be left in the dark about what January 1, 2014, will mean to them, their healthcare needs, and the cost.

The subject of today's hearing is certainly not a magic elixir that can solve all of these problems for every small business, but it could be available option. Amid all of this confusion, small firms need as many options as they can find to keep their businesses moving forward and make money so they can invest in the growth of their companies.

In a self-insured situation, an employer can choose to assume all or a portion of the cost and the risks associated with sponsoring a healthcare plan. Under this arrangement, the employer forecasts how much it is likely to spend on health benefits—it is usually an actuarial calculation—and then decides whether or not it makes practical or economic sense for that employer to pay these costs out of pocket or to purchase a fully-insured product. Traditionally, small businesses have not utilized the option to self-insure. According to the Kaiser Foundation, only about 16 percent of employees at small firms are currently covered by a self-insured policy, as opposed to nearly 83 percent of employees at large firms. But with the onslaught of regulations, cost increases, and uncertainty surrounding fully-insured plans as a result of the president's healthcare law, more small businesses may choose to explore self-insurance as a manner of providing competitive benefit packages for their employees. Some small business owners may find that a self-insured policy would be cheaper as it may offer them greater flexibility in designing the health coverage they want to provide for their employees.

With that said, there are some potential disadvantages as well, such as an instance of higher than expected employee claims and additional administrative costs that could discourage smaller firms from utilizing the self-insured plans. We are not here today to advocate one method over the other, but rather we are here to examine if self-insurance is a viable for some businesses. When we say if, it really is, but that is what we are going to cover today. And so we ought to continue to preserve that option for small businesses, especially considering the uncertainty surrounding the fully-insured marketplaces Obamacare continues to be implemented.

Again, I want to thank everyone for being here today. I look forward to the testimony. And before we do that I want to yield to Ranking Member Hahn for her opening statement.

Ms. HAHN. Thank you, Mr. Chairman. I am pleased that we are holding this hearing today.

The Affordable Care Act introduced many substantial changes to health care, and these reforms will improve access to and adequacy of coverage, allowing young people to stay on their parents' insurance, expanding Medicaid, and not denying coverage as a result of a preexisting condition. California knows how to do things right. We have already had 59,000 enrollees in Covered California, so we are ahead of the nation in terms of having our website working and people actually going online and getting good plans, affordable plans, so we are very proud of what we are doing in California.

The small businesses exchanges will offer opportunities for small businesses to provide quality health insurance to their employees. At the same time, self-insurance or self-funding could be an option for small businesses to offer insurance coverage at low prices or with greater flexibility. Though this option is not for everyone, it could reduce the cost of coverage for small businesses willing to take on that challenge. While self-funding has traditionally been more common among larger employers than small ones, there is growing interest in this method of insurance. However, it is still

unclear just how many companies have already self-insured in response to the law or are planning to do so.

With the opportunity to minimize risk but still offer comprehensive coverage, small entities have expressed an interest in learning more about self-insuring. Today's hearing will allow us to learn more about how self-insurance works for small firms and what factors they must consider before deciding to move in this direction. We will also hear from witnesses about the benefits and pitfalls of self-funding for employers and what role health reform plays in these decisions. While this option holds promise for small firms, experts have indicated it could prevent much needed consumer protections from applying to workers in small entities. For that reason, we will also discuss how self-insurance could affect these companies' hardworking employees. As we examine this very important insurance alternative, we are looking for feedback to see how it will impact small employers and how we can ensure a broad range of insurance vehicles.

I thank all the witnesses for being here today, and I look forward to your comments. Thank you, and I yield back.

Chairman COLLINS. Thank you.

To begin with, if Committee members do have an opening statement, I ask that they be submitted for the record. And I would like to take a moment to explain the timing lights that are in front of you. You each have five minutes to deliver your testimony. The light starts out as green. When you have one minute remaining, the light turns yellow. And finally, at the end of your five minutes it will turn red. I would ask that you try as you can to adhere to that time limit.

Our first witness today is Michael Ferguson, president and CEO of the Self-Insurance Institute of America. Welcome. He has been with the association for more than 18 years, and in his current role he provides executive management leadership as well as serving as the federal lobbyist for the association. Mr. Ferguson has significant expertise on self-insurance matters related to group health plans, workers' compensation programs, and captive insurance companies, and operates his own blog which includes original reporting and commentary regarding legislative or regulatory developments affecting the self-insurance industry. Prior to joining SIIA, he was a corporate communications specialist for Rockwell International at the company's world headquarters. Mr. Ferguson earned his bachelor's degree in political science from California State University, Long Beach. Thank you for being here, Mr. Ferguson.

STATEMENTS OF MICHAEL W. FERGUSON, PRESIDENT AND CEO, SELF-INSURANCE INSTITUTE OF AMERICA, INC.; ROBIN P. FRICK, COMBINED BENEFITS ADMINISTRATORS, INC.; THOMAS FARIA, PRESIDENT, SHEFFIELD PHARMACEUTICALS; LINDA J. BLUMBERG, SENIOR FELLOW, THE URBAN INSTITUTE.

STATEMENT OF MICHAEL W. FERGUSON

Mr. FERGUSON. Well, good morning, Chairman Collins, Ranking Member Hahn, members of the Committee. I am pleased to

have an invitation to come and join you this morning. I think this is a very important and timely topic, and I am hoping to add some value to the hearing today.

The couple areas that I am going to hit on in my oral comments today is talk briefly about what self-insurance is and how it differs from traditional insurance, who self-insures, the ACA and self-insurance trends, the advantages and disadvantages of self-insurance, and talk about the federal regulation of self-insured plans. So the trick will be to do that all within five minutes. So let me get right into it.

Real briefly here, if you are ready to talk about the differential between self-insurance and fully-insured, if you are an employer and you want to provide group coverage to your employees, you really have one of two options. You can do a traditional insurance plan where you pay a premium to an insurance carrier, and that carrier in exchange for a premium basically takes the risk and provides coverage to your employees. The alternative is, as an employer, you can say, well, instead of paying an insurance company to provide coverage for my workforce, I am going to self-insure. In other words, I am going to pay the claims out of my own operating expenses or trust that I set up to pay the claims. So instead of transferring that obligation to an insurance company, the self-insured organization basically takes that obligation onto itself and pays the claims as they are incurred. So that is the differential between the fully-insured and the self-insured environment.

Chairman Collins has already thrown out some statistics in terms of the prevalence of self-insurance. Just to pick up on that is of particular relevance to this Committee. About 16 percent of smaller businesses self-insure. That would be defined within sort of three to 200 band; that is reported by the Kaiser Family Foundation. But what I think would be interesting for this Committee to also add, although this is the purview of the Small Business Committee, self-insurance is not simply a business strategy that the private sector implements. Self-insurance is also very prevalent within many labor plans—self-insured Taft-Hartley plans that self-insure smaller groups as well as many public sector entities, municipalities, many of which are self-insured.

Collectively, it is estimated about 100 million Americans receive their health benefits through various forms of self-insured plans. So the self-insurance market is kind of an underreported business story but it is pretty significant and it spans, again, both private sector, as well as the labor plans, and a third area is municipalities. So it is a fairly big marketplace, and so your hearing today is particularly relevant.

So now that we have talked a little bit about what self-insurance is, who self-insures, I want to go ahead and address one of the questions that has sort of been raised by the Committee. Obviously, we are here because in the context of the Affordable Care Act, what does that mean for self-insurance? Is that influencing companies to self-insure? If so, why that is.

Now, it is interesting. In the last year or two you hear a lot of public comments that self-insurance is somehow a loop hole to the ACA or this is a way to bypass the requirements under the Affordable Care Act. And as my testimony is going to demonstrate and

hopefully we can get in some Q&A, I actually think that is an incorrect observation of the marketplace and what you actually see is companies that self-insure actually subject themselves to more regulation collectively, not less than if they were in a fully-insured environment. And we will get into some of that.

So the question is, well, why are companies looking at self-insurance if it is not for some regulatory motivation? Well, I think the answer if you talk to companies is that particularly in this environment where there is some uncertainty in the marketplace, there is cost fluctuations that have been at least indirectly influenced by the healthcare law, what you find is companies that are migrating to self-insurance. They want to take more control of their costs. They do not want to be subject to an insurance company or a government entity dictating to them what my costs are going to be, what overages I am going to have. So by self-insuring, you are able to take more control over your plan. To the extent that you have decided that you want to provide benefits to your workers, a self-insured arrangement puts you in the driver's seat. You are the one that controls your plan going forward, and certainly there is some work to go that we will talk about in terms of managing the plan, but basically, it is control. It is ownership of your plan which self-insurance provides. So that, I think, would be our observation of what is driving that.

There are several disadvantages to self-insurance. I would say that not everybody is cut out for self-insurance. There is a lot of financial and regulatory requirements that you have to adhere to, which is detailed in my testimony, but there are also several advantages being self-insured. You can better manage your plan, cost savings, and a variety of other things that make self-insurance an advantage. Again, not the right choice for all organizations, but it is a choice for some.

So with that I will go ahead and—time is short here. I will conclude my testimony, and look forward to answering questions from the Committee as they arise. Thank you.

Chairman COLLINS. Yeah, no, thank you. And we will try to cover a lot of these issues. The intent today is really to be informative to small businesses. They are in what we call the traditional sign-up period right about now trying to figure out what they are going to do the first of the year.

Our next witness is Robin Frick, who is responsible for key account management, compliance, and corporate operations with Combined Benefits Administrators, an enrollment firm and third-party administrator, or TPA, that performs insurance carrier billing, claims advocacy, and benefits management located in Madisonville, Louisiana. Robin is testifying on behalf of the National Association of Health Underwriters. She has been an active member of the organization for several years and has served on the boards of both the local New Orleans chapter and the Louisiana state chapter in several different positions. In 2011, she was accepted onto the National AHU Legislative Council, which provides legislative advice, communication, and policy positions to the membership, Congress, and the administration. Robin received her associate's degree from Emory University in Atlanta, her bachelor's degree

from Louisiana State University, and is certified in transplant contract management.

Thank you for being here. You can begin your testimony.

STATEMENT OF ROBIN P. FRICK

Ms. FRICK. Good morning, and thank you.

My name is Robin Frick, and I am licensed professional health insurance agent from Slidell, Louisiana. I would like to thank the Committee for inviting me here today to talk about self-funding health benefit plans and whether it is an appropriate option for smaller employers. I have been in the insurance industry since 1999, and I have spent my career helping businesses design and implement self-funded benefit plans for their employees. I have also been a part of my professional association, NAHU, for 14 years, and I am speaking on behalf of all of our members who work on a daily basis to help millions of individuals and employers with their health coverage needs.

Regarding today's discussion of self-insurance, health benefits, and the small employer, I will be frank that the decision to self-fund coverage should not be taken lightly. It is a multi-year commitment in which the employer assumes the financial risk for providing medical insurance to its employees and their families rather than paying an insurer to bear the risk. The appropriateness of a self-funding arrangement is not only determined by the size of the employer but also the financial stability of the employer, his or her risk tolerance, and the ability to administer a compliant plan. There is an increased interest by smaller employers in self-funding since the passage of healthcare reform, but this is a transient time, and again at the state level when there are market reforms. The outcome of small employer self-funding though as a result of market reform measures is still rare.

Self-funding and stop-loss is not a new phenomenon. It has been around long since the days of cargo ships sailing to the New World. This new awareness of self-funding and stop-loss marketplace stems from the employer anxiety about changes to the new healthcare law that may bring to their employee benefit offerings such as the new national health insurance tax, the "Cadillac tax," and the changes to premium rate calculations. Self-funding a health plan provides a means to structure benefits to meet the specific needs of an employer but does not allow employers to escape the impact of healthcare reform.

Most of the reform laws market protections apply to employer groups of all sizes regardless of how they are financed. For example, a safety compliance client with 75 employees in good health and stable age-gender demographic, is interested in alternative funding such as self-funding with reinsurance in lieu of paying an increase over increase each year to fully-insure an insurance policy without experiencing the large ongoing claims that would normally directly impact the rates. He is experiencing a significant increase each year that is not indicative of his employee population.

On the other hand, an electrical contractor with 50 employees that has ongoing health, both medical and prescription drug claims each year, would not be able to financially support a benefit plan in a self-funded arrangement. His company may be in a healthy fi-

nancial position now, but if we extrapolate the expected risk two, three, and five years out, he will very much risk losing what he has worked so hard to grow. He would pass on the assumption of risk.

I have experienced quite the opposite, too. A bank client of 170 employees is considering the transition to fully-insured from self-funding with reinsurance as they can no longer sustain the adverse claims. The impact over the last three years has significantly depleted any reserves previously realized and gained through their self-funded arrangement, and the concern is that they are behind the 8-ball, so to speak, and they cannot get ahead. They are tired of assuming that all of the financial risk, the administrative responsibilities, and the compliance liabilities. The growing interest in alternative funding mechanisms has led some self-funded marketplace innovation with the development of hybrid level funding plans which can ease the transition from fully-insured to self-funding, and we anticipate further growth and innovation within this regard.

From a compliance and regulatory perspective, although self-funded plans fall outside of state-level insurance regulation, though they have always been subject to ERISA, stop-loss policies are actively regulated by state insurance departments and are held legally accountable for marketplace conduct; likewise for the licensed insurance professionals advising in those arenas.

In short, as healthcare reform has moved forward, employers are looking to gain greater control over their employee benefit options and funding mechanisms. I truly appreciate the opportunity to provide testimony to your Committee today. I consider it a huge honor to be here and a privilege to be able to inform you, our elected representatives, how the self-funded health insurance marketplace works for employers, both large and small.

Thank you.

Chairman COLLINS. Thank you very much.

Up next is Thomas Faria. Is that correct? Faria. President and CEO of Sheffield Pharmaceuticals in New London, Connecticut. He has been president and CEO of Sheffield, one of the nation's fastest-growing contract manufacturers of over-the-counter pharmaceutical creams, ointments, and toothpastes since 2002. In this role, he is responsible for overseeing all areas of operation of 160 employees, $30 million pharmaceutical products manufacturing company. The responsibility includes the absolute authority on all major decisions that affect the company and he acts as the public voice in all legal, public, and customer relations. Mr. Faria received his B.S. in industrial and operations engineering from the University of Michigan and his MBA from Bryant University in Smithfield, Rhode Island. We appreciate your participation, Mr. Faria, and please begin your testimony.

STATEMENT OF THOMAS FARIA

Mr. FARIA. First of all, I would like to thank you for the opportunity to speak to you all. I think this is truly a very important topic to talk about, especially for small businesses because as you review information and some of the topics that are most important to small businesses, what usually rises to the top is the ever-in-

creasing costs and the unknown costs of the future of providing health care for their employees.

Our experience that got us and Sheffield to try self-insurance, it really started in 2007. Up until that point, every year we would go through and review our health care costs and quote them, and we would expect a moderate increase of 5 to 10 percent on our insurance premiums. In 2007, we had a few unfortunate events with our employees. They were using—that caused our healthcare costs to go up. In response to that, our fully-insured provider increased our rates 25 percent. The next year, they were looking to increase our rates 39 percent, and when we looked around for any comparable products from their competitors, they were even higher. So at that point we took a look at and really did a leap of faith knowing that our staff were both fairly young and fairly healthy, we went for the opportunity to self-insure ourselves, and we have been doing that since 2009. What I can say is that so far that has been a great decision. We have saved over that four-year period roughly $400,000 compared to what we would have paid for our insurance premiums. And that is about a 19 percent savings. What we did with that savings, really, that allowed us to keep our benefits the same. We have a gold quality insurance program and we have kept that affordable for our employees.

When I look at some of the benefits that self-insurance can help with small business, first, obviously, there is an opportunity to save costs. Secondly, whenever you give an entrepreneur or business the opportunity and the information that is provided, you give them an opportunity to get responsible for those costs and accountable for those costs. And so self-insurance allows for some transparency on the healthcare costs that these businesses are incurring. This allows them to cater, and self-insurance allows for the flexibility to change their plans pretty much on the fly to adjust their plans for efficiency and also in some cases to reduce costs. What self-insurance also does, it allows and gives great incentive for small businesses to invest now in education and incentives that help improve overall efficiency of their programs. As a businessman, I can say that such investments usually you would not go and invest in such incentives when the benefit may turn out to be your fully-insured provider. Here we are looking at mitigating future costs by providing incentives for people to first go out and get physicals yearly, and also we provide incentives for them to lead healthy lives. That means checking your cholesterol, blood pressure, not smoking, keeping a healthy weight. And it is truly these self-insurance plans that allow us the flexibility to really kind of cater our programs to the needs that we see in our employees and also that we see coming up through the data that we are reviewing.

I thank you and look forward to contributing in any way. I look forward to your questions. Thank you.

Chairman COLLINS. Thank you very much.

I would like to now yield to Ranking Member Hahn for introduction of our next witness.

Ms. HAHN. Thank you, Mr. Chairman.

It is my pleasure to introduce Dr. Linda Blumberg. Dr. Blumberg is a senior fellow at the Urban Institute's Health Policy Center. Her recent work includes a variety of projects related to the anal-

ysis of health reform and state implementation of the Affordable Care Act. Dr. Blum berg serves as a senior advisor for the institute's Health Insurance Policy Simulation Model, and is also a member of the Health Affairs Editorial Board.

Welcome, Dr. Blumberg.

STATEMENT OF LINDA J. BLUMBERG

Ms. BLUMBERG. Thank you very much.

Mr. Chairman, Ranking Member Hahn, and members of the Committee, I appreciate the opportunity to testify before you today. The views that I express are my own and should not be attributed to the Urban Institute or its sponsors. My testimony draws on my own and my colleagues' analysis of the ACA, some of which rely on a 10-state case study effort of ACA implementation which the Urban Institute continues, along with our colleagues at the Georgetown University for Health Insurance Reforms, and some of which relies on the Urban Institute's Health Insurance Policy Simulation Model, HIPSM, a micro-simulation model that estimates individual and employer responses to specific provisions of the law.

Our analyses lead to the following main conclusions. Changes to small group insurance under the ACA intended to broaden sharing of healthcare risk across firms. An increased premium stability and access to insurance do not in general apply to self-insuring firms regardless of size, nor do they apply to private stop-loss policies, the product that makes it feasible for small firms to self-insure. As a result, small, young, and healthy firms will have increased incentives to self-insure once the ACA's reforms are fully in place, possibly trying to move between self-insurance and healthy years and fully-insured products and less healthy ones.

However, stop-loss policies combined with the self-insurance approach itself carry substantial financial and legal risks for small employers. As such, sales of stop-loss to small firms are relatively uncommon today. In fact, many sources in our case study were from the insurance and producer communities felt it was irresponsible to market stop-loss policies to small firms. However, we are seeing increasing marketing activity by reinsurers since passage of the ACA, including the emergence of bundled products which combined stop-loss coverage with administrative services. Many traditional insurers report that they do not want to get into this business, but if they see their traditional products being undermined they will have to participate as well.

While some states, for example, Colorado and Rhode Island in 2013, continue to pass laws due to the risks involved. In the vast majority of states, stop-loss coverage is not regulated like insurance, and as such, the policies can be denied to small firms outright due to their health status, are not required to cover specific benefits, are not guaranteed renewable, and can charge premiums based upon the claims experience of a particular firm with reunderwriting occurring frequently.

Reinsurers can also include lasers that exclude coverage for the expenses of a group's highest cost or highest risk members. Stop-loss policies may not pay claims until the end of the first quarter after the plan year ends, leaving small financially vulnerable firms to pay all incurred claims upfront. Small employers may be wholly

financially responsible for claims incurred in a plan year but filed after the end of that year once a reinsurance policy ends, leaving the employer exposed for large dollar amounts not anticipated.

Significant increases in self-insurance also pose substantial risks to those small firms wishing to remain in the fully-insured market, an issue that has led some states to prohibit the sale of stop-loss to small firms. And due to these risks, in 2012, an actuarial subgroup of the NAIC recommended changes to their model law which would set the attachment point or deductible for stop-loss coverage at a minimum of $60,000 per insured individual. Our micro-simulation analysis finds that their suggested parameters would, in fact, dissuade the vast majority of small firms from self-insuring. Under this approach, average premiums in the fully-insured small group market would be lower than under a scenario with looser stop-loss regulations or none at all. If these recommendations were implemented in a uniform manner nationally, the fully-insured small group market would be roughly one and a half times as large and the average fully-insured small group premium would be 20 to 25 percent lower than if reinsurance effectively acts as unregulated insurance.

To conclude, self-insurance and unregulated stop-loss coverage carries substantial risks for small employers who are often already financially vulnerable and frequently ill-equipped to take on the additional financial and legal risks associated with it. It also carries risks of undermining the ability of other small firms to purchase affordable coverage for their workers in the fully-insured market. A majority of states do not regulate the sale of stop-loss insurance today, and many of those that do regulate it require minimum attachment points well below recent actuarial recommendations.

In addition, we were unable to identify even a single state that currently monitors the sales of these policies to small firms, and only one that has plans to begin doing so. The Federal government could intervene, prohibiting the sale of stop-loss insurance to small employers, requiring its sale to small employers be regulated by small group rules, or setting minimum attachment points consistent with the new recommendations. At a very minimum, the Federal government can develop and implement an effective plan for closely monitoring increases in small firm self-insurance nationally and by state. Given the magnitude of other tasks and time pressures, states are not inclined to do so on their own, which means that in the absence of a concerted federal effort, states will be unprepared to intervene as warning signs increase the time at which major market disruptions could more easily be avoided.

I am happy to answer any questions that you might have.

Chairman COLLINS. Thank you to all the witnesses. I think we can have some very interesting questions. Ms. Hahn and I tend to run our hearings a little different than most. Instead of going first, which you find with many chairmen and ranking members, we like to go last. Our fellow members have busy schedules and so I will defer, as she will, to our fellow members here and then we will bring up the rear.

So with that I would like to start with the Congressman from Colorado, Mr. Coffman, if you would like to ask some questions.

Mr. COFFMAN. Thank you, Mr. Chairman. I think this is—certainly having been a former small business owner, that this is a very important hearing given all the changes to health insurance in America right now under the Affordable Care Act, better known as Obamacare. And I would like to ask each of the panelists to, if you could, answer relatively quickly, but to basically say under the pressures of the Affordable Care Act, do you think that self-insurance will grow under—in this new environment as a mechanism for small businesses to afford health insurance for their employees?

Start with you, Mr. Ferguson.

Mr. FERGUSON. Sure. Thank you, Congressman, for the question.

To answer that, I think our view would be that we would predict a continued growth in the marketplace, although that growth will probably be somewhat moderate just because for reasons that some of us have talked about already, stipulated self-insurance is not the best choice for all companies, particularly small employers. For some it is a great choice. But what we are seeing in the marketplace, there is a lot of companies that are looking more at self-insurance, and as part of that process to evaluate whether that choice is right for them, many of them as they sort of go through the process realize, well, this may not be the right choice for us so they do not go forward with that. But for companies that they have the financial viability, they have the sophistication to pursue this funding method, it is a good choice. So for that reason, since there is more interest generally, I think you are going to see a continued growth. But again, I do not see it as a wholesale migration. I think you are just going to see more companies gradually shift into the self-insurance marketplace.

Mr. COFFMAN. Thank you.

Ms. Frick.

Ms. FRICK. I agree with Mr. Ferguson. I do not know that it would actually explode as far as all of a sudden vast rush of people to come in to self-fund. The growing interest does not necessarily equate to a growing number of new self-insurance or stop-loss policies. Just as Mr. Ferguson indicated, you will have more people that are looking into it, doing the math, and as insurance professionals, that is our job, to help them determine the risks and advantages of every kind of funding mechanism available to them. So the increased interest is in something that is now newer to them than there has been before or rather may be available to them than it has been before. You still see reinsurance carriers that would provide the stop-loss behind it still a little hesitant to come down into the market of under 100 or under 50 just because that market space is typically not very self-funded friendly from a risk standpoint.

Mr. COFFMAN. Mr. Faria.

Mr. FARIA. I guess my answer would be I hope so. But I belong to an organization called the Young Presidents Organization, and in that organization we have had numerous talks about self-insurance, and actually, literally, one of the topics was about how to respond to Obamacare, and they were actually pointing towards self-insurance as a way to potentially mitigate the unknown costs that Obamacare may cause in terms of increased fully-insured pre-

miums. I think right now, especially right now, when you are looking at a situation where the fully-insured providers have an unknown, certainly with this website problem and other issues, and of course, the issue here with people losing their coverage, they are not quite sure what the premiums are going to be going forward. And I think right now self-insurance might be a great option for some people to mitigate that potential liability of increased fully-insured plan premiums.

Mr. COFFMAN. Thank you.

Dr. Blumberg.

Ms. BLUMBERG. Because under the Affordable Care Act price discrimination based on health status of a small group is prohibited nationally for the first time, the self-insurance becomes a more attractive option for firms that have healthier than average risks in their firm. And so we do expect there to be an increase in self-insurance as a consequence barring other intervention, either federally or at the state level.

I will mention to you that in terms of the uncertainty that one of the witnesses was mentioning, the issues with the website are very strongly unrelated to the vast majority of the small group insurance market which will continue to, in the fully-insured market, buy through brokers and agents as they have in the past with some percentage going through the exchange. But the markets are merged between the exchange and the non-exchange small group market. And so anything that creates a segmentation of risk between the self-insuring firms and the fully-insured firms affects the entire small group market.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Chairman COLLINS. Thank you.

At this point we would like to yield five minutes to the Congressman from Oregon, Mr. Schrader.

Mr. SCHRADER. Thank you, Mr. Chairman. And I appreciate the tone of the hearing if I may say so. It is a great idea, great topic. I am curious myself to see how this may or may not work out for businessmen and women around the country. So I really appreciate it.

First, I guess to Mr. Ferguson, if you could elaborate why you do not think this is a loophole in the ACA, and then you first comment on how this stop-loss works. It seems to me small business to me is something under 50 employees, and you are one catastrophic event away from losing your business if you do not have big cash reserves. How does that stop-loss really work? I would ask Ms. Frick the same question in a minute. Why is it not a loophole and why is this remotely possible for small business?

Mr. FERGUSON. Sure. I am glad you asked that question, so let us explore actually both of those variations.

The issue about the loophole is that there is concern or express stating that somehow self-insured plans are these unregulated entities that are out there and are sort of operating in kind of the Wild West. But, the fact is if you put a finer point in it, what we are really looking at in this discussion is what is the trend. Employers that are moving to self-insurance post-ACA. And by definition, those plans would be non-grandfathered self-insured plans. We have got two varieties—the grandfather and the non-grand-

fathered self-insured plans. So all of those plans that are moving to self-insurance would be non-grandfathered plans, and as such, they are subject to almost all of the regulations under the ACA. There are a few. There are about three or four that they are not subject to, and there are particular reasons why they are not applicable to self-insurance. Because essentially, self-insurance plans are the equivalent of nonprofit health plans. They are not in the health insurance business. They are widget manufacturers. And so in addition to that, not only are they regulated by the ACA, they are also regulated by ERISA. Also, HIPAA, COBRA. There are all these other federal laws that apply. So if you are going self-insured, you are actually subjecting yourself to more regulation, not less, if you are looking from a business owner standpoint.

Now, to your question about stop-loss insurance, distinction between stop-loss insurance and health insurance. Stop-loss insurance is essentially a liability-type of insurance product between the carrier and the employer. A stop-loss insurance policy does not cover individuals, it does not pay claims, and so there is a distinction that you need to keep in mind whereby you have got the plan, the self-funded plan, and you have the participants within that plan. And those participants are in the plan, they get coverage under the plan, no matter what the stop-loss insurance arrangements are. The stop-loss arrangement is simply a reimbursement mechanism between the employer and the carrier. So the fact, any of the arrangements of the stop-loss does not affect the plan participants, whether there is a laser, which means that the employer retains liability for one or more people under the plan not subject to liability. It is simply a reimbursement mechanism. So that is a financial tool that the employer uses and really has nothing to do with the healthcare, per se, delivery for the plan participants. I hope that addressed your question.

Mr. SCHRADER. And then, Ms. Frick, if you will chime in. So what does it cost? I mean, if the stop-loss companies are willing to assume that ultimate risk, you know, I have got only so much cash, my employee develops cancer, has this catastrophic crippling injury, you know, I do not have enough money to pay that, that is the reason I got you as a stop-loss insurer or backstop. What does it cost me to have you do that and what caveats do stop-loss companies put in to make sure they are not on the hook?

Ms. FRICK. Very good question.

With a stop-loss arrangement, self-funding, either you are going to assume everything without the backstop or reinsurance, or you purchase reinsurance just as you said to cover your more catastrophic risk. So rates are determined just as you would in a fully-insured market from the reinsurance but without the medical piece. The medical piece is added in after when you are looking at your specific medical claims experience and how you can turn that forward for your expected, and then the maximum liability over that next plan year.

So in the reinsurance piece, you are still taking into consideration the size of the group, the demographics, the area factors, where it is, and just the cost of what you are needing to cover. And then, how large of a deductible do you want on each bellybutton that is covered on the plan. And then if you are in that size market

of say 1,000 or less, you are going to want the extra aggregate protection that protects collectively all of the bellybuttons in the plan. So you have one on each and one as the whole.

So in that perspective there is always—you have to take all of that in to develop some kind of fixed premium cost that is a known factor over the 12 months. Your claims, you do trend out and expect where they will be. It is safe to put a corridor so you have a maximum liability to which you maximum would pay out, say about 125 percent of where you expect your claims will fall, but the reinsurance provides, if I set a deductible on each bellybutton as $10,000, then after that $10,000, my plan is reimbursed by the reinsurance carrier for anything over that expectation. So there is a cost factor. The reinsurance carrier is looking at everything, looking at the claims experience, what has happened before.

Now, what is interesting is if you are moving in typically that small group market under 100, you do not get the claims experience, or if you do, it is very aggregated. It is not very specific as we have known in the past. So now it is not a guessing game but you are looking at a whole market or a pool in and of itself. So now you are having to determine across a broad spectrum what do I believe for this area, for this type of industry, for these kinds of workers, where should we place the deductible level? What do we expect out of them? An oil rigger is going to have a much higher risk factor than someone who sits behind a desk every day. So those are all taken into consideration. But the reinsurance does provide sleep insurance. I know at night that my total exposure is X. I know if I have an aggregate coverage that my total as a plan is X and there are reimbursables. As was noted earlier, just totally crippling someone, it does just help to have that something in the background.

Mr. SCHRADER. Sure. Thank you very much.

I yield back. Very helpful.

Chairman COLLINS. Thank you.

At this point we would like to yield five minutes to the Congressman from Kansas, Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the opportunity to visit here and learn much more about this topic. My first question would be for Ms. Frick. Thank you for being here.

How many years of background do you have in this industry and your education that qualifies you for your current position?

Ms. FRICK. Sure. So I have been in the industry ever since I graduated from college basically. So a little over 14 years ago.

Mr. HUELSKAMP. Two years ago?

Ms. FRICK. Yeah, about five. Thanks.

And I have been active—just from the perspective, I started—when I started my career I started out with an insurance consulting firm and just started asking a lot of questions and moved from the small group space and fully-insured into our client-size, the middle market space, starting to get a mix of self-funding, and then to a larger self-funded market space. I was curious. I asked a lot of questions. I like to learn, and if I need to educate you about it, I need to know what I am talking about. I worked with a managed care company for a year so I had a very interesting and in-depth look on the inside from how an HMO self-functions. I had a

very good relationship with the underwriting actuarial departments, so I really understand how rates are calculated. What is the value of a co-pay? What is a value of the deductible and the out-of-pocket. And from then, back on the consulting side.

Mr. HUELSKAMP. Last week in a hearing, for instance, the HHS secretary did admit a felon could serve as a navigator potentially. How comfortable would you be to call up a navigator or visit with them in order to make your healthcare decisions?

Ms. FRICK. Honestly?

Mr. HUELSKAMP. Yes.

Ms. FRICK. Not comfortable at all, unless I knew that they were a licensed, regulated entity that had to conform to continuing education as we have to or a required number of hours every two years. And we are subject to market conduct and are held legally accountable for what we do, what we say. We carry E&O insurance. We have, you know, for any claim against us. I want to know that the claim that I am talking to on the other line knows exactly what I am talking about or asking the questions for. I appreciate if someone does not know and is honest and says I do not have that answer but I will find out for you, but I would much rather if I am making a big healthcare decision, just as an employer or as an individual, this is your number two for an employer payroll. This is the number two list on your accounting statement. You have got to know who you are talking to and who you are dealing with and they are going to be able to be objective in helping you determine what is best for you.

Mr. HUELSKAMP. Well, thank you. I share that concern as well and hear that from constituents worried about instead of the agent they usually rely on or the folks that help manage their account at their employer, just worried about a navigator, untrained, perhaps for a month, not even that. No insurance. I had not even thought about that. I mean, that is just a basic requirement of the agents.

The second question would be for Mr. Ferguson. I am looking at a story from my district in Kansas, which is about the middle of the country, and a company by the name of Vortex Corporation. They work really hard. Their insurance renewal date just happened to be July 1st, and they worked really hard and made that requirement, did everything they needed to do, and then shortly thereafter the administration announced, you know what? We are just going to ignore the portion of Obamacare that says the business mandate. We are going to put that off. Other companies, were they in this situation? And what has been the impact of delaying that? I have heard various reports of what that has meant for businesses. If you could provide some light on that, Mr. Ferguson.

Mr. FERGUSON. Well, I assume you are referencing companies that currently maintain a plan or determine whether to continue that plan through 2014. Is that the direction of the question?

Mr. HUELSKAMP. Yes. In this case, the renewal is July 1st.

Mr. FERGUSON. Right.

Mr. HUELSKAMP. And they worked everything they could in the law and all of a sudden it was suspended for a year.

Mr. FERGUSON. Well, what I can simply tell you is anecdotal, so disclaimer there, and the companies that I have spoken with is

that all of the companies that provide or are thinking of providing a group health plan, they have run the numbers so to speak. They have done the analysis in terms of whether they want to start a plan or maintain a plan, and they have probably reached some initial conclusions as to whether they want to play or pay. But most of those companies are taking a wait-and-see attitude, particularly the ones that are thinking about that they might drop the coverage and go ahead and pay because they are kind of waiting to see what exactly—how is the experience in the exchanges going to be. For instance, for companies that would be considering potentially dropping their coverage, one of the things that they are looking at is, okay, are the exchanges, are they going to be functional? Are they going to be effective? Because that is going to impact the decision of the employer. If they are thinking, well, if my assumption is that I could drop my coverage and there is a viable option for my employees and it is easy and you can get your affordable coverage as the law anticipated through the exchanges. That might influence my decision to go ahead and drop my plan.

On the other hand, if there is uncertainty in the marketplace and the exchanges are not delivering on that promise, then that would sort of push them back to maintaining the plans. I think if you talk to most companies that are self-insured that have run successful self-insured programs, their preference is to keep their plans just because for no other reason it is a value to them. It is a value to retain and attract talent. So for those successful plans, they are inclined to keep them. But they have all run the numbers. They have all had their initial analysis. Most, if not all, will not publicly state what their intentions are but in some backroom they have a spreadsheet that shows all the different variations. And again, as I said, a lot of them are just sort of waiting to see how—obviously, there is a lot of uncertainty that is going on in the marketplace right now so they are kind of waiting to see how this all plays out.

Mr. HUELSKAMP. All right. Thank you, Mr. Chairman.

Chairman COLLINS. Thank you.

At this point we would like to yield five minutes to the Congressman from Missouri, Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Mr. Chairman.

Just a couple quick questions here. Mr. Faria, you have a plan in place and have been working with it for how long now?

Mr. FARIA. We have been working with it for over four years.

Mr. LUETKEMEYER. Four years. Okay. How has it been accepted by the employees? Do they like it? Do they have concerns with it? Mad at it? In love with it? Ready to go for some more? What is the story? How do they accept it?

Mr. FARIA. Well, I think in a lot of ways it is seamless. We are just replacing kind of the backend of the insurance. So for some businesses, they can choose to keep everything the same. You might not even have to tell the employees.

Mr. LUETKEMEYER. Does it help retention then by having, in your situation, a rather seamless transition to this new plan? I assume it does not hurt retention.

Mr. FARIA. Right. I mean, I think as I stated in my testimony, the savings that we have gotten from self-insurance has allowed us to keep a high standard plan. We consider our plan, it qualifies to

be a gold standard plan. We have also been able to keep that relatively affordable for our employees. And so for us we are using our self-insurance as a benefit for our employees to help us keep and retain our employees.

Mr. LUETKEMEYER. Okay. Do you fund the program entirely or do you have a reinsurance stop-loss behind your plan?

Mr. FARIA. Absolutely. We have a stop-loss.

Mr. LUETKEMEYER. Okay. Very good.

Ms. Frick, you deal with lots of plans. I know that the bigger you get probably the more functional this becomes, the more of an option it becomes. How small does it get down to where it is really not an option or not something that needs to be considered or you need to just go ahead and let the insurance company take the risk? What has your experience been?

Ms. FRICK. Obviously, the larger you are the more credible your claims experience is, which that being, it is more indicative of where you will be in the future. There is the one-in-five rule where one out of every five years you will probably tank, you will have a bad one, but for the most part you are going to run pretty well. The larger you get, it becomes a very predictable number. As you become smaller, your claims experience is less—there is more volatility just from the perspective that it is less predictable. When you are around about 100, 200 employees, you need to gain the time to have a plan in place to really see where your trend is going because just as was mentioned earlier, you can have the one that just blows the whole plan out of place but that one person in a smaller group is more damaging to that group than the one person in a larger group.

Mr. LUETKEMEYER. What has your experience been with reinsurance? Do most companies have a stop-loss behind them or are there companies out there that just take the full risk and just let it fly?

Ms. FRICK. Most will have reinsurance except when you find a very large employer with tens and thousands of employees that can really financially put it behind them.

Mr. LUETKEMEYER. Do those companies that participate in this, is it more based on the revenue of the company so they have more cash flow or is to more based on the number of employees?

Ms. FRICK. More on the financial perspective. What can I assume? What is my risk tolerance?

Mr. LUETKEMEYER. And expense to put this money into—my next question is do most of them use a trust fund to put this into or do most of them just write a check out of their account whenever, you know, they just have a separate bank account and then just write checks out of it whenever something happens?

Ms. FRICK. Sort of that. Both. They have a claims fund. So you set your employees—employees still have a premium they are paying, and you set that premium based on the claims and the administrative costs, just as you are in a fully-insured plan. You pay $100 a month in premium. That is encompassing the claims that have to be paid, the administrative fees that have to be paid all in one lump dollar. You do the same thing on the self-funded side. So from an employee's perspective, I do not know the difference. I do not know the funding mechanism behind the plan. So the claims

dollars that you as Mr. Employer are withholding from my payroll, for example, are put into that separate fund. The administrator who is physically paying the claims since the request to the employers in the past however often that is—two weeks, one month. You have had these claims. Please send the check for this money.

Mr. LUETKEMEYER. Okay. I am running out of time here. If one of you, probably Mr. Ferguson, I would imagine, could give me just sort of a thumbnail sketch of how this fits into the McCarran-Ferguson act. You know, basically states need to be in charge of health care, yet this comes under sort of an ERISA situation. So can you give us a thumbnail sketch on what applies, what does not apply, how this all fits together?

Mr. FERGUSON. Sure. As you mentioned, the Employee Retirement Income Security Act is the controlling main federal regulation that governs self-insured health plans. So as a self-insured health plan, you are regulated under federal law by ERISA principally but then other laws also apply, including as I mentioned, many of the applications and provisions under the Affordable Care Act. The McCarran-Ferguson dictates that the business of insurance is regulated at the states. So we talked a little bit about stop-loss insurance carriers. The stop-loss insurance carriers are state-regulated entities. So you have the plan that is regulated by the Federal government, stop-loss insurance carriers are regulated at the state level. Does that answers your question?

Mr. LUETKEMEYER. Yeah. That just adds to confusion. Thank you very much.

Mr. Chairman, I appreciate your time.

Chairman COLLINS. Thank you.

Well, Ms. Hahn and I will now kind of jump in and try to connect some of the pieces. I guess, Mr. Ferguson, let me start with you because you are the Self-Insurance Institute. Just to be clear, an employee designs a self-insured plan. One thing that is a big thing, they do not, as I understand it, have to meet the eight or 10 minimum requirements of the ACA. If they choose to have a self-insured plan, for instance, that does not have a free gym membership or does not have maternity care or contraceptive coverage, they are allowed to do that. That is one of the three or four exceptions. Is that correct?

Mr. FERGUSON. You are correct. They are exempt from the essential health benefits rule. But there is a longer answer. They are subject to the minimum value requirement that the plan has to provide minimum value for them to meet their employer mandate requirement as well as their plan participants to meet the individual mandate requirements. So it is sort of an indirect sort of regulation in terms of the composition of the quality of the plan.

Chairman COLLINS. So, for instance, if a company had a religious objection to providing contraceptive coverage, they do not have to do it in a self-insured plan. But the point you are making is—I call it the 60 percent rule—their plan actuarial still needs to cover 60 percent of the expected costs that would be incurred. Is that what you are talking about?

Mr. FERGUSON. That is correct.

Chairman COLLINS. Right. So overall it meets the standards but not "one size fits all." Each company can design the plan they

want, which I would like to think is what America should be all about.

Now, today we have community-rated plans which a lot of small businesses are in. We have experience-rated plans, which obviously is what Mr. Faria had as a fairly large small company, 160 employees. He was experience-rated each year, and if somehow he had some unhealthy situations, his rates could go up, up, up. If you are that 25, 30, 40 employee company, you are probably in a community-rated plan. And then you have self-insured. And maybe now you throw the exchanges in. But is it fair to say then experience-rated, community-rated, self-insured are maybe the three big things out there?

Mr. FERGUSON. I think that is one way to describe it.

Chairman COLLINS. And Ms. Frick, if a company at some size, like Mr. Faria, he probably would not qualify for a community-rated plan. Is that correct? They are only going to take him on an experience rated plan, so each and every year they are going to say what happened this year, look back a couple of years, and then design the premium schedule which he could be fortunate it goes up 1 or 2 percent or he could have a bad year and have it go up 30?

Ms. FRICK. Typically, the under 100 group size is where you are put into that community-rated pool. But when you get over the 100 you start jumping out of the pool.

Chairman COLLINS. All right. So that brings my next question. As companies, and actually, I am looking at this in a couple of my businesses, on the stop-loss, I do not think any small business owner would ever enter into this without stop-loss. So, and I am sure this may vary state-by-state, location-by-location, but is there a point at which somebody wants self-insurance but they cannot get stop-loss? What would that employee, you know, like if you had 25 employees, could it be if I hired you to go find me self-insurance you might not be able to get a competitive stop-loss quote? But if I had 80 or 100 I could? And is there any generalities there?

Ms. FRICK. You are right. I mean, that is a fair statement. Because the reinsurance carrier is still looking at they are assuming some risk at some point in time. So how much is it going to cost them on that small group when there is not going to be a lot of premium per se to come out.

Chairman COLLINS. Is there a number, like, one thing we hoped to get out of the hearing is—and I am going to talk to FOX News today, is maybe some generalities. Is it 25? Is it 50 employees? Is it 75? Because there may be—there are a lot of people looking at options but we do not want to mislead someone that has got 10 employees who think they can do a self-insured plan and actually get a stop-loss.

Mr. FERGUSON. That is a great question. It is an obvious question. And the answer is a little less precise. And the reason for that is as we talked about—now, self-insurance, the larger you get on the continuum, you are more likely to be a viable candidate for self-insurance. So by converse, the smaller you are, the less likely. But you cannot just look simply at the employee size. As we talked about a little bit earlier, to a large extent is a balance sheet. It is a financial decision. And so you may have—let us just take an example—you may have a law firm that has 30 or 40 attorneys that

is cash rich, that has a fairly stable workforce that has the financial wherewithal to self-insure. And they may be a great candidate to self-insure. Look at the opposite way. You may have a much larger employer that is really having challenging—does not have much cash reserves. They are a larger employer. They may not be viable for self-insurance because of their financial condition. So it is tough to sort of pin down an exact number. It really is, again, the smaller you get on the spectrum it is certainly more difficult. But to the extent that again you are strong financially—and the other component, too, is, I make the point, is the successful self-insured companies are largely the ones where the principals, the owners, the executives of those companies decide they want to take ownership of the plan. They want to roll up their sleeves and make the plan work. Because one of the advantages of self-insurance is you have the ability to really customize your plan and really make it work well, but it takes some effort. It takes some time. Your executives are going to have to reserve some time. They are going to have to meet with their business advisors. They are going to have to evaluate different things that they want to incorporate as part of their program.

So if you have a corporate culture, such as Mr. Faria and his company, where the senior executives are saying, hey, healthcare cost is a high-ticket item on our P&L, we want to do something about it. We understand we are going to have to commit the time, and they do that. The smaller firms can be successful again if they have the financial wherewithal. But the opposite is true. If you are a small business owner and you are just looking at this I just want to save costs but I am not willing to put the time in, do not do it. It is not going to be a good investment for you.

Chairman COLLINS. So, Ms. Frick, I have got 75 employees. I am in a community-rated plan, not experience-rated. I am really worried about what my insurance costs are. It is now whatever today is, November 14th or whereabouts, and I have got a short time to make a decision. So I come to you and I say I really want to explore self-insurance as opposed to my community-rated plan that I am offering. What do you do? Could you walk us through step-by-step like the actuarial calculation? You call an insurance company. How do I get stop-loss, et cetera, et cetera. What do you bring forward as far as a network, you know, renting a network, having a network, the blues, getting to. What does the employee seek because he used to a Blue Cross Blue Shield card or some other HMO. So walk us through someone like me coming to you saying I do not know anything much about anything. How do I get started? Where do we go? And what is the timing?

Ms. FRICK. Okay, sure.

So first, we take your census of eligible employees with all their demographic data—age, gender, zip code—so that you can do——

Chairman COLLINS. Number of family members, et cetera, et cetera?

Ms. FRICK. Who is covered under the plan. Then take if any kind of experience is available, even on an aggregated basis. Take that information into consideration. Take your current plan design. Call up reinsurance markets. There are a lot of them. And market it. See who bites, who does not. There will be reinsurance carriers

that say no, this is not a risk area based on the industry or the size that we want to take a look at. There are others that are willing to take a harder look. So we get that information back, look at the contract basis, the time period meaning are there claims incurred within 12 months but then paid out in 12 months, 15 months, 18 months. Take a look at the administrators that you have available. Not every third-party administrator will pair with a reinsurance carrier, for example, so you have to make sure that they match. Then who is the pharmacy benefit manager that I want in there? What is the PPO network that I can rent? A lot of times with third-party administrators, they can bring those pieces to the table for you, but certainly, in a self-funded arena you have the option to put together those pieces and parts that work best for you.

On the other side, with market innovation, instead of going straight over to the self-funded side, maybe we look at a hybrid. Look at something that looks and smells and is self-funding but still appears or still can function as fully-insured from a premium payment perspective. For example, there are a couple of national carriers out now that have come out with something that is like a level funding plan. So it is self-funded. There is ASO administrative services in there. There is reinsurance. All the pieces and parts, but they set a fixed dollar amount every month as far as premium payment versus that little volatility you will get in a claims payment from a truly self-funded plan. It is a fixed dollar amount. So at the end of the contract period, take a look and see, okay, if I paid less in premium than was paid out in claims, then I have the opportunity to receive a portion of that back. I keep it. It is mine. In a fully-insured market, I am sure you all are aware that if I pay less in premium that the carrier paid out in claims, they keep the money. It is their win. In truly self-funded, that is all my money back.

So this hybrid gives the opportunity for them to get a percentage of it back, so a split, for example, with the insurance carrier. Now, on those times when the employer pays more or more claims are paid out than premium is received, obviously there will be adjustment for the next time period to account for claims and expected risk going forward. So it makes a little bit of an easier transition, so it is more stable month-to-month versus the volatility of this month I have 25,000 in claims, next month I might only have 7 and the next month there is 17. It gives some more stability to that employer of that 7,500, 150 space.

Chairman COLLINS. All right. So now how long does this take? I call you today. When can you come back at me? Does this take a week, a month, two months? What would you say?

Ms. FRICK. I would like to do it in two weeks or less.

Chairman COLLINS. Okay.

Ms. FRICK. My methodology has always been to have a 60-day lockout period and an agreement with a reinsurer. Meaning 60 days before the effective date the plan is going to be set up, locked in, and if we are going to have a January 1, then we are going to make sure that by October 1st or November 1st at the very latest, we know what we are doing, who we are playing ball with, where the claims are going, who is the pharmacy benefit manager.

You pointed out a good illustration about everyone is used to their Blue Cross card or United Healthcare card and it has got that logo on it. Well, the cards that come out still have the logo on it. It still has a network attached to it. Now, maybe it says ABC administrator where the claims go, but the logo for the network is still there, the pharmacy benefit manager, such as an Express Scripts, Caremark is still on there. So it is still identified by the employee as theirs. The pluses in self-funding the employer also throws their log on there a lot of times because they are the ones that are responsible for the plan.

Chairman COLLINS. Good. That is I think helpful as, you know, again, people are facing this. Right now, Mr. Faria—by the way, I am a fellow YPOer. I have been in a little bit longer than you. I graduated into once you are 49 years old you become a W, world president organization. So I am officially a WPOer but long-time YPOer.

So you are, I am assuming, in a forum group?

Mr. FARIA. I am.

Chairman COLLINS. So just out of curiosity, eight or 10 guys, you all share your information monthly in confidence, but without breaking a confidence, I am just curious. How many of your fellow eight or 10 forum members are self-insured like you are?

Mr. FARIA. That is forum confidential. Just kidding.

No, I think there is about two of us out of the eight.

Chairman COLLINS. Is it a discussion point that is pretty active right now?

Mr. FARIA. A lot of the time. I think, again, as I had mentioned, YPO has done more call-out sessions for our entire chapter to discuss this point, but definitely—and we also have an individual who is affected by the medical device tax and he certainly has had some issues with that, of course. So from time to time it is a discussion. It is not immediately. I think right now everybody has already made their decisions on what they are going to be doing. We kind of planned ahead.

Chairman COLLINS. So now yesterday I did meet with Mr. Ferguson ahead of time. He came in a little bit early. We were talking about the fact that you, as the self-insured now get some interesting information monthly or quarterly. You do not know which employee may have gone to the emergency room or which employee is on what particular prescription drug but you get active information, what your cost drivers are, in some kind of aggregated fashion. And as Mr. Ferguson was sharing, sometimes, because now you are bearing the cost, you could make changes in some way or another that would address to maybe incentivize healthier behavior. He gave me the example of maybe lowering a deductible to go to Urgent Care, raising a deductible to go to the emergency room, because you see, oh, my God, I have three employees that just went to the emergency room. They should have gone to an Urgent Care. Share with me as someone four years experienced into self-insurance how you have used that data to either have a healthier workforce or incentivize what we would call cost-effective user-driven behavior.

Mr. FERGUSON. Certainly. You gave an example that was one of our true success stories. When we gained access to our data, we

do not usually look at it on a monthly basis and we are not reacting like that, but typically, we will evaluate it on a half-year basis or so. But when we first got our data and we compared the national norms, we realized that our employees were using the ER at a higher than national rate. We also were given information to realize that it was not actually emergency care that they were getting. So that these employees were really going to the emergency room for issues that really should have been handled by a physician. So we were able to structure our plan in a way to incentivize people to go to and get a physician. And the benefit of that is obviously I kind of look at it as a win-win-win. The overall plan wins because we are not spending—typically one ER visit for a common visit we are being charged $1,000. The business wins out because we are able to reduce that cost. I look at the employee now wins because they also have a lower cost but now they are developing a relationship with a physician. They are developing a history with that physician so that the next time that they come in it is not that they are just going up to some stranger in the ER. And so this starts to help promote healthy values. And then the other win of this is that the overall health system is now being used more efficiently. The ER is not being used to cure the common cold. A physician is treating that. And so the ER can be focused on more pertinent matters.

Chairman COLLINS. So now, Ms. Frick, if you have a pharmacy benefits manager, a formulary, if you will, for your prescription drugs, a company could decide I really want—and really encourage generic drugs—so I am going to have a plan that has got a $5 co-pay for generics but if somebody wants to opt into the name brand, have a significantly higher, again letting the user make that determination, is that something that you could tailor into a self-insured plan?

Ms. FRICK. Yes, absolutely. And then I would encourage on top of that to have lesser language so that you are paying the lesser of the co-pay or the retail price of the drug. So you are still encouraging people who need their prescriptions to fill their prescriptions. Still go get your $4 generics if you want to from the Wal-Marts, the Targets, but know that you are not going to pay any more than say if our plan has a $10 co-pay for generics, that is where your cap is. So it is still encouraging the healthy behavior.

And I will say to a point on employees, when the employer is engaged in the plan and they take an active look at where there is spend, employees value the plan more. It does not matter if now I have to pay $100 to see the doctor whereas I paid $50 before, if they can see in other areas where the employer is really engaged and understands what is important to his employee population, then they are more likely to tailor their plan better and you will have the more effective measure and usage from the employees. They will stay out of the ER and go to Urgent Care or an after-hours clinic more than they were before.

Chairman COLLINS. One last question. If I sign up and I go self-insured and a year in I got, you know what, I did not quite know what I am getting into, is it very easy or just automatic that you could drop that plan at that point and move back into a community-rated plan?

Ms. FRICK. You can. However, you need to make sure that you have a run out provision for the claims that were incurred before. So you are either electing the terminal liability and the run out upfront or you are reserving the option to execute it upon the policy termination. You never want to jump in and out of self-funding and fully-insured, back and forth. From an employee perspective, they do not know how it is, as we said before, how the plan is funded, but from an employer and an administrative, that would be a nightmare.

Chairman COLLINS. Okay. Before I go to Ms. Hahn to close, I notice that our Congressman from South Carolina has arrived.

Mr. RICE. I yield my time.

Chairman COLLINS. All right. I guess——

Mr. RICE. I yield.

Chairman COLLINS. Oh, okay. He came to listen. Thank you. Mr. Rice, I appreciate you being here.

Ms. Hahn.

Ms. HAHN. Thank you. I have certainly found this a very interesting hearing. I have certainly learned a lot.

Mr. Faria—is it Faria? Faria. You all have said it differently.

Mr. FARIA. Faria. Yes.

Ms. HAHN. So I am just curious about a couple things. Now, you talk about having a gold plan, which sounds admirable. How does that compare to what the Affordable Care Act is qualifying as a gold plan and the benefits that have to be offered?

Mr. FARIA. To the best of my understanding, that is why I am saying gold. I am comparing it to an Obamacare gold plan.

Ms. HAHN. Okay. So you, even though some of these consumer protections under the ACA do not apply to self-funded groups, you have decided to cover those?

Mr. FARIA. Yes.

Ms. HAHN. So you do not discriminate against someone who has a preexisting condition or being a woman.

Mr. FARIA. Not at all.

Ms. HAHN. Not at all. So that is admirable.

One of the things I am interested in, and I do not know if Ms. Frick or Mr. Faria could speak to that, so when the reinsurance company is analyzing your company and determining what they would charge you, what are they looking at and what are they charging more for?

Ms. FRICK. They look at the current plan design or the plan design that you have created. And every piece in part to that plan has an actuarial value. So there is a value to the plan itself, just as we know we have the minimum value at the 60 percent, so we all understand how that works. But then when they look at the potential risk or the health conditions—let us say it is a known factor, that we know what some health conditions are, there is a dollar amount that is associated with the cost of the care of those particular measures. And then further, has the employer or its administrator or a disease management company helped to take steps to mitigate some of those claims? For example, for diabetes management, I have put in a plan before where it was not opt in or out. First fill of a diabetic drug the patient was put into the plan. They were now followed by the nurse. I would rather pay more in phar-

macy costs as an employer than more costs for the medical part because you are going to pay—that person will have more medical problems over time if they do not control their disease and have disease management with healthier living, taking the required medications, have their timely A1 season, something of that nature.

So the reinsurance carrier takes a look at everything so they have an understanding of okay, that employer has now decided that they are going to have a $50,000 specific deductible for each person on the plan. So where does that put me after the 50 for this employer, for the diseases or health conditions that are contained therein. Where does that place me? If I see that the employer is assuming more of the risk upfront on the first dollar, then that is better for me. I will reduce it a little bit. If I see that I will potentially take more on the backend from a reimbursement perspective and now I am funding that, then I am going to have to put some more into my rates.

On the flipside, they can also laser, but a laser is just putting either a different contract on an individual or a higher specific deductible on that individual. They are not excluding them from having reimbursable claims. They are saying if my specific is at 50 but because Susie-Q's specific—because of her conditions is now at 100,000, then the reinsurer will start reimbursing after her 100,000 claims and the employer has taken the first 100. They are not excluding her from coverage. They are not excluding her from reimbursable claims. They are just putting——

Ms. HAHN. What would be some examples of some laser contracts?

Ms. FRICK. Kidney disease. End-stage renal failure. High dollar premature babies that have been born that it is obvious that they will have longer time for recovery, they will have multiple surgeries going forward. Those are typically the two highest cost drivers.

Ms. HAHN. And do you have any laser contracts, Mr. Faria?

Mr. FARIA. Yes, we do, actually. We had a situation where an individual has some cancer and they were lasered. I will say that the laser does add some risk to the self-insurance plan. You can have a situation where a person gets cancer and then the reinsurer comes in and says we are going to laser, meaning that their deductible now is let us say 300,000. I will say, however, that there are plans out there, and we have actually signed one now, that you can have a no laser contract so for an additional amount of money you can actually put forth and say that next year when we reapply, there will not be any lasers.

Ms. HAHN. And does your employee who has been lasered, do you charge them more?

Mr. FARIA. No.

Ms. HAHN. No?

Mr. FARIA. No, we do not do that.

Ms. HAHN. So everybody pays the same?

Mr. FARIA. Right. I mean, we have a tier based off of whether you are single or have a family. We also have a tier based off of how the person scores on the physical, their biometrics, how they are doing in improving healthy living.

Ms. FRICK. I am sorry to interrupt. May I make a comment to your question about lasers and what employees pay?

Ms. HAHN. Right.

Ms. FRICK. The employee typically has no idea what their laser is. They see their plan benefit design. They see I have $1,000 deductible and a $20 office visit co-pay. The stop-loss deductibles and the lasering is on the financial funding side of the plan. So his employee that might have that $300,000 does not know that he is responsible for $300,000 of her first dollar claims versus 50 for mine.

Ms. HAHN. Got it.

So the other thing that was interesting was you having access to the data. Now, you do not have access to the individual employee and whether or not they went to the emergency room, or you just have a cumulative——

Mr. FARIA. Right. It ends up being cumulative.

Ms. HAHN. But do you know who the employees are?

Mr. FARIA. I would say that you do not have direct names.

Ms. HAHN. You can figure it out?

Mr. FARIA. Unfortunately, in a small business environment, you do know that a certain employee might have been out and to the hospital for a period of time and you will get claim data that said this particular surgery happened at that point in time.

Ms. HAHN. Yeah, you know, I have been having an open mind about this but that part of it really would bother me as an employee. That is a real loss of privacy with your employer. It is one thing for your insurance company to have that information. It is another thing for your boss to know what is going on in your personal life and why or why not you have chosen to seek medical care. So that part bothers me. What do they feel about it?

Mr. FARIA. Well, I think in a lot of cases, in fact, most of the cases, just the environment that we have created, kind of a family culture, in most of the cases——

Ms. HAHN. I would not want my own family to know when I go to the emergency room.

Mr. FARIA. Yeah. I mean, we are hearing that information actually from the employee themselves so that it is not really a situation where we are finding out that through nefarious means. But I will have to say that is an issue. And just like everything, the wrong person with that information can make some bad decisions. But now we are talking almost like fraud or a HIPAA violation. Somebody has to really kind of break the law to really start utilizing that information.

Ms. HAHN. Right. Except you are not a doctor so you have not really taken a Hippocratic oath.

Dr. Blumberg, so in your report, Small Firm Self-insurance under the Affordable Care Act, you present a situation in which a stop-loss insurance plan would pay for all medical costs. The employers would bear no risk and the stop-loss insurance would essentially act as a traditional health insurance without several ACA regulations. Would you elaborate a little bit on that because I am getting sort of mixed messages here about what these stop-loss or these reinsurance companies actually are. Are they just reimbursement financial vehicles or are they, in fact, acting like health insurance?

Ms. BLUMBERG. Sure. And I think the lines begin to blur a bit. And some of it is the increased incentives for these small firms to self-insure under the ACA without other action being taken. And the reason is that most states today do not regulate the definition of stop-loss insurance, and neither does the Federal government. So as a consequence, we are seeing more and more "attachment point" plans being issued. Some regulators in Michigan, for example, informed us that they are seeing not only more stop-loss policy forms being filed with regard to small firm coverage but with much lower attachment points, as low as they have seen $5,000. And so what that means is if there is no regulation that defines what stop-loss means, then you could sell—not that I am saying these folks do, but you could—others could sell a stop-loss plan with a zero dollar attachment point. And what that would mean is essentially it would act as unregulated health insurance. So if the employer that was self-insuring, for example, said I am going to have a $1,000 deductible plan, a zero dollar attachment point on a stop-loss plan would mean that the stop-loss plan would start to reimburse after the individual hit their $1,000 deductible. So when you do not define regulatorily what stop-loss is, then stop-loss can morph into whatever you want it to be.

Ms. HAHN. In terms of what the self-insured employer has—what kind of plan they have created?

Ms. BLUMBERG. Right. So the self-insured employer can decide, okay, as I used as an example, I am going to have a $1,000 deductible plan for my employees with a 15 percent co-insurance on expenses over that just to lay something out simply.

Ms. HAHN. Right.

Ms. BLUMBERG. And then they can go and buy a stop-loss policy that is going to internalize all of the claims that would come into the firm beyond what the individual is required to pay. But because it is referred to as stop-loss and it is sold by a reinsurer, then that means that the individual—the individual firm that is providing a self-insured plan to its workers, is not subject to the regulations, the premium rate regulations, the essential health benefit regulations, the actuarial value rules within the Affordable Care Act for other small fully-insured firms.

Ms. HAHN. So if this—and I know in California, we have actually passed legislation that would prohibit stop-loss insurance from issuing plans with specific deductibles under $35,000 to small businesses with less than 100 employees. So do you think that kind of regulation is helpful?

Ms. BLUMBERG. It is helpful. According to the actuaries at the National Association of Insurance Commissioners who have reevaluated the situation very recently, that $35,000, which is helpful, is still too low in terms of the level at which we want to dissuade more vulnerable small businesses from taking the self-insurance option. And while there are a number of regulations under ERISA to which these small self-insuring firms are subject, as was mentioned earlier, the issue is really that the specific regulations to which they are exempted from are precisely the ones that are changing the way that small group insurance is priced under the Affordable Care Act. So it is not so much the number of them as which ones we are actually talking about. And so that is important

to keep in mind is that once you give people an out to the very rules that determine how risk is shared in a small group market, you can have a very significant effect.

Ms. HAHN. And maybe for the whole panel, how do we strike a balance between the need to protect firms against unexpected costs and the need for an affordable method of insurance for small businesses, including small businesses that choose to go to the exchanges, and how do more self-funded and reinsurance combined, how is that going to affect small businesses going onto the small business exchange?

Does anybody have——

Ms. BLUMBERG. Well, I can comment. There are very direct implications as our analysis showed for those small firms that want to buy fully-insured products. Once you have basically an outlet from the sharing of risk for potentially the healthiest and most financially valued firms. So if you have self-insurance and it is easy to go back and forth, even with some financial risk for the healthy small employers, the implications are that the average risk in the fully-insured market, which is both the exchange and outside of the exchange, the way that a lot of the small employers are buying already today, it ends up increasing their risk very substantially. So the idea is you can salvage the stability and the security of the plans and the average price of the plans that are expected to emerge in the new small group fully-insured market by limiting the number of small employers who would end up going into self-insurance either by increasing the attachment point at which they can buy stop-loss coverage or by prohibiting its sale for small firms.

Ms. HAHN. Thank you. Thank you.

Chairman COLLINS. Well, thank you. Let us see. It is 11:35 and the president is going on the air as we speak announcing that he is going to allow insurance companies to continue to offer plans that have been canceled. We will just see where that ends up, but I guess that is happening even as we speak.

I want to thank all the members for speaking today. This testimony is very timely, and the issues are real. Certainly, Dr. Blumberg does point out that as small employers look to control their own costs, to control their own profits and their future, in doing so there could be a negative impact on the community-rated pools. But I would point out that happens today because the large employers are all self-insured. So when you really look at what is happening today, that segmentation of risk has happened in a huge way because any and all employers with over 500 employees are all self-insured. And so it is just a true statement as people peel out and they manage their own risk as Mr. Faria is managing his and understanding how to incentivize good behavior, going to Urgent Care instead of emergency rooms. As that happens, the pool of folks left in the community-rated pools may get more and more toxic from a standpoint of risk and hence, cost. But there is nothing perfect in life and I think small business exists to produce a product, to make money, to grow their business, create jobs, and anything we can do to help small business create jobs by controlling their costs is, in fact, the biggest benefit that we have and the biggest problem we have in this country today is a lack of jobs. So for that reason I know I am going to and the Committee will certainly

be suggesting to someone—and I will pick the number, over 25 employees—to go out and take a look at self-insurance. It is not going to be perfect for everyone. Buyer beware as was also pointed out. Make sure you have got a good TPA. Make sure that TPA has got a good pharmacy benefit manager. Make sure that you understand your risk on the stop-loss piece, both individually and in the aggregate. And it is going to take time but I certainly, as it is mid-November, would encourage any and all companies. And as I understand it, many could do so and decide to kick it off on April 1st. When they sign up for community plan, generally they are not locked in. So again, I want to thank you all for coming. I think this was very timely and I, to the best of my knowledge, pretty much covered, crossed most of the Ts and dotted the Is.

I will ask unanimous consent that members have five legislative days to submit statements and supporting materials for the record. Seeing no objection, so ordered.

The hearing is now adjourned. Thank you again.

[Whereupon, at 11:18 a.m., the Subcommittee was adjourned.]

APPENDIX

House Committee on Small Business
Subcommittee on Health and Technology Hearing

November 14, 2013

Self-Insurance and Health Benefits:
An Affordable Option for Small Business?

Testimony Delivered By

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INTRODUCTION AND EXECUTIVE SUMMARY

Good morning Chairman Collins, Ranking Member Hahn and members of committee. My name is Mike Ferguson and I serve as President and CEO of the Self-Insurance Insurance Institute of America, Inc. (SIIA). I am pleased to join you here this morning for such an important and timely hearing.

SIIA is a national trade association that represents companies involved in the self-insurance marketplace, including self-insured organizations and their business partners, mostly in the small and midsized market segments and represent both private employers and union-sponsored Taft-Hartley plans.

My testimony this morning will address six general areas that should be of interest to the committee.

- What is Self-Insurance and How Does it Differ from Traditional Health Insurance
- Who Self-Insures
- The ACA and Self-Insurance Trends
- The Advantages and Disadvantages of Self-Insurance
- Federal Regulation of Self-Insured Group Health Plans
- Stop-Loss Insurance Overview and Marketplace Demographic

WHAT IS SELF-INSURANCE AND HOW DOES IT DIFFER FROM TRADITIONAL HEALTH INSURANCE?

Should an organization wish to sponsor a group health plan for its employees or members it has two basic options. The first option is to purchase a traditional group health insurance policy from a licensed health insurance carrier. Under this arrangement, the organization pays the insurance carrier a fixed premium and the carrier provides health care coverage to the group in accordance with specified policy terms. By choosing the traditional insurance option, the organization transfers the health care-related financial and legal risk to the carrier.

The other option is to retain the financial and legal risk through the use of a self-insured group health plan. This is also known as self-funding. Under this arrangement the organization pays eligible health care claims as they are incurred, either directly like other business expenses or through a separate trust. Self-insured employers typically outsource claims administration functions and retain stop-loss insurance as a financial backstop for catastrophic claims.

WHO SELF-INSURES?

According to the 2013 Employer Health Benefits Survey, 61% of covered workers in private employer plans receive coverage through self-insured arrangements. Of more particular interest to this committee is that 16% of small employers with 3–199 workers are self-insured. This is up slightly from 15% in 2012.

But self-funding is not limited to the private employer marketplace. It is estimated that there are about 1200 union-sponsored Taft-Hartley health plans serving a variety of industries and that more than half are self-insured. And again, of particular interest to this committee, many of these self-insured Taft-Hartley plans are small, with as few as 50 to 100 members.

Given these statistics, it's clear the topic of self-insurance is important to both the business and labor communities. And it's also clear is that self-insurance is not simply a privilege for the very largest organizations.

THE ACA AND SELF-INSURANCE TRENDS

Now that I have provided this general background information, let me address a recurring question of what effect has the Affordable Care Act had on the decision process of smaller employers who may be considering self-insurance?

Recent pronouncements by many policy-makers and pundits that by self-insuring organizations are able to bypass ACA regulatory requirements and operate health plans with little or no consumer protections are misleading. As my testimony will demonstrate, smaller organizations that choose to self-insure actually subject themselves to more regulation, not less. In this regard, we respectfully dismiss the conclusion by some that the decision to self-insure is influenced by the objective to "get out of Obamacare."

Rather, it is our view that the ACA is more of an indirect factor in the decision to self-insure for smaller organizations. This more nuanced conclusion is based on the belief that the primary motivating factor of most organizations that have or are considering the self-insurance option is that they want to take more control over the cost and quality of the health benefits they are providing to their plan participants over the longer term.

While we will leave to other stakeholder groups to make broader statements about the merits of the ACA, we believe it is fair to say that the law has created added uncertainty in the health care marketplace and contributes to more acute cost fluctuations, at least in the short run. So in this current post-ACA environment, self-insurance does provide smaller organizations more certainty in their ability to be able to continue to provide quality health benefits along with will providing them better costs containment capabilities.

Now that we have established the size and diversity of the self-insurance marketplace and provided some general commentary on how the ACA has influenced this marketplace, let's talk about the advantages and disadvantages of self-insurance in order to better understand how organizations must consider this plan funding decision.

DISADVANTAGES OF SELF-INSURANCE

It's important to state right up front that self-insurance is not the right option for all organizations. Smaller organizations, in particular, should carefully consider what it means to be self-insured.

Financial Liability

The primary consideration is that as a self-insured organization, you are responsible for paying all eligible health care claims incurred by plan participants. While stop-loss insurance provides for a limited reimbursement mechanism for higher cost claimants, the self-insured organization accepts all financial liability for the group health plans. Simply stated, if you are not prepared to cut checks to pay providers, you should not be self-insured.

Legal Liability

In addition to accepting financial liability, self-insured plan sponsors also subject themselves to significant legal liability. Plan fiduciaries (normally organization executives) are subject to civil and criminal penalties under the Employee Retirement Income Security Act (ERISA) to the extent that plans are not administered in the best interests of the participants. Simply stated again, if you are not prepared to understand and ensure compliance with applicable federal law, you should not be self-insured.

Time and Focus Commitment

While self-insurance allows plan sponsors more flexibility to deliver quality health benefits in a more cost effective way, sponsors commit the necessary time and focus to design and manage their plans in order to achieve the desired results. So the final simple statement is that if you are not willing to make this commitment, you will likely be better off in a traditional, fully-insured arrangement.

ADVANTAGES OF SELF-INSURANCE

There are many reasons why organizations conclude that self-insurance is the best health plan funding option, despite the considerations noted above.

More Cost Effective Than Fully-Insured Plans

A well run self-insured health plan is generally less expensive over time compared with the traditional insurance options. The "over time" caveat is important because claims experience often varies from year-to-year. Traditional insurance premiums must account for the carrier's marketing cost and profit margin, among other cost escalators that are not applicable to self-insured plans, as they are essentially not-for-profit health plans.

Plan Design Flexibility

Federal law provides self-insured plans greater flexibility in designing benefit packages that better meet the specific needs of their plan participants. For example, organizations with a predominately female workforce can structure their plans to incorporate more robust health benefits that would be utilized by female plan participants. Self-insurance plans can also structure more innovative reimbursement arrangements with health care providers.

Improved Cash Flow

Self-insuring allows claims to be funded as they are paid. Fully insured premiums constitute a form of pre-payment. With self-in-

suring, a plan pays health plan costs only after the services have been rendered. Insurers set health insurance premiums at levels that anticipate projected increases in healthcare costs—usually well in excess of the actual rise in costs.

Ownership of Health Claims Data

Health claims data is extremely valuable for plan design purposes. But under traditional insurance arrangements, carriers maintain that they own this data and employers cannot get access to it. By contrast, self-insured organizations have control over this data and can use it to help deliver benefits more efficiently and control costs.

ERISA Preemption of State Regulation

ERISA provides uniform regulatory stability to employers that operate in several states, so those companies do not have to adopt a patchwork of design variations to comply with various states' requirements. This is particularly important for multi-state organizations.

Incorporation of Value-Based Benefits and Wellness Programs

As medical costs have skyrocketed, self-insured plan sponsors have been taking steps to reduce medical costs by emphasizing prevention and maintenance care for chronic diagnoses. Employees have the flexibility to design and integrate into overall strategies, health risk assessments, prevention and wellness programs tailored to the employer's specific employee demographics and needs.

FEDERAL REGULATION OF SELF-INSURED PLANS

Some health care market observers contend that policy-makers should be concerned about employers switching to self-insured health plans and purchasing medical stop-loss insurance in order to "dodge" requirements and fees applicable to fully-insured health plans as provided for by the ACA. They further argue that such a trend will contribute to adverse selection and therefore compromise the viability of the health insurance exchange.

SIIA believes this analysis is inaccurate based on a review of how self-insured plans are actually regulated and the recent findings of the RAND Corporation on this subject.

For purposes of our discussion, we will focus on non-grandfathered self-insured plans, which by definition include organizations who have switched to self-insurance since the passage of the ACA. Non-grandfathered self-insured group health care plans, regardless of stop-loss insurance arrangements, are subject to almost all ACA health care market reforms, including:

- Prohibition on annual & lifetime limits
- Coverage of dependents up to age 26
- Prohibition on discrimination based on preexisting conditions
- Coverage of preventative services
- Summary of benefits and coverage
- Disclosure of plan transparency

- Right to external claims denial reviews
- Limitations on waiting periods
- Right to provider designations
- Mandated coverage of emergency services

Of the few ACA health care market reforms that do no not apply to non-grandfathered self-insured health plans, there are specific reasons why as follows:

Medical Loss Ratio - As self-insured plans are essentially non-profit entities with the fiduciary requirement to use plan assets for the exclusive benefit of the plan participants, there is no "profit margin" to regulate.

Review of Rate Increases - Again, as self-insured plans are non-profit entities and prohibited from using plan funds for any other purpose, sponsors have no incentive to increase rates any more than the rate of increase of medical claims and expenses.

Essential Health Benefits - Existing federal law (ERISA) explicitly declares that self-insured group health plans should not be subject to state law. The ACA delegates the establishment of EHB standards to the states. Self-insured plans are subject to other federal mandates, so if Congress intended these plans to subject to EHB requirement the law would have been drafted accordingly. That said, self-insured groups health plans are subject by the ACA's minimum plan value rules and cannot establish coverage dollar limits on benefits that are deemed to be EHBs. Finally, self-insured employers have a significant human resource incentive to offer quality health benefits.

Self-insured group health plans (grandfathered and non-grandfathered) are highly regulated by other federal laws such as ERISA, HIPAA and COBRA that existed prior to the ACA. Consumer protection requirements/mandates under these laws include:

- Prohibited from denying coverage based on preexisting conditions
- Prohibited from discriminating on cover based on health status
- Mandated internal review procedures
- Privacy protections
- Plan fiduciary standards
- Prohibited from rescinding coverage for non-fraudulent purposes
- Continued access to coverage post job termination

Will Self-Insured Health Plans Contribute to Adverse Selection With Health Insurance Exchanges?

It is SIIA's view that there may be many factors which could contribute to adverse selection among the federal state health care exchanges but the growth in the self-insurance marketplace is not one of those factors.

In support of this view, RAND Corporation concluded in a 2012 report that if small groups have the option to leave the insurance exchanges to self-insure, there would be no negative effects in

terms of pricing for the remaining groups—no adverse selection would result. A key excerpt of the report follows:

> *"However, eliminating the option to self-insure does not substantially reduce premiums on the SHOP exchanges. This is because when self-insurance is not an option, most firms that would otherwise have self-insured decline to offer coverage rather than moving to the exchanges. This result is driven by the assumption that self-insured workers have low health insurance costs relative to wages. Although the majority of people who would otherwise have enrolled in their employers' self-insured plans find coverage elsewhere, these enrollees are spread out across other employer policies, individual exchanges, SHOP exchanges, and Medicaid. As a result, they have little effect on the cost of premiums."*

STOP-LOSS INSURANCE OVERVIEW AND MARKETPLACE DEMOGRAPHICS

Stop-Loss Insurance Overview

As referenced earlier in this testimony, virtually all smaller and mid-sized self-insured organizations retain stop-loss insurance to provide a financial backstop to guard against catastrophic claims. In this regard, I believe it would be useful to clearly explain what stop-loss insurance is and how it differs from traditional health insurance as it is more closely related to liability insurance products than health insurance products.

Quite simply, stop-loss insurance provides financial reimbursements to self-insured organizations for health care payments that exceed pre-determined levels, known in the industry as "attachment points." Stop-loss policy attachment points can either be for specific plan participants and/or for total claims incurred by the plan, known as "aggregate."

Unlike health insurance, stop-loss insurance does not cover individuals nor pay health care providers regardless of attachment point levels. It can only reimburse the sponsor or the plan for health payments in excess of the attachment point.

Stop-Loss Insurance Marketplace Demographics

Milliman released a report earlier this year commissioned by the Self-Insurance Educational Foundation (SIEF) highlighting key policy characteristics found in the U.S. employer medical stop-loss (ESL) market. The underlying policy data was provided by eight of the largest stop-loss carriers which collectively represent approximately 50% of the market. Milliman therefore assumed that the data is a reasonable approximation of the entire ESL market. A summarization of this data revealed the following:

- Employers with 100 or fewer covered employees represent approximately one-quarter of the ESL market if the market is measured by count of employers. If measured by covered employees, however, that same segment represents only 2% of the ESL market.

- Most ESL purchasers obtain both specific and aggregate stop-loss. However, employers with over 1,000 employees are more likely to purchase specific stop-loss without aggregate. Very few employers found in the underlying data purchased aggregate coverage without specific stop-loss.
- The data included employers that purchased specific deductibles ranging from $5,000 to $2,000,000. However, 81% of employers purchased deductibles of $50,000 or greater.
- The median specific deductible found in the calendar year (CY) 2012 data across all plans was $80,000. For groups with 50 or fewer covered employees, the median deductible was $35,000. For groups of 51–100 employees, the median was $45,000.
- Less than 0.2% of specific stop-loss policies had specific deductibles of $10,000 or less. About 0.3% of specific stop-loss policies were written with specific deductibles of less than $20,000.
- The data included employers that purchased aggregate corridors ranging from 110% to 200% of expected claims. By far, the most common corridor (found on 90% of policies with aggregate coverage) was 125% of expected claims.

CONCLUSION

In conclusion, I would like to thank the committee again for this opportunity to provide input on the increasingly important topic of self-insurance and I look forward to addressing any questions you may have. Additional Information about self-insurance can be accessed on-line at www.siia.org.

Testimony of Robin P. Frick
on behalf of the National Association of Health Underwriters before the
U. S. House of Representatives Small Business Committee
Health and Technology Subcommittee
Hearing on
"Self-Insurance and Health Benefits: An Affordable Option for Small Business?"
November 14, 2013

Good Morning. My name is Robin Frick and I am a licensed professional health insurance agent from Slidell, Louisiana. I serve the health coverage needs of my clients by helping them purchase, administer, service and utilize health insurance policies and other related benefits. I have spent my entire career helping businesses design and implement self-funded benefit plans for their employees. Many of the clients I have worked with are very large employers, but many are also employers that would fall under the jurisdiction of both this committee and the United States Small Business Administration.

I would like to thank the House Small Business Committee and, in particular, Chairman Graves, Ranking Member Velazquez, Subcommittee Chairman Collins and Ranking Member Hahn for inviting me here today and for electing to hold this public hearing. As a result of not only the passage of the Patient Protection and Affordable Care Act (PPACA), but also the ever-increasing cost of medical care and the economy in general, our private health insurance market options are changing. Employers of all sizes are responding to these changes, so I appreciate your committee's recognition of the issue and bipartisan willingness to bring it to the public's attention.

I am here on behalf of my professional association, the National Association of Health Underwriters (NAHU), which represents approximately 100,000 health insurance agents, brokers, general agents, consultants and other employee benefit specialists from all over the United States. I have been involved with NAHU and its Louisiana affiliate since I began my career in the insurance industry in 1999. I am a past president of the Louisiana Association of Health Underwriters and am honored to currently serve as a member of NAHU's Legislative Council. All of the members of NAHU work on a daily basis to help millions of individuals and employers with their health insurance coverage needs. A significant portion of our membership is like me and helps employers develop and administer self-funded health plans for their employees. As such, I am happy to share our experiences with you with regard to this market.

I would like to state up front that the appropriateness of a self-funding arrangement is not determined by the particular size of any business. While group size is one factor that an employer and their licensed employee benefit advisor considers as part the self-funding determination process, it is only one of many.

NAHU recognizes and appreciates that this hearing may stem from the desire to protect small employers from inappropriate financial exposure. As licensed benefit professionals, NAHU members share your concern and extend it to our employer clients of all sizes. Our members have a legal obligation to explain all possible benefit plan options to their clients and educate them about the risks and advantages of each type of plan design. State-licensed agents and brokers must protect their clients and develop benefit plans that best meet their clients' financial and coverage needs, or face both civil and criminal penalties. As an association, we have significantly increased our professional-development offerings regarding self-funding and stop-loss coverage options in recent years.

NAHU has always stood for choice in private health insurance coverage markets. We believe the public is best served when there are many difference kinds of private health insurance market options available to consumers, and that all consumers should have direct access to licensed benefit professionals who can help them determine which coverage options best meet their specific needs and budgets. We also feel that the dynamic private market is the best way to

offer innovation in health coverage to all Americans and have always supported the right of employers to offer, or not offer, health insurance coverage and other employee benefits. We encourage the development of policies that will continue to allow both employers and individuals to choose the benefit options that are most appropriate for them, and self-funded coverage is one of those options.

Choosing to self-fund a health benefit plan is very different than purchasing traditional, fully insured health insurance coverage. In an entirely self-funded arrangement, the employer assumes the financial risk for providing medical benefits to its employees rather than paying a monthly set premium to an insurer that bears the risk. The employer generally utilizes the assistance of a third-party administrator to handle customer-service issues, pay and administer claims, manage networks and utilization, contract with pharmacy benefit managers, and handle other compliance duties. In most cases, including virtually all smaller employers that make the decision to self-fund, complementary stop-loss insurance coverage is purchased by the employer to mitigate the financial risk. Generally, such stop-loss coverage is written to provide employers with protection in two ways. One protects the employer against a specific high claim by any one individual and is known as the "specific" or individual deductible. The other is to protect the employer against the total amount it could pay in claims for all beneficiaries during the contract period, which is known as the "aggregate" deductible. Occasionally, employers may determine that only specific stop-loss coverage meets their need for protection, but this is fairly rare and almost all stop-loss coverage sold includes both individual and aggregate claims protection for the employer.

The decision to self-fund coverage is not one to be taken lightly by an employer of any size and represents a multi-year commitment. For administrative reasons alone, an employer would not be able to hop in and out of the self-funded market on a year-to-year basis. The choice to self-fund means that the employer has absorbed a big administrative obligation and has substantially changed its health benefit offerings. It's also not a change an employer can make on its own. The assistance of a state-licensed professional who is legally obligated to help the employer weigh all possible options is required to implement a self-funded benefit plan offering.

The decision whether or not to offer employee benefits through a self-funded arrangement, as well as the decision of whether or not to purchase stop-loss coverage and the type of stop-loss coverage that may be purchased, is also a highly variable decision and depends on the unique needs of each employer. While many of our nation's largest businesses use self-funded arrangements to provide coverage, not all do. A smaller employer with significant cash reserves might be much more suited to a self-funding arrangement than a company five times its size in a different financial position.

An informed decision to self-fund is not based on the perceived youth or health of the employer group's risk pool, either. While claims experience certainly plays a large part in the costs of and decision-making process surrounding self-funding a health plan, there is no way for an employer to gauge for certain the long-term health of a group of varying employees.

There are many benefits to self-funding, including the ability to create plans that address the specific needs of the workforce and the ability to incorporate unique and often cost-saving features that employees truly appreciate, such as worksite clinics, significant wellness initiatives and disease-management programs, among others. However, there are risks an employer must absorb too. When making the choice to self-fund a health plan and purchase accompanying

stop-loss coverage, each employer must weigh its ability to spread risk, the needs of its employees, the company's specific financial position, its risk-tolerance, its administrative capabilities and many other factors.

NAHU members do report an increased interest in the self-funded arena from employers of all sizes since the passage of PPACA. However, we think it is very important to note that increased interest in the marketplace will not necessarily translate into a long-term increase in the number of self-funded groups.

We also believe it is important to note that increased interest in self-funded arrangements on the part of employers both large and small is not a new phenomenon. When individual states have taken action over the years to significantly alter their health insurance marketplaces, employers and the self-funded insurance marketplace have responded just as they are right now. Interest in self-funding is exacerbated when factors like coverage pricing, plan design and employer flexibility appear to be uncertain. At the state level, we have seen this trend occur time and time again.

PPACA's national health reforms are different than state-level market reforms in many key ways though, which may account for even greater interest. First of all, PPACA is much larger in scope than any state-level market reform ever attempted previously, including in Massachusetts, and it impacts every single state in the union, not just one. Further, at the state level, insurance reforms were often phased in over multiple years to avoid market instability and allow for unintended market consequences to be worked out. However, PPACA calls for an unprecedented number of insurance market changes and employer requirements to take effect all during the coming plan year.

We believe that the new awareness of the self-funded and stop-loss marketplace stems from anxiety on the part of most employers about the changes the new health law may bring to their employee benefit offerings. This same anxiety is causing employers to consider dropping their coverage altogether as well as investigate any other new means of providing coverage to their employees that the private market may offer, including offering coverage through new private exchange options. One reason employers of all sizes are considering self-funding when they haven't in the past is the new national health insurance tax, which only applies to fully-insured plans and will increase premiums by an average of $500 per family in 2014. Another is the looming "Cadillac tax," which will place an excise tax on plan offerings with higher premiums. While this tax will apply to all types of group plans in 2018 and beyond, employers may feel that they have more control over premiums and benefit offering s with self-funded coverage. Finally, changes to the way health insurance premiums will be rated and structured in the years ahead is having an impact on the interest in the self-funded marketplace. Fully insured rates for 2014 have been loaded to accommodate the unknown risk, thereby causing employers to review all possible options to gain better control of their costs and the benefit designs they offer.

However, we feel it is important to note that self-funding a health plan does not allow employers to escape the impact of health reform. Most of PPACA's market protections apply to all employer group health plans, regardless of how they are financed. Further, some protections, like non-discrimination testing, already apply to all self-funded plans, and these rules have not yet been enforced on the fully insured marketplace. The Department of Health and Human Services has also provided health insurance participation and contribution requirement relief to employers who buy fully insured group coverage for employees to ensure that they will be able to meet the law's shared employer responsibility requirements. This relief does not extend to employers that choose to self-fund their health plans and are subject to the employee-participation and contribution requirements of stop-loss issuers.

Furthermore, at the end of the day, we don't see employers that actually make the decision to self-fund their benefit plans doing it merely to skirt looming regulatory changes. Instead, they are making this monumental decision to be able to continue to provide their employees with the benefits exactly needed, especially for recruitment and retention. The bottom line is vastly important, but gaining control of how dollars are spent and benefits that are offered is just as important for these employers.

While there may be greater interest in self-funding and stop-loss plans among small employers at the current time than there has been in the past, this type of coverage is still relatively rare amongst very small employers. Most stop-loss carriers do not offer coverage to groups of under 50 lives, which in the health insurance space has been the typical legal dividing line between a large employer group and a small employer. Some companies do market to smaller groups, but that has always been the case, particularly in the states that already had a highly regulated fully insured group market prior to the passage of PPACA.

The majority of stop-loss carriers nationally still focus on groups of 100 or more lives and some even set a minimum deductible level because claims experience generally is not considered stable enough or "credible" for smaller employer groups. While some claims credibility may be given to smaller groups, it will take group growth both in the number of lives covered and months under a self-funded arrangement for more weight to be given to a group's claims credibility. Then attachment points can be based on the aggregate claims factors plus the overall employee benefit marketplace "trend."

In the past year or two, growing interest from employer groups on alternate funding mechanisms has led to some self-funded marketplace innovation. We have seen some national carriers develop "hybrid"-level funding plans that look more like traditional fully insured group health coverage than self-funded plans have previously. These products can ease the transition from fully insured to self-funding for smaller employer groups and for larger employer groups that have not been self-funded previously. These plans offer smaller and mid-market employers stable premiums and provide rebates at the end of the year if claims are under a certain threshold. But if claims exceed the specified threshold, there is liability for the employer. All employers appreciate the fixed costs on a month-to-month basis these options provide, however, the larger employers tend to more easily tolerate claims volatility.

As the market changes over the time, we expect that carriers may develop even more new hybrid products that offer greater protection to smaller-employer groups. Where we really see the increased possible trend will be with what we in the industry refer to as "mid-market employers" with between 50-250 employees. In particular, we expect more hybrid products to hit the marketplace to serve groups from 50 to 100 employees over the next few years, because the health reform law will require that all employer groups of this size transition from being regulated as large employers for health insurance purposes to small employers in 2016. The premiums for these groups will no longer be based on their claims experience and these groups will become subject to the law's essential health benefit requirements and other plan-design specifications. We expect that when employers of this size become fully aware of the significant change in regulation relative to their benefit plans, increased interest in self-funding will occur among these employers and the market will respond. That doesn't mean that all, or even most, employers of this size will ultimately elect to self-fund their benefit plans, but we do expect even more attention to be paid to that possible option.

As this committee is probably well aware, self-funded employer groups are not subject to state-level insurance regulation and are instead subject to the Department of Labor's federal regulatory authority as per the Employee Retirement Income Security Act (ERISA). However, the stop-loss policies that almost always accompany a self-funding arrangement for small employers are regulated by state departments of insurance. State insurance regulators, who are the experts in both their field and in the unique market variances of their states, have a variety of means at their disposal to regulate stop-loss policies sold in their states as they feel is warranted. The means they may use include not just regulating stop-loss-specific and aggregate deductible amounts, but also the market conduct of stop-loss insurers and agents operating in their states. State regulators have the ability to hold agents like me who help employers design and implement self-funded plans legally accountable for the advice we provide to clients. If past history is any indication, they will show no hesitation in enforcing the law and regulating agent conduct if warranted.

As I stated earlier, our membership reports almost universally that the looming PPACA-related market changes are causing significant anxiety within the employer community. Employers large and small are looking at all possible ways to gain greater control over their employee benefit options. We believe this need for control has sparked a greater interest in the possibility of self-funding among the small and mid-sized employer community. Similarly, it has sparked new interest by employers large and small in other unique means of providing coverage, such as through PEOs or defined-contribution arrangements via private exchanges. It's also causing employers of all sizes to reduce the hours of certain types of workers and consider the possibility of dropping coverage altogether.

As the implementation of PPACA moves ahead in the coming year, we hope that Congress and this committee will consider providing additional flexibility to employers of all sizes to help relieve their anxiety and ensure that they can continue to provide affordable and stable coverage options to employees. Some of the changes to the law we believe are critical for small-business owners could be achieved by immediate action on the following bipartisan measures:

- H.R. 2995, The Unnecessary Cap Act of 2013, which would repeal the arbitrary $2,000 deductible cap on small-group health insurance policies
- S. 1188, H.R. 2988 and H.R. 2575, all of which would allow American business owners to use the traditional definition of 40 hours a week as "full-time" when offering health insurance benefits
- H.R. 763, H.R. 3376 and S. 603, all of which would repeal or delay the new national health insurance premium tax that will cost families in fully insured health plans an average of $500 a year in 2014 and more in each successive year
- H.R. 544, The LIBERTY Act, which allows states to determine the age discount in their insurance markets
- H.R. 2328 and S. 650, which will ensure that employers and consumers have access to licensed professional health insurance advisors

I truly appreciate the opportunity to provide testimony to your committee today. I consider it a huge honor to be here and a privilege to be able to inform you, our elected representatives, how the self-funded health insurance marketplace works for employers both small and large. If you have any questions, or if I can be of additional assistance to you as you continue your important work representing American small-business owners, please do not hesitate to contact me. Thank you.

House Committee on Small Business
Subcommittee on Health and Technology Hearing

November 14, 2013

Self-Insurance and Health Benefits: An Affordable Option for Small Business?

Testimony Delivered By

Thomas Faria
President and CEO
Sheffield Pharmaceuticals
www.sheffield-pharmaceuticals.com

INTRODUCTION AND EXECUTIVE SUMMARY

Good morning Chairman Collins, Ranking Member Hahn and members of committee. My name is Thomas Faria and I am President and CEO of Sheffield Pharmaceuticals. I would like to thank you for this opportunity to speak with you today with regards to my experience on utilizing self insurance options to provide affordable health insurance to the employees of my company. I believe that self insurance can be a powerful option to help the right small businesses understand and control the continuously growing burden of health care costs.

My Testimony this morning will address four general areas that should be of interest to the committee.

- A brief background on Sheffield Pharmaceuticals
- Sheffield's experiences that led it to decide to self insure
- Sheffield's experience with self insuring
- My opinion on and examples of the benefits of self insurance for small businesses

COMPANY BACKGROUND

Sheffield Pharmaceuticals is a family owned, mid-sized manufacturer of over the counter toothpastes, creams and ointments located in New London, Connecticut. Sheffield has a proud history of manufacturing in New England with the company originally being founded in 1850 by its namesake Dr. Washington Wentworth Sheffield, the man who is also credited with being one of the first inventors of toothpaste. For over 160 years Sheffield has strived to provide quality, affordable, domestic made health and beauty products to the American consumer. Today, Sheffield manufactures and sells over 22 different types of tubed drug products to every major retail and discount store chain in the country. Over the past decade Sheffield has grown to a company with roughly $30 Million in revenue and an employer of 162 workers. Sheffield provides health insurance to 75 of these employees and their families.

SHEFFIELD'S DECISION TO SELF INSURE

Like all big and small businesses, every year at the beginning of spring, Sheffield would evaluate its health care costs and send its health insurance plan out to bid to try to gather competitive quotes. While, every year a modest increase was expected, starting in 2005 the increases began to average over 10% per year. At times we would look to lessen the blow of this increase by either increasing the employees' share of premiums or by cutting back on some of the benefits. This worked somewhat effectively until 2008. In that year, a small amount of employees in the company experienced significant health issues which drove our utilization up. In response, our existing health insurance provider increased our rates 25%. This was followed up in 2009 when our provider told us that due to our high utilization our rates would increase 39% while other providers quoted higher. The company began at that point earnestly looking at Self Insurance as a viable option. We weighed

the potential positive benefits of being able to gain greater awareness and mastery of our total health care costs versus the potential negatives of not having a fixed cost to budget along with the potential for a catastrophic occurrence to severely impact our costs. We knew that, due to the relatively good health of our employees, the odds of having another high utilization year were very low. When we asked our insurance broker if he expected the insurance provider to reduce premiums following a better utilization year and he answered no, the decision to move to self insurance became an easy one for the company.

SHEFFIELD'S EXPERIENCE WITH SELF INSURANCE

While switching to self insurance provided a new set of challenges and has at times been a bit nerve racking in high utilization years, our decision to self insure has been a good one. Based on estimates of the yearly average increases that the traditional health care plans charged in Connecticut for plans of our size, we believe that self insuring saved the company over $400,000 over the span of four years (see exhibit A). This dollar figure amounts to roughly a 19% savings over the expected costs of insuring traditionally during this period. Our success with self insurance has allowed the company to realize savings which have allowed it to still provide "Gold" caliber insurance coverage to its employees that covers 75% of the total health care costs, all while holding the overall costs to the employees in check.

BENEFITS OF SELF INSURANCE TO SMALL BUSINESSES

There are many benefits that self insurance can have for businesses that have the right conditions and mindsets to utilize it. First, as shown above, self insurance can have the ability to save individual business plans considerable costs. This however comes at the expense of having health insurance costs fixed for a period time. Secondly, it allows access to cost data that can show not only where a company spends it health care dollars but also allows for comparison against national norms. When a company knows these costs it becomes more responsible for them. Thirdly, this cost transparency can allow a business to develop its individual plan to educate and incentivize its consumer activities to most efficiently use health services, reducing both the business's, consumers' and overall health system's costs. Finally, self insurance encourages companies to invest now in education, incentives for healthy6 living and preventative care to help promote long term healthy behavior changes in its workforce. This leads to better lives for their workers and hopefully can help stem off major and expensive health issues in the future.

A perfect example of the benefits of the transparency that self insurance provides small business occurred when after a year of utilizing self insurance we examined our data on health costs. The data showed that our employees had a higher utilization of the Emergency Room than what should have been expected. Further analysis showed that some employees were utilizing the ER for non

emergency care items that normally should be handled by a physician, who typically charges a quarter of what hospitals do. By doing this, not only were these employees unknowingly increasing the costs to themselves and the plan but also they were negatively impacting their future health by not creating a regular relationship with a primary physician. By adjusting our plan to incentivize employees to find and utilize physicians instead of the emergency room, Sheffield was able to use its health data in a way that reduced overall employee and plan costs while also benefiting the current and future health of its employees.

As an example of how self insurance motivates companies to invest more into the health of its employees, once Sheffield had committed long term to being self insured, we established several programs aimed at educating and incentivizing healthy habits amongst our employees. Along with paying for yearly physicals, Sheffield also rewarded employees who received yearly physicals with reduced premiums. This allowed employees and their physicians an opportunity to develop a health history and address potential major health issues before they occur. In addition to the physicals, Sheffield has developed rewards programs for employees that work towards maintaining healthy biometric levels, including cholesterol, blood pressure, body mass index and smoking activity. By addressing these important health factors now we believe our employees' future health can be dramatically improved. I do not believe that if Sheffield was in a traditional insurance plan we would have invested in these activities as the present day costs would have not translated into long term savings in a traditional plan.

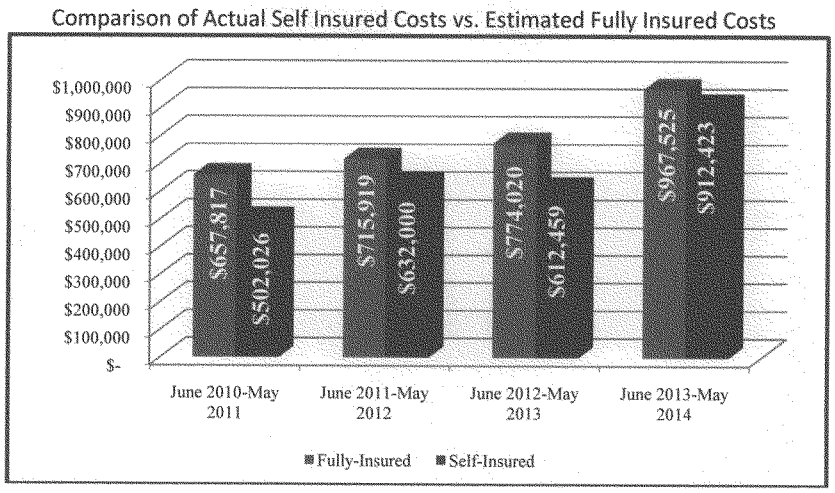
CONCLUSION

In conclusion, I would like to thank the committee for the opportunity to speak with you on a topic that I believe can and should be an important part of helping solve America's health insurance woes.

Sincerely,

Thomas Faria
President and CEO
Sheffield Pharmaceuticals

Exhibit A


Comparison of Actual Self Insured Costs vs. Estimated Fully Insured Costs
$1,000,000
$900,000
$800,000
$700,000
$600,000
$500,000
$400,000
$300,000
$200,000
$100,000
$-
$657,817
$502,026
$715,919
$632,000
$774,020
$612,459
$967,525
$912,423
June 2010-May 2011
June 2011-May 2012
June 2012-May 2013
June 2013-May 2014
Fully-Insured
Self-Insured

November 2012

Issue Brief

Small Firm Self-Insurance Under the Affordable Care Act

Matthew Buettgens and Linda J. Blumberg
The Urban Institute

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

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Commonwealth Fund pub. 1647
Vol. 30

ABSTRACT: The Affordable Care Act changes the small-group insurance market substantially beginning in 2014, but most changes do not apply to self-insured plans. This exemption provides an opening for small employers with healthier workers to avoid broader sharing of health care risk, isolating higher-cost groups in the fully insured market. Private stop-loss or reinsurance plans can mediate the risk of self-insurance for small employers, facilitating the decision to self-insure. We simulate small-employer coverage decisions under the law and find that low-risk stop-loss policies lead to higher premiums in the fully insured small-group market. Average single premiums would be up to 25 percent higher, if stop-loss insurance with no additional risk to employers than fully insuring is allowed—an option available in most states absent further government action. Regulation of stop-loss at the federal or state level can, however, prevent such adverse selection and increase stability in small-group insurance coverage.

* * * * *

OVERVIEW

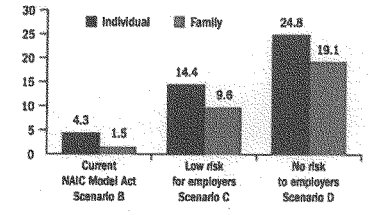
The Patient Protection and Affordable Care Act will substantially change the organization and market rules of the small-group insurance market, beginning January 1, 2014. Reforms focus on improving access to and adequacy of coverage, while increasing transparency and accountability of insurance products, but will also significantly increase the sharing of health care risk across employers and their workers. Through modified community rating, provision of essential health benefits, prohibition of preexisting condition exclusions, and increased standardization of cost-sharing burdens via defined actuarial value tiers, fully insured small-group coverage under the Affordable Care Act is expected to create more stable premium pricing from year to year and across groups, regardless of the health status of the workers and their dependents. However, broader based sharing of risks means that small employers with younger and healthier employees than average or those that have purchased more narrow benefits in the past

may experience somewhat higher premiums, at least at a point in time.

While the law introduces these reforms nationally into the fully insured small-group market, they do not apply to self-insured group plans, regardless of the size of the employer. This exemption provides a potential avenue for small employers with healthier worker and dependent profiles to avoid participating in the broader-based insurance risk pools and instead take advantage of experience rating as a self-funded plan. In addition, because the fully insured small-group markets will be guaranteed issue with limited waiting periods and no preexisting condition exclusions allowed, small employers could self-insure during "good" times, accruing savings from having healthier-than-average employees, then enter the fully insured market during "bad" times, and again accrue savings from having their higher medical costs shared by the wider small-group market. If permitted, this dynamic will create adverse selection in the fully insured market, where higher-than-average risks concentrate in particular plans or markets, increasing their relative costs and potentially compromising their viability.

This analysis uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to estimate the magnitude of the effect of adverse selection of small-group self-insurance on premiums and coverage in the fully insured market under the Affordable Care Act. We compare the extent of self-insurance and its implications under several policy scenarios within the auspices of state and federal legal authority, demonstrating the sensitivity of likely outcomes to regulatory limits on the structure of private stop-loss policies that are generally necessary to make small-firm self-insurance feasible. We find that if states or the federal government do not effectively regulate stop-loss policies or restrict access to stop-loss policies for small employers, coverage in fully insured small-group insurance will be substantially lower and premiums will be significantly higher. Without such steps, new incentives created by the Affordable Care Act will increase self-insurance among small employers, drawing many of the healthier firms out of the fully insured market and increasing premiums for those who remain. However, if the stop-loss parameters recently recommended by an actuarial subgroup of the National Association of Insurance Commissioners (NAIC) are uniformly adopted, such adverse selection would be prevented.

Exhibit 1. Percentage Difference in Small-Group Fully Insured Premiums Compared with the NAIC Actuarial Subgroup's Recommendation



Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012. Simulations done as if the Affordable Care Act was fully implemented in 2012.

The NAIC's actuarial subgroup recommends that stop-loss deductibles—also known as "attachment points"—be set at a minimum of $60,000 per insured individual. The suggested parameters would expose small employers to significant financial risks if self-insuring and would dissuade the vast majority from doing so. As a result, under this approach, average premiums in the fully insured small-group market would be lower than under a scenario with looser stop-loss regulations or none at all. If these recommendations were implemented in a uniform manner nationally, average fully insured small-group premiums under the law would be up to 25 percent lower than could be the case otherwise. Exhibit 1 shows the difference in average fully insured small-group single and family premiums under the range of stop-loss scenarios modeled in this brief compared with the NAIC actuarial subgroup recommendations. For example, if the Affordable Care Act was fully implemented today and small employers were allowed to purchase stop-loss coverage that imposed no additional risk to employers than fully insuring (an option available in most states absent further government action), average single premiums in the fully insured market would be about 25 percent

Glossary

Reinsurance or stop-loss coverage in the context of this brief is insurance purchased by a self-insuring employer to reduce the financial risk of providing health benefits to the workers and dependents in that firm. The employer purchases a reinsurance policy that details the conditions under which the reinsurer will pay a portion of the health care claims incurred by the group. The employer pays a premium to the reinsurer, and then issues insurance policies to its own employees. The reinsurer may be a firm that only sells reinsurance or it may be an insurance company that also sells fully insured traditional insurance products.

Attachment points are the deductibles specified in reinsurance policies. For example, a reinsurance policy with a $20,000 individual attachment point would cover all health care claims incurred by the firm's worker in excess of $20,000. Reinsurance policies often have aggregate attachment points as well, which define the level of claims summed over all enrollees that would trigger reimbursement by the plan.

Small-group thresholds define the employer size below which a firm is eligible to buy insurance that is subject to regulations applying to the fully insured small-group market. Prior to full implementation of the Affordable Care Act, most states define their small-group markets as including employers of 50 workers or fewer. Beginning January 1, 2016, the law requires the small-group threshold be set at 100 workers or fewer; however, the law allows states to set the threshold anywhere from 50 to 100 in 2014 and 2015.

Self-insured health plans are those in which the employer takes on the financial risk of providing a defined set of health care benefits to the firm's employees and dependents. A self-insuring employer pays directly for the claims incurred by the plan's enrollees, as opposed to paying a set premium to an insurance company. Self-insuring employers may purchase reinsurance policies as a way to reduce their exposure to the financial risks of self-insuring.

Fully insured group health plans are those in which the employer pays a premium per covered worker to an insurance company and the insurance company takes on the financial risk of providing a defined set of health care benefits to the firm's employees and dependents.

higher and average family premiums about 19 percent higher than under the subgroup recommendations.

Accepting the subgroup recommendations for minimum stop-loss parameters will lead to significantly lower average premiums in the fully insured small-group market. In addition, the recommendations would create more stability in insurance coverage by substantially reducing employers moving between self-insurance and fully insured plans and by providing greater consistency in insurance benefits provided to workers in small firms. While setting requirements for stop-loss insurance in this way will increase premiums for particular small employers at a point in time (e.g., some will be unable to self-insure during low-cost years), the approach will significantly lower their premiums in years when their health care costs or the health experience of their workers or the workers' dependents have worsened, and will improve the stability, accessibility, and long-term viability of the small-group market for all small firms. Alternatively, requiring that self-insurance sold to small employers comply with regulations in the fully insured market or prohibiting the sale of self-insurance to small employers would have similar effects as the regulation of stop-loss parameters.

BACKGROUND

Health insurance plans offered by employers to their workers can be divided into two broad categories: self-insured and fully insured. In fully insured plans, employers pay a premium to an insurer, which reimburses providers for an agreed upon portion of the medical costs incurred for covered benefits for enrolled workers and their dependents. Fully insured plans are subject to state insurance market regulations. In self-insured plans, the employer is liable for the incurred medical expenses within the parameters of coverage defined for the plan. Because of the Employee Retirement Income Security Act of 1974 (ERISA), self-insured plans are not subject to state insurance market regulations. Importantly, because of the risks of incurring very large claims in a given year, all but the very largest self-insuring employers reduce their risk of exposure to claims costs by purchasing stop-loss insurance from a reinsurer. Stop-loss coverage is generally defined in terms of two deductibles, or "attachment points." The specific deductible applies to the claims costs of each individual covered under the plan. For example, if the specific deductible is $10,000 and an individual incurs $15,000 in claims during the year, the reinsurer will pay the $5,000 in excess of the deductible. The aggregate deductible sets a limit on the total claims costs for which a firm is liable, applying to the claims of all covered lives under the plan, after the specific deductible is applied to each individual's claims.

Hence, the stop-loss deductibles of a self-insuring firm's reinsurance plan determine the firm's risk of liability for high claims costs. Current stop-loss plans generally require firms to accept a significant amount of risk, so self-insurance is much less common among small firms than among large ones. Slightly less than 12 percent of firms with fewer than 100 workers who offer some health coverage offer at least one self-insured plan.[1] For firms with 500 or more workers, this figure rises to slightly less than 90 percent. Small firms that currently self-insure do so for several reasons. There is evidence that small firms that self-insure do not have lower-than-average costs. For example, the 2012 Employer Health Benefits Survey from the Kaiser Family Foundation and Health Research and Educational Trust found average self-insured premiums for small firms to be higher than average premiums for fully insured small firms, though the difference was not statistically significant.[2] This finding suggests that small firms may self-insure to provide more comprehensive benefits than are typically found in the fully insured market.

While self-insurance among small employers is not widespread today, the Affordable Care Act significantly changes the incentives to self-insure beginning in 2014 by exempting self-insured plans from several provisions. Most important:

- Under the law, fully insured small-firm plans will be priced according to modified community rating. Claims experience rating, now common, will not be allowed. Self-insurance will provide an experience-rated option to healthy small groups post-reform. Fully insured plans will also continue to be guaranteed issue and guaranteed renewal, as is required under the Health Insurance Portability and Accountability Act of 1996; these rules do not apply to reinsurance plans. In addition, only fully insured plans are subject to the Affordable Care Act's medical loss ratio requirements, the requirement that carriers explain and provide support of large premium increases, and risk-pooling strategies like risk adjustment and risk corridors.
- Essential health benefits and standardized cost-sharing tiers based on actuarial value will not apply to self-insured plans but will apply to fully insured small-group plans. Many firms currently seeking richer benefits in self-insured plans will be able to purchase benefits consistent with their preferences in the fully insured market under the law, while firms with healthy workers may seek out self-insurance options to offer more parsimonious plans that do not meet the Affordable Care Act's standards.

- The law includes an insurer fee—a fixed amount to be collected each year—which is allocated according to covered lives. Self-insured plans are exempt from this fee, which will essentially be a premium surcharge of 2 percent to 4 percent on fully insured plans.[3]

Thus, firms with lower-than-average-cost workers will be more likely to save money by self-insuring beginning in 2014. If a small-group self-insured firm's claims costs rise, the firm can move to the fully insured market at any time, as the exchanges will have rolling enrollment, although the employer will still be liable for claims already incurred. Many industry experts are concerned that if low-risk stop-loss plans are available to small employers when the full provisions of the law come into effect, the fully insured market could end up being a magnet for bad claims risk with healthier risks diverted to self-insurance. As a result, we could see higher premiums and decreased stability in the fully insured market.

The federal government does not currently regulate stop-loss insurance. Only a minority of states—approximately 20[4]—do so. A few states ban sales of stop-loss policies to very small firms, virtually eliminating self-insurance among them. For example, New York bans stop-loss for firms with fewer than 50 workers. Other states set minimum standards for stop-loss deductibles, essentially ensuring that a certain degree of risk is part of any stop-loss policy. In 1995, the NAIC adopted a model state law regarding the regulation of stop-loss insurance. To date, only six states have enacted it in full, although other states have passed other forms of stop-loss regulation. Even among states that currently regulate, many allow attachment points below $20,000.[5] An actuarial subgroup of the NAIC is considering updating the stop-loss model act to reflect increases in medical costs.[6]

In this brief, we use the Health Insurance Policy Simulation Model (HIPSM) to model the self-insured and fully insured markets for small-firm health insurance under a variety of stop-loss scenarios, ranging from requiring firms take on substantial risk, consistent with the recommendations of the NAIC actuarial subgroup, to no risk at all—that is, nominal stop-loss policies that cover virtually all claims costs. In the absence of state regulation, the latter types of policies are expected to be sold. We examine the magnitude of adverse selection in fully insured small-firm premiums that would occur at various self-insurance risk levels.

An earlier study by RAND also used a micro-simulation model to examine small-firm self-insuring decisions.[7] However, the main scenario assumed specific stop-loss deductibles exceeding $75,000 and aggregate deductibles of $2 million. There was an alternative simulation in which the attachment point was $20,000, but even this is much higher than many stop-loss policies currently marketed to small firms.[8] RAND states that self-insurance could be far more common if insurers offer "policies geared specifically toward small firms that wish to avoid regulation," but did not model such policies. Also, this study does not appear to include the insurer fee.

RESULTS

We simulate scenarios for stop-loss attachments points, representing the full spectrum from large financial risk to small employers to no risk at all. Results simulate the impact of the Affordable Care Act as if fully implemented in 2012. (See Methods for a description of the HIPSM model and the methods used here.)

Scenario A: Recent Recommendations of an NAIC Actuarial Subgroup

An actuarial subgroup of the NAIC has recommended minimum stop-loss deductibles based on a study by Milliman.[9] Essentially, the recommended minimums were tripled from the prior recommendation. Following this approach, the specific stop-loss applying to any single individual would be $60,000, and the aggregate stop-loss applying to the group as a whole would be the maximum of: a flat amount of $60,000, $15,000 per group member, and 130 percent of expected claims. The risk involved in this stop-loss scenario is notably higher than many packages currently being marketed to small firms.

Because of the large financial risk, we estimate that in the context of the Affordable Care Act, less than 2 percent of policies issued to workers in firms with 50 or fewer workers would be self-insured (Exhibit 2). In firms with 51 to 100 workers, we estimate that 4 percent of single and 5 percent of family policies would be self-insured under these parameters. Only 600,000 people—2 percent of the small-employer market—would be covered by small-group self-insured policies, or 207,000 single policies and 153,000 family policies, which cover 2.6 people on average.

Average premiums in the self-insured market are 63 percent and 70 percent of average premiums in the fully insured market under this reinsurance scenario, for single and family policies respectively. However, the relative premiums for self-insured and fully insured coverage vary significantly by employer size, with the largest differences occurring for smaller employers. With the higher risk for employers associated with self-insurance in this simulation, gains from self-insuring have to be substantial for an employer to decide to do so, and the gains have to be even greater for the smallest employers since the risk they face is greater than for their larger counterparts who have more covered lives over whom to spread their costs. Thus, under a stop-loss policy with substantial risk, the smallest self-insuring employers will tend to have the lowest average claims costs. For example, the average premium for single coverage in a self-insuring plan for firms with fewer than 10 workers is only 51 percent of the average for fully insured plans. In other words, the savings for these firms from self-insuring is larger than for employers of 51 to 100 workers where average single premiums are 71 percent of those in the fully insured market.

This scenario serves as the basis of comparison for the other scenarios.

Scenario B: Current NAIC Model Act

Next, we consider the current NAIC recommendations on reinsurance minimums. The specific stop-loss is only a third of that used in Scenario A ($20,000 versus

Exhibit 2. Reinsurance Scenario A (NAIC Actuarial Subgroup Recommendation)

Reinsurance parameters		
Specific stop-loss		$60,000
Aggregate stop-loss the maximum of	Flat	$60,000
	Per member	$15,000
	% E[claims]	130%

A

	Self-insured			Fully insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,180 total policies)					
1–9	28	$2,577	1%	3,113	$5,041
10–24	31	$2,398	1%	3,368	$4,747
25–50	32	$2,955	1%	2,701	$4,591
51–100	116	$3,259	4%	2,791	$4,579
Total	207	$2,994	2%	11,973	$4,749
Family policies (5,967 total policies)					
1–9	32	$8,396	2%	1,496	$13,343
10–24	17	$7,295	1%	1,498	$13,059
25–50	22	$7,292	2%	1,381	$12,682
51–100	82	$10,058	5%	1,439	$12,704
Total	153	$9,016	3%	5,814	$12,955
			Total	Self-insured	Fully insured
Covered lives (millions)			29.6	0.6	28.9

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

$60,000), and the aggregate stop-loss conditions are also substantially lower—the maximum of a $20,000 flat amount, $4,000 per member, and 110 percent of expected claims. Overall, 12 percent of single and 15 percent of family policies issued to small-firm workers are self-insured under this structure (Exhibit 3). Self-insured plans represent a significant share of the market for small firms with 51 to 100 workers: 26 percent of single and 29 percent of family policies. In total, 4.2 million people obtain their coverage through small-group self-insured policies. The total number of people covered through small employers does not differ significantly from Scenario A (29.7 million versus 29.6 million).

Scenario B shows noticeable adverse selection relative to A, as healthier risks are pulled out of the fully insured market into the self-insured market since the risk to the small employers self-insuring is reduced. Average single premiums in the fully insured market are 4.3 percent higher and family premiums are 1.5 percent higher than in Scenario A. Basically, we see that firms with healthy people who would pay more under modified community rating than under experience rating are more likely to self-insure, provided they can bear the risk. Thus, we find that the difference between current NAIC recommendations and those of the NAIC actuarial subgroup does matter for fully insured small-group premiums. Our results come to a similar conclusion as the Milliman analysis, which used a very different methodology.

The average self-insured premiums in Exhibit 2 are higher than the self-insured premiums in Exhibit 3. As we saw, very few small firms, particularly those employing fewer than 50 workers, are willing to take on the risk of self-insurance under Scenario A. Those who would self-insure face the lowest risk of doing so and have lower claims cost than average; however, they are not necessarily the firms with the lowest

Exhibit 3. Reinsurance Scenario B (Current NAIC Model Act)

Reinsurance parameters		
Specific stop-loss		$20,000
Aggregate stop-loss the maximum of	Flat	$20,000
	Per member	$4,000
	% E[claims]	110%

B

	Self-insured			Fully insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,218 total policies)					
1–9	229	$1,843	7%	2,938	$5,259
10–24	188	$2,108	6%	3,214	$4,988
25–50	338	$2,602	12%	2,402	$4,810
51–100	768	$3,132	26%	2,141	$4,818
Total	1,523	$2,694	12%	10,695	$4,988
Family policies (6,003 total policies)					
1–9	180	$6,663	12%	1,356	$13,454
10–24	98	$7,338	6%	1,411	$13,247
25–50	196	$8,173	14%	1,210	$12,959
51–100	452	$9,137	29%	1,100	$12,918
Total	926	$8,262	15%	5,077	$13,163
Percent by which average fully insured small-group premiums are higher than under NAIC actuarial subgroup's recommended updates:				Single	**4.3%**
				Family	**1.5%**
			Total	Self-insured	Fully insured
Covered lives (millions)			29.7	4.2	25.5

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

claims costs, as other factors go into computing the risk of self-insurance besides the firm's current claims costs.

Scenario C: Low Risk

The next self-insurance scenario imposes much lower risk on small employers than Scenario B. The specific deductible is $10,000.[10] The aggregate deductible is also much lower than Scenario B, computed as the maximum of a $20,000 flat amount and $2,000 per member. Not only is the dollar amount per member lower but, more important, there is no minimum percent of expected claims. Expected claims for most adults are over $2,000 a year, so without an expected claims minimum, a large majority of firms would reach their aggregate deductible. The risk would not be negligible, however, for the smallest firms.

We find that for workers in firms with fewer than 25 workers, about a fifth of single policies and a quarter of family policies are self-insured given these parameters (Exhibit 4). A little less than two-thirds of policies for workers in firms with 51 to 100 workers are self-insured. Overall, about 40 percent of people covered in the small-firm market receive that coverage through self-insured plans under this scenario.

The average single premium in the fully insured market is 14.4 percent higher than with the model recommended by the NAIC actuarial subgroup; the average family premium is 9.6 percent higher. We did three sensitivity analyses around simulation C: one assuming a higher level of employer risk aversion, one assuming a lower level of employer risk aversion, and one assuming that self-insuring small employers can offer their workers a high-deductible plan, as opposed to the typical employer plan provided under the Affordable Care Act. Results from each are presented below, followed by an analysis of Scenario D, where small employers face no additional risk if self-insuring.

Exhibit 4. Reinsurance Scenario C (Low Employer Risk)

Reinsurance parameters		
Specific stop-loss		$10,000
Aggregate stop-loss the maximum of	Flat	$20,000
	Per member	$2,000
	% E[claims]	no min.

C

	Self-Insured			Fully Insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,200 total policies)					
1–9	647	$2,063	20%	2,510	$5,723
10–24	721	$3,878	21%	2,673	$5,486
25–50	1,199	$4,039	44%	1,534	$5,288
51–100	1,861	$4,113	64%	1,055	$5,314
Total	4,428	$3,755	36%	7,772	$5,550
Family policies (6,054 total policies)					
1–9	410	$7,321	27%	1,126	$14,117
10–24	372	$10,967	25%	1,141	$14,567
25–50	700	$11,535	49%	726	$14,331
51–100	1,017	$11,597	64%	562	$14,288
Total	2,499	$10,784	41%	3,555	$14,332
Percent by which average fully insured small-group premiums are higher than under NAIC actuarial subgroup's recommended updates:				Single	**14.4%**
				Family	**9.6%**
			Total	Self-insured	Fully insured
Covered lives (millions)			29.9	11.7	18.2

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

Scenario C Sensitivity Analysis: Employer Risk Aversion

The willingness of employers to bear the risk of high claims costs is a crucial factor in their decision whether or not to purchase coverage, provided stop-loss deductibles still expose them to some risk. We simulated Scenario C with the risk-aversion factor in the employer's expected utility function raised by 25 percent, making the employers less willing to take on risk, from that used in Exhibit 4 and with it lowered by 25 percent, making the employers more willing to take on risk. The higher assumed risk aversion leads to 10.5 million lives covered by small firm self-insured policies (Exhibit 5), down from 11.7 million in Exhibit 4 (Scenario C with our standard risk-aversion assumption). Single premiums with higher risk aversion are 12 percent higher than under the NAIC actuarial subgroup recommendations and family premiums are 8 percent higher. Thus, higher risk aversion leads to lower levels of adverse selection in the small-firm fully insured market.

Lowering risk aversion by 25 percent compared with our standard assumption leads to 13.1 million lives covered by small firm self-insured policies under the Scenario C reinsurance parameters (Exhibit 6). With lower risk aversion, single premiums are 15.1 percent higher and family premiums 11 percent higher than under the actuarial subgroup's recommended parameters. Thus, lower risk aversion (i.e., greater risk-taking) leads to more lives covered through self-insurance and greater adverse selection in the fully insured market. Under our model, adverse selection does vary with risk aversion, but at a notably lower rate than the relative change in risk aversion. However, it is reasonable to conclude that even if firms are at the high end of the plausible range of risk aversion, the fully insured market will experience adverse selection of

Exhibit 5. Reinsurance Scenario C (High Risk Aversion)

Reinsurance parameters		
Specific stop-loss		$10,000
Aggregate stop-loss the maximum of	Flat	$20,000
	Per member	$2,000
	% E[claims]	no min.
Risk aversion 25% higher than in Exhibit 4		

C **High Risk Aversion**

	Self-insured			Fully insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,197 total policies)					
1–9	545	$2,092	17%	2,611	$5,617
10–24	553	$3,772	16%	2,833	$5,388
25–50	1,055	$3,943	38%	1,689	$5,202
51–100	1,751	$4,075	60%	1,160	$5,193
Total	3,904	$3,720	32%	8,293	$5,395
Family policies (6,044 total policies)					
1–9	345	$7,480	22%	1,189	$13,870
10–24	315	$10,882	21%	1,198	$14,338
25–50	650	$11,255	46%	767	$14,066
51–100	982	$11,454	62%	598	$14,021
Total	2,292	$10,721	38%	3,752	$14,084
Percent by which average fully insured small-group premiums are higher than under NAIC actuarial subgroup's recommended updates:				Single	**12.0%**
				Family	**8.0%**
			Total	Self-insured	Fully insured
Covered lives (millions)			29.8	10.5	19.3

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

Exhibit 6. Reinsurance Scenario C (Low Risk Aversion)

Reinsurance parameters		
Specific stop-loss		$10,000
Aggregate stop-loss the maximum of	Flat	$20,000
	Per member	$2,000
	% E[claims]	no min.
Risk aversion 25% lower than in Exhibit 4		

C **Low Risk Aversion**

	Self-insured			Fully insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,220 total policies)					
1–9	765	$2,068	24%	2,402	$5,809
10–24	876	$3,978	26%	2,515	$5,577
25–50	1,391	$4,119	51%	1,350	$5,392
51–100	1,917	$4,181	66%	1,004	$5,400
Total	4,949	$3,801	40%	7,271	$5,595
Family policies (6,068 total policies)					
1–9	476	$7,275	31%	1,061	$14,324
10–24	460	$11,134	30%	1,062	$14,779
25–50	805	$11,730	56%	628	$14,585
51–100	1,047	$11,770	66%	529	$14,565
Total	2,788	$10,886	46%	3,280	$14,560
Percent by which average fully insured small-group premiums are higher than under NAIC actuarial subgroup's recommended updates:				Single	15.1%
				Family	11.0%
			Total	Self-insured	Fully insured
Covered lives (millions)			29.9	13.1	16.8

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

more than 10 percent if plans comparable to Scenario C are allowed.

Scenario C Sensitivity Analysis: Self-Insured Plans with Lower Actuarial Value

Employers might also use the self-insurance option as a route to offering their workers a policy with a lower actuarial value than those permitted in the fully insured small-group market under the Affordable Care Act. Consequently, we simulate the reinsurance structure presented under Scenario C, but assuming that self-insuring small employers have the choice of providing their workers with a standard small-group plan or one with a higher deductible and out-of-pocket maximum than the standard plans. These less comprehensive plans would presumably be attractive to the small employers with the healthiest groups. When the lower actuarial value plans are permitted, 1.2 million more lives are covered by self-insured plans as compared with the standard Scenario C assumptions, and average self-insured single premiums are about $360 lower, family premiums about $670 lower (Exhibit 7). Note that these premiums represent a mixture of high-deductible and more comprehensive self-insured plans. The resulting premiums are higher than under the standard Scenario C, but the difference is smaller than between lower risk aversion and standard Scenario C. The results of this high-deductible simulation do not differ substantially from the standard Scenario C because many of the same employers benefit under both scenarios, but the magnitude of the savings for some of those employers differs between the two.

Scenario D: No Risk to Employers

At the end of the stop-loss spectrum is the case in which the attachment point is $0. Employers thus bear

Exhibit 7. Reinsurance Scenario C (Self-Insured HDHP Plan Available)

Reinsurance parameters		
Specific stop-loss		$10,000
Aggregate stop-loss the maximum of	Flat	$20,000
	Per member	$2,000
	% E[claims]	no min.
	Self-insured high-deductible plans available	

C **High-Deductible Plans**

	Self-Insured			Fully Insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,194 total policies)					
1–9	650	$1,667	21%	2,502	$5,804
10–24	815	$3,458	24%	2,577	$5,562
25–50	1,416	$3,646	52%	1,320	$5,361
51–100	1,969	$3,756	68%	945	$5,367
Total	4,850	$3,394	40%	7,344	$5,583
Family policies (6,118 total policies)					
1–9	445	$7,326	29%	1,100	$14,178
10–24	430	$10,286	28%	1,099	$14,584
25–50	808	$10,752	56%	645	$14,394
51–100	1,097	$10,699	69%	494	$14,258
Total	2,780	$10,111	45%	3,338	$14,369
Percent by which average fully insured small-group premiums are higher than under NAIC actuarial subgroup's recommended updates:				Single	14.9%
				Family	9.8%
			Total	Self-insured	Fully insured
Covered lives (millions)			30.0	12.9	17.1

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

no risk of increased claims costs by self-insuring than they do when fully insuring. This is essentially traditional health insurance marketed as stop-loss insurance, providing small employers with an experience-rated product that is not subject to many of the Affordable Care Act's other small-group insurance reforms either. If a state does not regulate stop-loss deductibles, nothing would prevent such plans from being sold. In such a case, our model estimates that more than 60 percent of lives covered by small-firm plans would be covered by self-insured plans (Exhibit 8). In particular, self-insurance would dominate in firms employing 25 or more workers. Single fully insured premiums would be nearly a quarter higher than under the actuarial subgroup recommendations, and family premiums would be nearly a fifth higher.

The total number of people covered by small-firm plans exceeds that under the actuarial subgroup recommendations modestly—30.1 million, or an additional 400,000 as compared with Scenario A (Exhibit 2). However, this 1.3 percent increase in enrollment is primarily a shift from nongroup or large-firm employer coverage, rather than a reduction in the number without insurance (data not shown), and thus does not suggest that widespread self-insurance leads to more insurance coverage on net.

DISCUSSION

Significant reforms to the way that small-group health insurance is sold and priced will be implemented starting January 1, 2014. Many of these reforms are intended to broaden the way health care risk is shared across small employers. These changes will end insurer price discrimination against small groups with higher-than-average expected health costs and those with prior experience with higher claims. The reforms will

Exhibit 8. Reinsurance Scenario D (No Additional Risk to Firms)

Reinsurance parameters		
Specific stop-loss		$0
Aggregate stop-loss the maximum of	Flat	no min.
	Per member	no min.
	% E[claims]	no min.

D

	Self-insured			Fully insured	
	Number (thousands)	Average total premium	Share of total market	Number (thousands)	Average total premium
Single policies (12,266 total policies)					
1–9	1,409	$2,701	44%	1,776	$6,271
10–24	1,862	$4,374	55%	1,535	$6,151
25–50	1,853	$4,361	67%	901	$5,958
51–100	2,191	$4,352	75%	739	$5,911
Total	7,315	$4,042	60%	4,951	$6,123
Family policies (6,134 total policies)					
1–9	810	$8,471	50%	794	$15,244
10–24	849	$12,287	55%	682	$15,974
25–50	1,023	$12,256	72%	403	$15,903
51–100	1,176	$12,248	75%	397	$15,924
Total	3,858	$11,465	63%	2,276	$15,698
Percent by which average fully insured small-group premiums are higher than under NAIC actuarial subgroup's recommended updates:				Single	**24.8%**
				Family	**19.1%**
			Total	Self-insured	Fully insured
Covered lives (millions)			30.1	18.6	11.6

Note: NAIC = National Association of Insurance Commissioners.
Source: Health Insurance Policy Simulation Model (HIPSM), The Urban Institute, 2012.
Simulations done as if the Affordable Care Act was fully implemented in 2012.

also promote transparency and accountability among insurers in this market, encouraging competition based on efficiency and quality, as opposed to avoiding risk. However, these new federal regulations do not apply to self-insured plans, regardless of employer size, and they do not apply to reinsurance, the product that makes it feasible for small employers to contemplate self-insurance as an option. Thus, a significant migration of small employers with healthier-than-average risks to self-insurance from fully insured plans has the potential to undermine the effectiveness of the Affordable Care Act's small-group reforms and to destabilize the market. Our analysis demonstrates, however, that federal or state regulation of the definition of reinsurance can be effective in mitigating these problems.

Most states do not currently regulate reinsurance, either by restricting the size of the employers to whom it may be sold or setting minimum attachment points. Consequently, without further action, reinsurers can market policies consistent with our Scenario D presented above, which requires no additional risk to small employers of self-insuring, and would lead to significant erosion of and adverse selection in the fully insured small-group market. Because the Affordable Care Act requires fully insured small-group coverage to be sold guaranteed issue and without preexisting condition exclusion periods beginning in 2014, small employers could conceivably purchase experience-rated reinsurance and self-insure at times when their groups' health care profile has been relatively healthy and enter the modified community-rated pool when denied coverage or "rated up" by reinsurers.

Our results indicate that the reinsurance parameters included in the recommendations of the NAIC actuarial subgroup (Scenario A), which require a minimum specific stop-loss attachment point of $60,000 and an aggregate stop-loss determined as the maximum

of a flat $60,000 amount, $15,000 per member, and 130 percent of expected claims, would go a long way toward bolstering the ongoing strength of the small-group insurance market. If this approach is adopted uniformly across the country, the fully insured small-group market would be roughly 1.5 times as large and the average fully insured small-group premium would be at least 20 percent lower than if reinsurance effectively acts as unregulated insurance (Scenario D). These concerns could also be addressed by prohibiting the sale of reinsurance to employers of 100 or fewer workers.

Uniformly implementing regulatory safeguards across the country requires federal action. Absent such action, states can take the initiative to do so individually, following the recommendations of the NAIC's actuarial subgroup.

METHODS

The decisions of firms to offer their workers self-insured plans, commercial plans, or no coverage at all and the decisions of workers to enroll in plans offered to them are computed using HIPSM.[11] HIPSM is a microsimulation model designed to estimate the consequences of health policy changes for health insurance coverage and health care costs. The core of the model is a nationally representative population of individuals and families, together with their health care costs.[12] The base population is drawn from the March 2009 and 2010 Current Population Survey Annual Social and Economic Supplement (CPS–ASEC) combined. Health care costs are taken from three years (2008—2010) of the Medical Expenditure Panel Survey–Household Component (MEPS–HC), with corrections to certain categories of expenditures known to be underreported. The data are augmented with immigration status, eligibility for various Medicaid/Children's Health Insurance Program (CHIP) programs, and other data elements needed to simulate the Affordable Care Act, as described in the HIPSM Methodology Documentation. Then, data are aged to the year of interest, taking into account demographic and economic changes.

In order to compute firm-level premiums for employer-sponsored coverage and to model firm decisions of whether to offer insurance or not, and if offering, the type of health insurance coverage they provide, workers are grouped into simulated, or "synthetic," firms. The distribution of synthetic firms mimics the known distribution of employers by size, industry, region, and baseline insurance offer status. Workers matched into each firm are those reporting employment in the same type of firms. For fully insured small-group plans, costs at the various Affordable Care Act actuarial value tiers (60 percent, 70 percent, 80 percent, and 90 percent) are constructed, and premiums are based on the insured costs of those currently covered by such plans. We implement modified community rating, with premiums variation limited to age and tobacco use at ratios not exceeding 3:1 and 1.5:1, respectively. The Affordable Care Act includes an insurer fee that applies to commercial policies, but not to self-insured ones. The effect of this provision will be to add a premium surcharge on commercial policies. We model a surcharge of 3 percent, which is in the range of several analyses.[13]

Fully insured small-group plans are constructed based on plans typical of those currently offered by small employers, using data on deductibles, out-of-pocket maximums, and coinsurance rates from the Medical Expenditure Panel Survey–Insurance Component (MEPS–IC) and Kaiser/HRET Employer Health Benefits Surveys. For each firm-size group, we adjust the actuarial value of the plan so that the average premium computed (based on those covered by plans in the small-group market in the underlying survey data) is aligned to the average premiums reported by the MEPS–IC. The resulting actuarial values range from just over 70 percent for the smallest firms to just over 80 percent for those employing 50 or more, with deductibles averaging $1,000 for single policies and $1,900 for family policies. For self-insured plans offered by small employers, we use two insurance packages. The first is the typical fully insured coverage described above; this is available in all the simulations presented here. The second is a high-deductible plan,

which is made available to small employers in one of our sensitivity analyses, discussed above. The deductibles for the high-deductible plan are $2,300 single and $4,500 family.

We model several different types of stop-loss policies that self-insuring employers purchase to limit their exposure to claims costs. These are defined by specific and aggregate deductibles. The Background section of this paper describes how they are applied. Aggregate deductibles are specified by three conditions: a flat dollar amount, a dollar amount per covered person, and a minimum percentage of expected claims. These three are computed for each self-insured firm, and the firm's aggregate deductible is the largest of them.

Premiums of self-insured plans are computed as follows. A firm's stop-loss deductibles are applied to determine which costs are borne directly by the firm and which are covered by the reinsurer. The reinsurer charges a premium to cover its costs. A few states, such as North Carolina, require that stop-loss premiums follow the same market regulations as fully insured premiums. North Carolina also prohibits insurers from serving as third-party administrators for self-funded small employers. However, our intent here is to model the effect in states not regulating stop-loss coverage, so premiums in the simulations are experience-rated, the predominant situation nationally. This is done by taking into account both a person's expenses for the current year and the expected value of his or her expenses, with the average taken over age, gender, and health status. The total self-insured premium for a firm covers the stop-loss premium, claims costs not covered by stop-loss, and administrative costs.

Once fully insured and self-insured premiums for a firm are set, the firm can decide which type of coverage, if any, to offer to workers. We use an expected utility model, taking into account a number of factors:

- The expected utility of coverage (or remaining uninsured) to workers. This takes into account premiums, out-of-pocket costs, and risk of high insurance costs, in particular, the difference between self-insured and fully insured premiums.[14]
- Total worker compensation remains constant, regardless of the insurance decision. More spending on health benefits means lower wages, and vice versa.
- The tax exclusion for employer-sponsored insurance.
- Affordable Care Act employer assessments for firms of 50 or more employees that have at least one full-time worker obtaining a subsidy for the purchase of nongroup coverage through a health insurance exchange.
- Affordable Care Act premium tax credits for the smallest firms that qualify.
- The Affordable Care Act insurer fee, as described above.
- Administrative costs of offering insurance.
- For self-insured policies, the risk of additional claims costs to the employer.

The last factor is crucial in this analysis. We first look at the standard deviation of health care costs among covered lives in a firm as a measure of how much claims could reasonably rise from their expected values. The 90th percentile of a typical distribution of health care costs is roughly 70 percent of a standard deviation. We then apply this level of claims to a firm's stop-loss deductibles to determine how much of this additional cost will be borne directly by the firm. If a firm's expected claims are already in excess of the deductibles, for example, the additional cost will be borne by the reinsurer to be covered through premiums. The willingness of firms to take risks is not precisely known, so we perform a sensitivity analysis. Current patterns of stop-loss insurance show clearly that the willingness of employers to risk self-insurance and the willingness of reinsurers to offer coverage both increase with firm size. The default level is calibrated to take into account that the model being considered

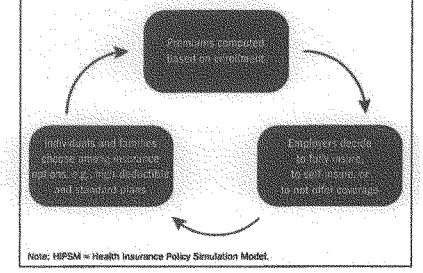
by the actuarial subgroup of the NAIC requires a self-insured employer to take on much higher risk than many stop-loss policies currently offered to small firms. Note that the results shown here assume implementation of the Affordable Care Act. Provisions such as the insurer fee do not currently exist, so the levels of self-insured coverage reported in this paper will not necessarily match current patterns.

A firm offers coverage if the employees' combined value of the offer exceeds the offering costs, and there are enough employees who gain from having the offer. A firm will offer a self-insured policy if its value (i.e., expected utility) to the firm and its workers outweighs the value of commercial coverage. For example, if experience-rating in the stop-loss market allows a firm of particularly healthy workers to purchase coverage comparable to a fully insured plan more cheaply, the employer spends less providing health care benefits. Keeping total compensation constant, this means a rise in wages for workers, so they gain.

The interaction between how much a firm would benefit from self-insuring and whether it would be willing to bear the resulting risk is particularly important for understanding the results of our high-risk stop-loss scenarios. The update recommended by an actuarial subgroup at the NAIC (Scenario A) tripled most of the stop-loss deductible parameters from the current NAIC Model Act (Scenario B). While the risk involved in Scenario B is high enough to discourage most small firms, the risk is so much higher in Scenario A that only a very small minority would consider self-insurance. While, in general, firms with the most persistently low-cost workers would tend to gain the most from self-insuring, those who gain the most would not necessarily be those facing the lowest risk or those willing to take substantial risk. Because of random variation in health care costs, the smallest firms would have a greater chance of having only very healthy workers, but they are highly unlikely to self-insure under the NAIC actuarial subgroup recommended parameters. Besides that, those with the lowest claims will often be furthest from their deductibles, and may have a high standard deviation of costs. Thus, their risk in self-insuring may be greater than that of some firms with somewhat higher claims costs.

Once employers have made their decisions about offering coverage, workers and their families decide what coverage, if any, to take up. This decision includes alternatives to their firm's offer, such as offers of coverage from a spouse's employer, subsidized exchange coverage if the employer's offer is deemed unaffordable and the worker is income eligible, public coverage such as Medicaid or CHIP, or remaining uninsured. Once decisions have been made, premiums are updated to reflect changes in enrollment. The cycle of decision-making is repeated until the model reaches equilibrium (Exhibit 9). We then analyze the resulting small-firm insurance coverage, both self-insured and fully insured. Each of the seven stop-loss scenarios presented here require a separate simulation. For all scenarios, we simulated the Affordable Care Act as if fully implemented in 2012.

Exhibit 9. A HIPSM Simulation Cycle for Families with Small-Firm Workers



Note: HIPSM = Health Insurance Policy Simulation Model.

NOTES

[1] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component. Table I.A.2.a.

[2] Kaiser-HRET Survey of Employer-Sponsored Health Benefits 2012 (Menlo Park, Calif.: Henry J. Kaiser Family Foundation), Exhibits 1.5 and 1.6, http://ehbs.kff.org.

[3] Chris Carlson, *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans, Oliver Wyman,* 2011. Also, forthcoming analysis by R. Winkelman, M. Buettgens, and D. Myers.

[4] T. S. Jost and M. A. Hall, "Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options," *New York University Law Review,* forthcoming.

[5] Ibid.

[6] http://www.naic.org/documents/committees_b_hcra_wg_120606_milliman_interpretations.pdf.

[7] C. Eibner, C. C. Price, R. Vardavas et al., "Small Firms' Actions in Two Areas, and Exchange Premium and Enrollment Impact," *Health Affairs,* Feb. 2012 31(2):324–31.

[8] Online statements by reinsurers include examples of specific stop loss deductibles of $5,000, for example. See http://www.img-stoploss.com/about-img-stop-loss/IMG-si-advantage.aspx. A discussion of increased marketing of stop loss to small firms will appear in Jost and Hall, "Self-Insurance for Small Employers," forthcoming.

[9] J. T. O'Connor and E. C. Huth, *Statistical Modeling and Analysis of Stop-Loss Insurance for Use in NAIC Model Act*, Milliman, 2012, http://www.naic.org/documents/committees_b_erisa_millman_naic_final_report.pdf.

[10] See note 6 above for an example of a plan currently offered with a much lower attachment point.

[11] For an overview of the model's capabilities and a bibliography of research using it, see "The Urban Institute's Health Microsimulation Capabilities," http://www.urban.org/uploadedpdf/412154-Health-Microsimulation-Capabilities.pdf.

[12] For more detail, see "HIPSM Methodology Documentation: 2011 National Version," http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.

[13] Carlson, *Estimated Premium Impacts,* 2011.

[14] For details, see HIPSM Methodology Documentation, http://www.urban.org/UploadedPDF/412471-Health-Insurance-Policy-Simulation-Model-Methodology-Documentation.pdf.

ABOUT THE AUTHORS

Matthew Buettgens, Ph.D., is a mathematician and senior research associate in The Urban Institute's Health Policy Center. He leads the development of the Urban Institute's Health Insurance Policy Simulation Model. The model has been used to provide technical assistance for health reform implementation in Massachusetts, Missouri, New York, Virginia, and Washington, and to the federal government. His recent work includes papers analyzing aspects of national health insurance reform. Topics have included the costs and savings of health reform for federal and state governments, state-by-state analysis of changes in health insurance coverage and the remaining uninsured, the effect of reform on employers, the role of the individual mandate, the affordability of coverage under health insurance exchanges, and the implications of age-rating for the affordability of coverage. Dr. Buettgens received a Ph.D. in mathematics from the State University of New York at Buffalo.

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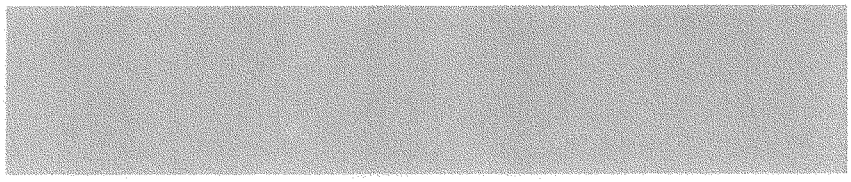
ACKNOWLEDGMENTS

We would like to acknowledge the valuable comments provided by Timothy Stolzfus Jost, Sabrina Corlette, and Kevin Lucia.

Editorial support was provided by Deborah Lorber.



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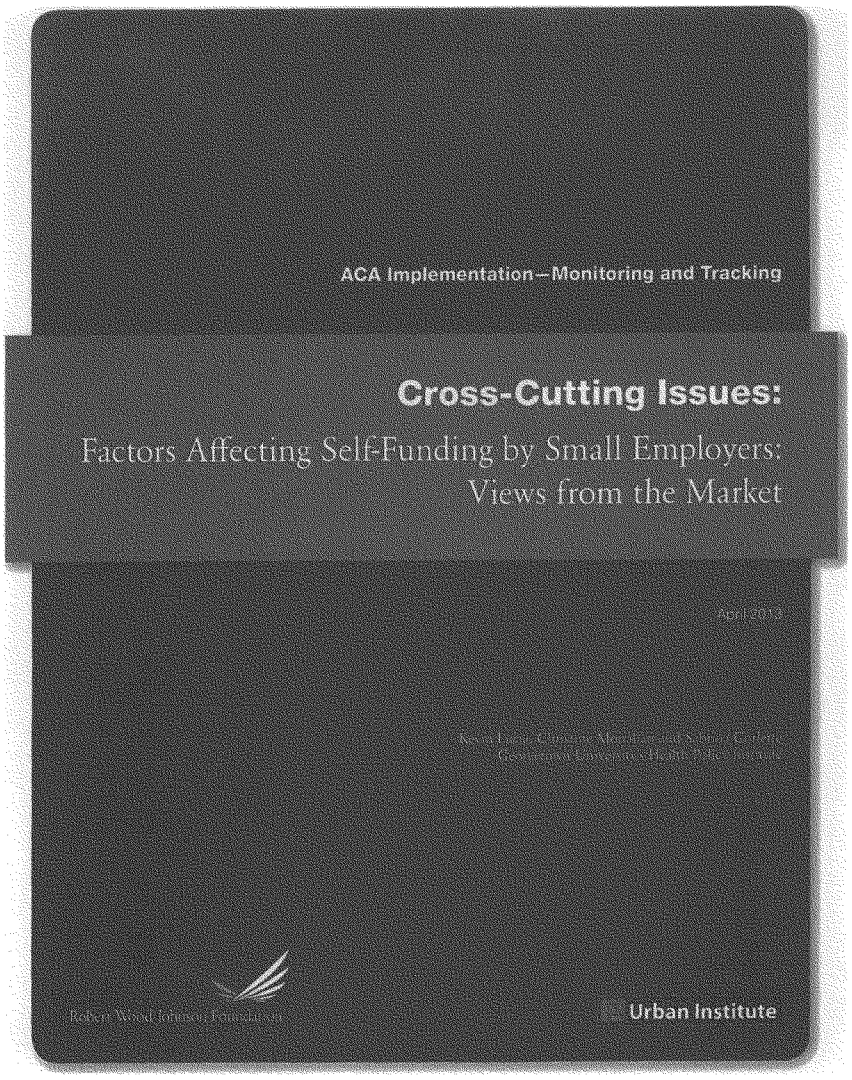
ACA Implementation—Monitoring and Tracking
Cross-Cutting Issues:
Factors Affecting Self-Funding by Small Employers:
Views from the Market
April 2013
Robert Wood Johnson Foundation
Urban Institute

With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access, and premiums in the states and nationally.

ABSTRACT

Policy experts predict that small employers, especially those with younger and healthier employees, will increasingly establish "self-funded" health plans, leaving the traditional fully insured market to obtain lower premiums and avoid market reforms under the Affordable Care Act. Through interviews with stakeholders in 10 study states, this paper describes factors that may influence whether and how extensively this change occurs. It also shows that states have minimal data on this potentially growing market, but they would be well-served to improve their monitoring efforts so they can identify any increases in small group self-funding and resulting adverse selection, and respond appropriately.

INTRODUCTION AND METHODOLOGY

The Affordable Care Act (ACA) will significantly change the regulatory standards that determine the accessibility, affordability, and adequacy of private health insurance coverage in the small group market. While these changes are intended to improve market conditions and the generosity of coverage for small employers, they could increase the cost of insurance for some small employers. Policy experts have speculated that such cost increases—and some of the new regulatory standards—may encourage small employers to establish "self-funded" health plans and leave the fully insured market, thus avoiding a number of the ACA's requirements, such as modified community rating, coverage of essential health benefits, limits on cost sharing, and the health insurer fee. However, most small employers would need to acquire stop-loss coverage—an insurance policy that operates like reinsurance and is typically underwritten by health, gender, and other factors—to help manage the financial risk inherent in self-funding. Thus, whether affordable stop-loss coverage is readily available to small employers could determine whether significant numbers of small employers turn to self-funding. Because self-funding may be particularly attractive to younger and healthier groups, a large increase in self-funding could cause adverse selection against the fully insured small group market, including but not limited to, the small business health options program (SHOP) exchanges.

This paper explores this premise through in-depth telephone interviews with small employer representatives, producers (agents and brokers), health insurers, stop-loss insurers, and state officials including insurance

regulators and exchange representatives in the 10 states participating in the Robert Wood Johnson Foundation's monitoring and tracking project (Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia). The authors reviewed statutes, regulations and guidance across the 10 states and conducted interviews with nearly 50 informants between October 2012 and January 2013.[1] This paper provides an assessment of the informants' perspectives on the current and future market for small group self-funding and the sale of stop-loss coverage.

Informants provided insight into the current status of self-funding among small employers and, looking ahead, the factors that may influence whether more small employers will self-fund in response to implementation of the ACA's market reforms. In addition, informants emphasized that the magnitude of market changes will depend on the definition of small employer—which will expand from firms with 50 or fewer employees, to those with up to 100 employees in 2016. These findings are limited, however, by the lack of publicly available data on the number of employers currently covered under stop-loss policies and the attachment points under which these policies are being sold.

Exhibit 1: Key Definitions

Term	Definition
Self-funded health plan (also known as self-insured health plan)	A plan for which the plan sponsor (e.g., employer) generally takes on the financial risk of paying claims for covered benefits.
Fully insured health plan	A plan for which the plan sponsor (e.g., employer) generally purchases health insurance coverage from an insurer who takes on the financial risk of paying claims for covered benefits.
Stop-loss insurance	An insurance policy that operates like reinsurance to reimburse sponsors of self-funded plans for claims above a specified level.
Self-funding arrangement	A bundled package that combines stop-loss insurance with other services required to properly administer a health plan, such as access to a provider network and claims processing.
Specific attachment point (also known as specific deductible)	The dollar amount, under the policy terms, where the insurer begins paying for claims incurred by an individual covered by a stop-loss policy and the employer's liability ends.
Aggregate attachment point	The dollar amount, under the policy terms, where the insurer begins paying for claims incurred by a group covered by a stop-loss policy and the employer's liability ends.
Producer	An agent or a broker.

BACKGROUND

Employer-sponsored health coverage generally is provided through one of two funding arrangements. Under the first, an employer purchases a health plan from an insurer who bears the financial risk of paying claims for covered benefits. Under the second, an employer may self-fund (or self-insure) a health plan. In this case, the employer takes on the risk of providing health benefits to plan enrollees. To protect against large, unexpected claims in a given year, however, an employer may reinsure its self-funded health plan by purchasing stop-loss insurance. Depending on state law, stop-loss insurance can be sold by insurers that specialize in either stop-loss or those that offer other forms of insurance. Typically stop-loss insurance will begin to cover claims after a

pre-determined amount, referred to as an attachment point. Stop-loss contracts may include individual-level (specific) and/or group-level (aggregate) attachment points.

Under the Employee Retirement Income Security Act (ERISA) and other federal laws, the federal government regulates employee health benefit plans, including self-funded plans, but does not regulate or collect data on the sale of stop-loss policies purchased by employers operating self-funded plans.[2] States, on the other hand, are prohibited from regulating employer health benefit plans under ERISA; they may only regulate insurance contracts that employers buy directly to provide benefits to their employees or to reinsure their self-funded plan. Therefore, a state may not prohibit an employer from self-funding or set rules for the coverage provided by a self-funded plan, but it is generally understood that a state may regulate a stop-loss policy as insurance.[3]

Among states that have taken regulatory action, approaches vary—such as setting minimum attachment points; banning the sale of stop-loss coverage to small employers; or regulating stop-loss coverage sold to small employers under the same rules that apply to fully insured plans sold in the small group market, such as underwriting and rating rules.

Self-funding has traditionally been more common among larger employers than small employers. Large groups usually have more resources and can spread the risk of high claims across a bigger pool of people than small employers can.[4] However, some policy experts speculate that self-funding could become more attractive to certain small employers as the ACA's market reforms go into effect.[5] By self-funding, a small employer could bypass some of the ACA's market reforms that apply only to the fully insured market, such as modified community rating, coverage of essential health benefits, and limits on cost sharing, as well as the health insurer fee, which does not apply to self-funded health plans. While these changes are intended to improve market conditions and the generosity of coverage for small employers, they are expected to increase the cost of insurance for some small employers, particularly those with younger and healthier workforces. Such employers may be able to save money by self-funding and purchasing more affordable stop-loss—which, in most states, insurers are allowed to underwrite based on health, gender, and other rating factors—only to re-enter the fully insured market if their health status declines at any time in future years. Bundled "self-funding arrangements" that offer significant financial protection through low attachment points and are designed to resemble traditional health insurance by building a provider network, claims processing, and other administrative services required to properly administer a health plan into a single administrative services contract[6] may be particularly appealing to small employers.

If low-attachment point coverage is widely available, a large number of small groups with healthier risk profiles may turn to self-funding. Economic models by the Urban Institute indicate that if this happens, there may be significant adverse selection against the small group fully insured market, increasing premium costs and potentially reducing the number of healthy covered lives in the fully insured small group market, including the SHOP exchanges.[7] However, because most small employers will not self-fund without the financial protection provided by stop-loss coverage,[8] regulating stop-loss insurance could be an effective way for states to limit the reach of self-funding into the small group market, if they determine it necessary or appropriate.

Regulation of stop-loss coverage sales to small employers

In 1995, the National Association of Insurance Commissioners (NAIC) adopted a model state law setting minimum specific and aggregate attachment points for stop-loss coverage.[9] Higher attachment points may dissuade some small employers from self-funding by exposing employers to greater risk than they would face with policies with low attachment points. For instance, while large employers may be able to tolerate the risk exposure of a stop-loss plan with a $60,000 or $100,000 specific attachment point, most small employers will likely find these points to be too high. On the other hand, a small employer may be more willing and able to self-fund if it can purchase stop-loss coverage with lower attachment points, which can be legally sold in states that do not regulate stop-loss coverage.

Most states, however, have not enacted the NAIC model law, and only a minority of states has otherwise attempted to regulate stop-loss coverage. Among states that have taken regulatory action, approaches vary—such as setting minimum attachment points; banning the sale of stop-loss coverage to small employers; or regulating stop-loss coverage sold to small employers under the

same rules that apply to fully insured plans sold in the small group market, such as underwriting and rating rules. The 10 states studied here are more aggressive than average in the regulation of stop-loss; however almost half—Alabama, Michigan, New Mexico, and Virginia—do not impose standards on stop-loss policies sold to small employers. Of the study states that have taken regulatory action, New York and Oregon prohibit the sale of stop-loss coverage to small employers altogether, while Colorado,[10] Maryland,[11] and Minnesota[12] have set minimum attachment points for the sale of stop-loss coverage. Rhode Island regulators report that they apply minimum attachment points consistent with the NAIC model law when reviewing stop-loss policy forms, although these standards are not specified in state law.

A few states, including Colorado and Minnesota, have additional regulatory standards that may limit the sale of stop-loss coverage to small employers. In Colorado, small employers re-entering the fully insured small group market after being covered under certain self-funding arrangements may face a premium surcharge of up to 35 percent above the required modified community rating that they would otherwise be charged.[13] In Minnesota, stop-loss policies issued to small employers are required to cover all claims incurred during the contract period regardless of when the claims are paid. This protects employers from claims above their specific or aggregate attachment points that were incurred during the plan year but not submitted or processed until after the end of their stop-loss plan year.[14]

OBSERVATIONS FROM THE 10 STATES

In-depth telephone interviews with small employer representatives, producers, health insurers, stop-loss insurers, and state officials, including insurance regulators and exchange representatives, in 10 states revealed that the vast majority of stakeholders have some level of concern about the prospect of employers with 50 or fewer employees self-funding. There is less unanimity, however, regarding the likelihood of self-funding by small employers increasing on a wide scale. Although data are minimal, interviews and anecdotal evidence suggest that most insurers and producers do not currently sell stop-loss insurance policies or self-funding arrangements that integrate stop-loss coverage to small groups and that few small employers self-fund today. Looking ahead, informants indicate that the extent to which small employers begin self-funding in 2014 and the effect this may have on the traditional small group market and SHOP exchanges will depend on a number of interconnected factors. These factors include insurers' interest in marketing stop-loss coverage or related self-funding arrangements to small employers, producers' willingness to sell such coverage options to small employers, small employers' interest in self-funding compared to other coverage options or not offering coverage at all, and states' regulation of stop-loss policies sold to small employers. In addition, informants emphasized that the magnitude of market changes will depend on who is considered a small employer—a definition that will expand from groups of 50 or fewer employees to groups of up to 100 employees in 2016.

Informants largely consider self-funding inappropriate for small employers.

Informants generally agreed that the most likely candidates for self-funding would primarily be employers who are financially secure and sophisticated—employers typically need to have enough money to set up a reserve to handle high medical claims—and who are comfortable taking on risk. Self-funding also may appear particularly attractive to employers providing coverage to healthier or younger groups who do not expect to have significant medical claims. However, most informants—insurance company representatives, producers, and regulators alike—emphasized that self-funding, even with stop-loss coverage, could expose small businesses to considerable, and unpredictable, financial and legal risks.

Regulators largely panned self-funding by small employers. According to an Alabama regulator, "If I had a small business, I wouldn't even think that way because only one or two claims could bankrupt you." Regulators in Minnesota commented that many small employers are ill-equipped to purchase stop-loss coverage, noting complaints from employers who were unaware of the full liability they faced under their policies. Similar sentiment was expressed by other stakeholders. A New York producer called it "malpractice" to advocate self-funding for small groups, while a producer from Virginia commented that businesses with fewer than 100 employees "have no business self-funding." A health insurer representative said that self-funding never

starts out as someone's first choice, adding that "many employers understand that it works well until it doesn't."

One reason given for such attitudes is informants' experience with small employers who were offered an inexpensive stop-loss policy in their first year, only to see significant rate increases in later years. A former producer in Colorado estimated that 10 to 15 percent of self-funded employers will face re-underwriting—screening by their stop-loss insurer to assess their health status and risk factors—within a couple of years and may face significant premium increases due to changes in their employees' health status. Another producer reported that insurers may re-underwrite a group if the employee population fluctuates more than 10 percent in a year. Further, stakeholders familiar with stop-loss contracts—including state officials and insurance representatives—pointed out that under some stop-loss policies a small business may be responsible for the "run out"—the full cost of any claims incurred while covered by a stop-loss policy but not processed until after the policy had expired. Thus, while employers may switch to a fully insured plan after their group's health status declines, they may remain liable for large claims that were incurred when they were self-funded.[15]

Insurers and producers also expressed concern that most small employers do not have the in-house expertise to take on the legal liability of self-funding.

In addition, while stop-loss policies marketed toward small groups are likely to include low attachment points to limit an employer's financial exposure, multiple stakeholders indicated that such plans would not necessarily take all the risk out of self-funding. A state regulator commented that "even a $15,000 specific attachment point is a big hit to a very small employer." A producer noted that stop-loss policies with low attachment points also may include contractual provisions called "lasers" that exempt high-risk employees from coverage by the stop-loss policy or subject them to higher specific attachment points. According to a producer from Oregon, another classic problem encountered with a stop-loss policy is that pharmacy claims may not be covered, leaving an employer fully exposed for the cost of any pharmaceutical benefits included in its group health plan. In addition, a producer reported that stop-loss insurers often do not pay claims above the stop-loss policies' attachment points until the end of the first quarter of the subsequent year. Consequently, the employer would need to pay the full claim out of pocket and may not be reimbursed for up to 15 months.

Insurers and producers also expressed concern that most small employers do not have the in-house expertise to take on the legal liability of self-funding. One insurer in New Mexico commented, "A typical small employer is wheeling and dealing each day, and doing their company's finances in their head. I see all kinds of risk for them to unintentionally break some rule under ERISA." A New Mexico producer agreed, noting that "brokers need to know their stuff in terms of compliance to not get their clients in trouble."

However, a number of informants suggested that self-funding can have benefits for certain employers who want to take a hands-on approach to designing their plan. In particular, producers and stop-loss insurers claimed that sophisticated employers could leverage their access to health care claims data to identify cost drivers within their group. Self-funding can provide employers with benefit design flexibility, allowing them to attempt to reduce their costs through wellness programs, network design, health education, and other strategies. However, other informants questioned the ability of small groups to generate sufficiently robust data to meaningfully identify cost trends or implement effective cost containment strategies.

Data are scant, but most informants believe that the sale of stop-loss policies or self-funding arrangements to small employers is currently minimal.

State officials in the study states acknowledged that they are not currently monitoring how much stop-loss coverage is being sold to small employers. Insurers are typically required under state law to file stop-loss policies with departments of insurance, in which case regulators have on file the name of the insurers that have been approved for the sale of stop-loss coverage and the form that was reviewed by regulators for compliance with state law. In some cases, this may include minimum attachment points and the size of the group to which the policy is intended to be sold. However, no state official was able to report the number of small employers currently covered under stop-loss policies. State officials

generally reported relying on either anecdotal evidence from insurers or, to the extent available, consumer complaints to inform them of the status of the small employer stop-loss market. One state official noted, "We don't have a way to monitor this. We hear from [health] insurers that they're losing customers to stop-loss [insurers], but we haven't been able to confirm." Another stated that she had never been asked for a report on the amount of self-funding in the small group market. One former state regulator indicated that it would not be difficult for state departments of insurance to collect more information through a data call, but that such steps may draw negative reactions and questions from stakeholders. Only in Rhode Island did officials indicate that they planned to begin collecting data on this market more closely in the near future.

Both regulators and insurers in other states, including those that set minimum attachment points for stop-loss coverage...and those that do not...suggested that they believe that the sale of stop-loss policies to small employers currently makes up only a very small segment of the market.

Lacking data, informants in most states provided anecdotal evidence that traditional health insurers limit their participation in the self-funding market to large employers. Producers in multiple states claimed that many major health insurers have been unwilling to sell stop-loss policies or related self-funding arrangements to employer groups below 100 to 200 people. The primary reason given for this reticence was competition. As one Colorado producer explained, traditional health insurers "don't want to cannibalize existing business. Their primary concern is maintaining current profit margins." An exchange official also noted that these health insurers control the fully insured small group market, which is generally profitable, and would be undercutting themselves if they began pushing products that encourage small employers to self-fund.

A number of informants—including insurers, producers, and state officials—also reported that some insurers believe that the sale of stop-loss coverage or related self-funding arrangements to small employers is not financially worthwhile. Stop-loss insurers specifically argued that while they might be able sell more policies if they lowered their minimum specific attachment points to a level that would attract smaller-sized employers, the number of claims would rise, and the administrative costs to handle such a large volume of claims would increase significantly. Ultimately, one representative concluded, "it's just not worth [it financially]." In Alabama, for example, a producer reported that he works with six to eight stop-loss insurers, but only one will handle a group under 50. However, other producers reported that selling self-funded arrangements to smaller groups can be profitable with the right business model.

Informants also reported that only a small subset of producers is currently selling stop-loss coverage or related self-funding arrangements to groups of 50 or fewer employees. Two former producers said they would have been hesitant to jeopardize the financial security of their smaller clients by moving them to self-funding. Many other informants—including current producers, regulators, and insurers—described the inherent complexity of the product acts as a barrier discouraging producers from pushing self-funding to small employers. According to a number of stakeholders, producers must be very sophisticated to understand complicated stop-loss contracts and determine that all the right components—including provider networks, benefit administrators, and financial reserves—are in place to ensure that a small employer is properly and adequately self-funded. Even when a self-funded arrangement is already bundled, some producers pointed out that it still requires a high level of expertise to understand the financial and legal risks for their employer clients.

Perhaps unsurprisingly then, informants in most study states speculated that the current sale of stop-loss policies to small employers, and thus self-funding, is minimal. In Oregon and New York, which prohibit the sale of stop-loss policies to small employers, state officials have not received any complaints or other information to suggest that insurers are violating the law by marketing or selling stop-loss policies to small employers. Both regulators and insurers in other states, including those that set minimum attachment points for stop-loss coverage (such as Minnesota and Rhode Island) and those that do not (such as Alabama, Michigan, New Mexico, and Virginia) suggested that they believe that the sale of stop-loss policies to small employers currently makes up only a very small segment of the market. Even in Colorado, which has had a long history of insurers marketing stop-loss coverage and self-funding arrangements to medium-to-large employers,

regulators, exchange officials, producers, and small business representatives suggested that there is limited sale of these arrangement to employers with fewer than 35 employees. Explaining this, one informant from Colorado suggested that "the current small group self-funding market employs very aggressive underwriting, and therefore actually writes only a small portion of cases submitted to it."

Insurers monitor the small group market for potential post-ACA expansion.

Implementation of the ACA's market reforms in 2014 may sufficiently change the incentives for stakeholders and cause them to reconsider the feasibility of self-funding by groups of 50 or fewer employees. Some informants highlighted signs that insurers are reconsidering the value of selling stop-loss policies or self-funding arrangements to small groups and are "preparing to turn the switch on with the ACA coming next year." Indeed, it appears that a small set of insurers—including a small number of traditional health insurers as well as some stop-loss insurers—have recently begun aggressively targeting small groups for bundled self-funding arrangements. As evidence of this, a number of informants reported that they had seen an increase in marketing materials for self-funding arrangements targeting groups with 50 or fewer employees and, in some cases, groups as small as five employees.[16] Multiple informants also reported that a national health insurer has invested heavily in developing self-funding arrangements that specifically appeal to small employers and at least one more may be following suit in some states.

As one insurer in New Mexico put it: "Strategically we would not want to be proactive about moving business from fully insured to a self-funded model, because our core business is fully insured HMO and PPO products. It's what we prefer to do. But, if there was a pull from the market to go in that direction, we would follow it."

According to one producer, such bundled packages attempt to address two major barriers to self-funding faced by small employers. First, these packages minimize the administrative burden of separately contracting and paying for a range of administrative services—such as a pharmacy benefits manager, a provider network, and disease management services—by bundling them together under one policy. Second, these self-funding arrangements aim to limit small employers' exposure to random peaks and valleys in claims, which can disrupt monthly cash flow. Specifically, rather than holding reimbursement for claims that go above the small employers' specific attachment point until the end of the plan year, such arrangements provide immediate reimbursement to small employers. In addition, instead of limiting a small employer's financial exposure for its group's aggregate claims annually, these self-funding arrangements limit a small employer's aggregate exposure monthly. This means that if there is a bad outbreak of the flu in a given month or other peaks in aggregate costs, a small employer would need to cover claims only up to a set aggregate monthly amount rather than the annual aggregate, enabling the employer to spread claims costs out more predictably over the course of the year. The employer and insurer would then come to a settlement at the end of the year to account for any excess claims paid by the stop-loss insurer if the group did not meet its annual aggregate amount.

Importantly, though, informants noted that the issuers offering these self-funding arrangements may be more willing to enter the small group stop-loss market than other health insurers, because they have not been active in the fully insured small group market, and are thus not cannibalizing their own products. Whether additional health insurers will move into the small group stop-loss market is less clear at this stage. A representative from one health insurer in Virginia admitted that the insurer was concerned about changes to the market, but did not want to overreact and, for now, is carefully watching developments related to self-funding among small employers. A Maryland exchange official expressed skepticism that traditional health insurers would change their entire business model just to get into the stop-loss market when the uptake may be small. Other insurance representatives felt that while most insurers in the traditional small group market would rather continue to sell fully insured policies, they may need to begin selling stop-loss policies in order to stay competitive and retain market share. As one insurer in New Mexico put it: "Strategically we would not want to be proactive about moving business from fully insured to a self-funded model, because our core business is fully insured HMO and PPO products. It's what we prefer to do. But, if there

was a pull from the market to go in that direction, we would follow it."

Reports varied across the states regarding whether more health insurers are moving into the stop-loss market for small employers. Regulators and exchange officials from Maryland, New Mexico, and Rhode Island were unaware of increased interest in selling stop-loss coverage or self-funding arrangements among health insurers in their state, but they acknowledged that insurers may be exploring options without telling them. A Colorado exchange official speculated that health insurers probably have a product line in the works, noting "when you talk to them, they just give you a knowing look." A stop-loss insurance representative agreed, predicting that insurance executives would file new stop-loss policies just in case. Indeed, this may already be happening in at least one state: Michigan regulators confirmed that they had seen an uptick in stop-loss product fillings for the small group market in recent years, including stop-loss policies with specific attachment points as low as $5,000. However, one producer suggested that insurers will file policies with attachment points as low as legally allowed to afford themselves maximum flexibility to accommodate market dynamics, even if they do not currently intend to sell policies at that level. While review of product filings can be indicative of market trends, it does not offer a complete picture of the market.

As premiums in the small group market continue to rise, producers are looking for more affordable alternatives they can present to hold onto existing clients or, perhaps more important, attract new clients.

Producers see new opportunities and challenges to selling stop-loss and self-funding arrangements to small employers.

Despite the challenges of packaging self-funding arrangements and explaining the risks and complexities of self-funding, many stakeholders predicted that more producers may consider entering the self-funding market in order to stay competitive. As premiums in the small group market continue to rise, producers are looking for more affordable alternatives they can present to hold onto existing clients or, perhaps more important, attract new clients. While some current and former producers indicated that compensation for selling stop-loss coverage may match or exceed that for fully insured plans, other producers and insurers believed the compensation was lower, in part because premiums for stop-loss coverage are significantly lower than for fully insured coverage. (Producer compensation is often calculated as a preset percentage of the premium.) In the latter case, producers may offer stop-loss policies or self-funding arrangements to increase market share, but not necessarily to convert existing clients from one type of business to another.

A few stakeholders specifically pointed to elements of the ACA as a reason more producers may turn to selling stop-loss coverage or self-funding arrangements—indeed, one producer representative reported that a small number of "self-funding activists see the ACA as a different opportunity to carve out a niche for themselves." Producers in Maryland and Oregon identified the creation of exchanges as a particular concern. In Maryland, producers feared that the exchange would limit their compensation, potentially making self-funded coverage options more attractive. A stop-loss insurer also indicated that producer compensation for selling stop-loss policies and self-funding arrangements could rise relative to compensation for traditional health insurance because self-funded plans are not subject to the ACA's medical loss ratio (MLR) rules. The MLR standard, implemented in 2011, requires health insurers to issue rebates to policyholders if their administrative costs are too high relative to their premium revenue. It has pressured insurers to become more efficient in their operations, and some have responded by reducing producer compensation.

Once a critical mass of producers in a market starts offering stop-loss coverage or self-funding arrangements, others may be compelled to follow suit. As one Maryland producer put it, "A broker would be committing professional suicide by showing one [coverage option], but failing to show another." Yet, while stakeholders sensed that some insurers and brokers are increasingly interested in selling stop-loss or self-funding arrangements, the extent of actual changes in producer behavior and market impact remains in question. In Colorado, one producer expected that more producers will begin offering these coverage options to small groups, but he commented that it would remain a very slim market segment and did not expect that producers would pursue groups under 30 or 35 for self-funding.

Even in states home to "self-funding activists," who see a business opportunity in marketing self-funded plans to small employers, producers reported that most of them would like to see business as usual and to continue offering traditional insurance products rather than self-funding arrangements.

How small employers will respond to the changing marketplace remains unclear.

Informants widely agreed that small businesses are frustrated by rising insurance premiums and open to opportunities to limit their and their employees' costs. Coupled with this frustration is a tremendous amount of confusion among small employers about their options. According to one informant, small businesses "are just nervous wrecks" who may be open to the idea of saving money and avoiding new regulations by self-funding. Nonetheless, small business representatives in Alabama, Colorado, Minnesota, and Oregon reported that they had not yet encountered any increase in interest in self-funding among small employers, and most informants were uncertain of the extent to which rates of self-funding would increase among smaller groups.

Various stakeholders suggested that defined contribution, in particular, would be a more appealing model than self-funding for small groups.

Many commented that they simply cannot predict what will happen until they have a better understanding of what the market will look like in 2014. Informants generally agreed that health insurance costs—and, in particular, the possibility of premium increases for younger, healthier small groups—will play an important factor in small businesses' decisions in a post-reform environment. Self-funding could become an increasingly attractive option to those groups, especially if marketed with an affordable self-funding arrangement that minimizes their exposure to financial risk. Informants indicated that it will be particularly important to watch whether more insurers create self-funding arrangements that take much of the risk out of self-funding, are easier to understand, and, from the employer perspective, look very similar to the traditional fully insured health insurance. As one producer in Oregon described such arrangements: "They offer the full meal deal. You get your burger, your fries, and your toy all in one package." While such packages may cost more than traditional methods of self-funding, the cash-flow protection they provide may make them more viable options for small employers. A small employer's maximum monthly costs with a bundled package may not be significantly greater than the premium for fully insured plans and, if claims are low, may be much less. At the same time, the appeal of self-funding arrangements may depend on fine details within the contracts. Producers and health insurers in New Mexico, where bundled packages have popped up in the past, indicated that small employers could still get "bitten in the end" and be liable for large claims at the end of the contract year, as in any other stop-loss policy. In such cases, if small employers want to return to the traditional fully insured market, they may need to pay premiums for the new plan while still paying claims on their old policy.

Informants also indicated that self-funding may just be one of a range of options that will be available to small employers. Various stakeholders suggested that defined contribution, in particular, would be a more appealing model than self-funding for small groups. Although small employers typically contribute a set percentage to their employees' premium costs, meaning their costs rise as premium costs rise, a defined contribution model would allow them to specify a flat dollar amount as their premium contribution. They then get to decide whether to increase that dollar amount in future years. According to one informant, "Employers just want to say, 'Here is $500/month for health insurance, go away.'" Informants in multiple states also reported an increase in the purchase of high deductible health plans at lower premiums than traditional health plans, while limiting their employees' out-of-pocket costs by funding health reimbursement arrangements (HRAs) to fill in all or a portion of the deductible. A Rhode Island exchange official expressed concern that while groups doing this are not taking themselves out of the fully insured market, it may serve as a stepping stone towards self-funding. In addition, informants in multiple states raised concerns about producers pushing other arrangements that may incorporate self-funding, such as medical stop-loss captives and professional employer organizations (PEO).[17] In Alabama, for instance, one producer indicated that he was forming a captive by pooling several small groups together and arranging with a stop-loss insurer to reinsure the entire group collectively. Small employers also may elect to drop coverage altogether without penalty, as the ACA's employer responsibility requirements do not apply to groups with 50 or fewer

employees. And, under the ACA's insurance reforms, their employees will, for the first time nationwide, have guaranteed access to subsidized insurance through the exchanges.

How these different options stack up against self-funding will depend in part on how stop-loss coverage and self-funding arrangements are communicated to small businesses. A range of informants—including current and former producers—expressed doubt that producers are always adequately explaining the risks of self-funding to small employers. One regulator reflected on prior experience with increases in self-funding among small groups, noting "If the small employers walked in eyes wide open, then fair enough, but I think a lot of them walked in with no idea and had not been appropriately guided." Small employers may be more likely to self-fund when they are not fully informed of their potential financial and legal exposure under such arrangements.

Expansion of the regulation of stop-loss to small employers is a low priority before 2014.

While they acknowledged that a significant increase in self-funding among small employers could destabilize the small group market and undermine the SHOP exchanges, neither state regulators nor state exchange officials identified the further regulation of the sale of stop-loss as a primary concern. Informants largely reported that further state action was unlikely before full implementation of the ACA.[18]

According to many informants, state inaction on stop-loss was due in part to a lack of capacity. Most study states are developing state-based exchanges and are focused on the mechanics of standing up their SHOP exchanges. State officials generally reported having limited time to focus on issues related to adverse selection against the exchange. As one small business representative active in exchange discussions in Colorado noted, "adverse selection [against the SHOP] is a downstream issue" and "right now, we are still trying to get our sea legs and get [the SHOP] up and running." This response did not surprise one major insurer in Maryland who noted that "States have a lot on their hands, and they don't have the bandwidth to focus on issues that are not of the utmost urgency at this time." This informant added: "There are so many pieces of health reform that need to get done, not only for the regulators, but also for the insurers, so nobody is paying that much attention to this right now."

In addition, state officials seem to regard the sale of stop-loss coverage and self-funding of small employers as a "tertiary adverse selection issue," and are instead focusing on how they can make the SHOP appealing to small groups in the first place. In Rhode Island, officials are focused on how to structure the SHOP to ensure that it offers plans and services that attract enough small employers to be self-sustaining in 2014. Instead of concentrating on how to eliminate options that may be offered outside the exchange, Rhode Island is concentrating its efforts on implementing an employee choice and defined contribution model that will attract small employers to the SHOP. As one state official noted, "Our approach is to do what is absolutely necessary, not necessarily what is needed for broader fixes to the market."

A number of state officials also noted that state legislatures are typically reluctant to engage in regulatory solutions before there is a defined problem. One state exchange official described the prediction of increased self-funding among small employers as a "hypothetical," and another informant noted that "most governments aren't going to deal with this preemptively." In addition, it was suggested that moving forward to further regulate the sale of stop-loss would be the "the third rail" politically. That being said, a number of regulators and exchange officials suggested that clear data demonstrating a significant increase in self-funding among small employers to the detriment of the small group market and SHOP exchange may trigger state action down the road, especially in states that are standing up an exchange. For example, in Rhode Island, a state official offered that if self-funding among small employers becomes a "defined problem" that is "causing harm to the SHOP" or "having an impact on the costs and trends of the small group market," then the state may be spurred to action.

Expanding definition of small group may further complicate the stop-loss discussion in 2016.

In 2016, under federal law, the definition of the small group market will expand to include businesses with 51 to 100 employees. This will enable groups of this size to purchase health insurance in the small group market and through the SHOP exchanges on a guaranteed issue basis. They will also be newly subject to the ACA's small group market reforms, including the adjusted community rating rules, coverage of essential health benefits and limits on cost sharing. This change also may

complicate the discussion over whether it is necessary or appropriate to regulate the sale of stop-loss coverage to small groups.

With these changes, informants often reported that they expect to see increases in self-funding by employers with more than 50 employees. For instance, Rhode Island officials suggested that the 51 to 100 market—where groups are mostly experience-rated and some of the healthier and younger groups could face increases in premiums under the ACA's rating reforms—may be more inclined to self-fund than employers in the current small group market, which is already subject to adjusted community rating. Stakeholders in New Mexico agreed; one producer note that groups over 50 are used to being underwritten, confronting lasers, and coverage denials, so "they might as well take on more risks to avoid the taxes and fees in fully insured coverage." A Minnesota small business representative thought employers with 51 to 100 employees are the more "natural audience" for self-funding, given their exposure to the ACA's employer responsibility requirements.

Informants were also often less concerned about employers with more than 50 employees self-funding than employers with 50 or fewer employees self-funding. As one producer described, if a business has survived long enough to have 60 or 80 employees, it is more likely to be financially and operationally ready for self-funding. Industry representatives also indicated that more insurers and producers are willing to sell stop-loss to this market than to smaller groups, and others may follow suit. In Oregon, a state official acknowledged that many groups in this market are already self-funding with the bundled arrangement described previously. At the same time, a growth in self-funding among these larger small employers would likely increase the risk of adverse selection against the fully insured small group market in 2016. State officials generally did not speculate on if or how they would address this issue if it arose.

CONCLUSION

In interviews with key stakeholders, most informants did not believe that insurers and brokers are currently selling stop-loss insurance to small groups, beyond a few niche sellers. None of the informants thought that small employers are self-funding in any significant numbers. However, insurance regulators and policy-makers are hindered by a lack of data, with no state able to report the actual number of small employers covered under stop-loss policies or the terms under which those policies are being marketed.

Most informants expressed concern that self-funding exposes small businesses to too much financial and legal risk. While some speculate that healthier small groups may increasingly be driven to self-funding because of the ACA's market reforms, informants indicated that a number of variables will influence employers' decisions and were hesitant to make firm predictions of what the 50-and-under market will look like in 2014 and later years. Many informants agreed, however, that groups between 51 and 100 employees are more likely to self-fund in greater numbers when they become subject to the small group market reform rules in 2016.

Given the uncertain future of the small group market and number of other pressing health insurance reform responsibilities facing state legislatures, departments of insurance, and the exchanges, informants widely reported that prohibiting or otherwise expanding regulation of the sale of stop-loss insurance to small employers is a low priority in the near future. Instead, many informants acknowledged that states would be well served to improve monitoring of the stop-loss market and trends in self-funding by small groups, so they can identify if changes in the marketplace are occurring and respond appropriately. At a minimum, state departments of insurance could collect data on the number of small employers self-funding, the number of small employers purchasing stop-loss insurance, and the attachment points of policies sold to small groups.

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About Georgetown University's Health Policy Institute—Center on Health Insurance Reforms
The Center on Health Insurance Reforms at Georgetown University's Health Policy Institute is a nonpartisan, expert team of faculty and staff dedicated to conducting research on the complex and developing relationship between state and federal oversight of the health insurance marketplace.

ENDNOTES

1. To gather qualitative research using a convenience sample, interviews were conducted with 22 state officials, including regulators, exchange officials, and others; eleven representatives of health and stop-loss insurers; ten current and former producers; and five small business representatives.
2. While the federal government does collect data related to self-funding among employers that cover groups of over 100 employees, these data do not specify whether employers are relying on a stop-loss policy to self-fund. Solis HL, "Report to Congress: Annual Report on Self-Insured Group Health Plans" (Washington: Department of Labor, April 2012), available at http://www.dol.gov/ebsa/pdf/ACAReportToCongress041612.pdf.
3. Experts note that state efforts to regulate stop-loss insurance may continue to face ERISA pre-emption challenges. For a full discussion, see, for example, Jost TS and Hall MA, "Self-Insurance for Small Employers under the Affordable Care Act: Federal and State Regulatory Options," NYU Annual Survey of American Law, forthcoming, Washington & Lee, Legal Studies Paper No. 2012-24 (Jun. 2012); and Korobkin R, "The battle over self-insured health plans, or one good loophole deserves another," Yale Journal of Health Policy, Law, and Ethics 1,UCLA School of Law Research Paper No. 04-2 (Winter 2005).
4. According to one recent analysis, the rate of self-funding by firms with fewer than 50 employees has hovered around 12 percent for over a decade, while the rate of self-funding by firms with 50 or more employees increased from 49.5 percent in 1999 to 68.5 percent in 2011. See Fronstin P, "Self-Insured Health Plans: State Variation and Recent Trends by Firm Size," Notes 33, n. 11 (Nov. 2012), available at http://www.ebri.org/pdf/notespdf/EBRI_Notes_11_Nov-12.Slf-Insrd1.pdf.
5. See, for example, Yee T, Christianson JB, and Ginsburg PB, "Small Employers and Self-Insured Health Benefits: Too Small to Succeed?" Center for Studying Health System Change, Issue Brief 138 (Jul. 2012), available at http://www.hschange.com/CONTENT/1304/; and Jost and Hall.
6. Employers, large or small, that purchase a stop-loss policy require access to a provider network, claims processing, and other administrative services required to properly administer a health plan. Some employers obtain these services through separate contracts; others buy them as a bundled package from a third-party administrator, who may also be the stop-loss carrier.
7. Buettgens M and Blumberg LJ, "Small Firm Self-Insurance Under the Affordable Care Act," Commonwealth Fund, Pub. 1647 (Nov. 2012), available at http://www.commonwealthfund.org/Publications/Issue-Briefs/2012/Nov/Small-Firm-Self-Insurance.aspx.
8. Hall MA, "Regulating Stop-Loss Coverage May Be Needed To Deter Self-Insuring Small Employers From Undermining Market Reforms," Health Affairs, 31, no. 2 (2012), available at http://content.healthaffairs.org/content/31/2/316.abstract
9. The NAIC Model Act prohibits insurers from issuing a stop-loss policy with an attachment point less than $20,000 per person per year or that provides direct coverage of an individual's health expenses. Aggregate stop-loss for groups of more than 50 may not be less than 110 percent of expected claims. For groups of 50 or less, aggregate stop-loss may not be less than the greater of $4,000 times the number of group members, 120 percent of expected claims, or $20,000. See "Compendium of State Laws on Insurance Topics," National Association of Insurance Commissioners (Feb. 2010).
10. Colorado applies a minimum specific attachment point of $15,000 and a minimum aggregate attachment point of 120 percent of expected claims for the small group market.
11. Maryland applies a minimum specific attachment point of $10,000 and a minimum aggregate attachment point of not less than 115 percent of expected claims.
12. Minnesota has applied a minimum specific attachment point of $20,000 and a minimum aggregate attachment point of not less than the greater of $4,000 times the number of group members, 120 percent of expected claims, or $20,000.

13. See C.R.S. 10-16-105 (13). This requirement, however, may be pre-empted in 2014 by the Affordable Care Act, which allows rate surcharges based only on age, tobacco use, geographic location, and family size.
14. A contract providing stop-loss coverage, issued, or renewed to a small employer, as defined in section 62L.02, subdivision 26, or to a plan sponsored by a small employer, must include a claim settlement period no less favorable to the small employer or plan than coverage of all claims incurred during the contract period regardless of when the claims are paid. See Minn. Stat. § 60A.236.
15. Such an employer, however, may have seen no or very few claims in the first two months of its policy (the "run in") because of the typical delay in medical bills being submitted and paid. An employer that is aware of its liability at the end of the contract year could bank any "run in" savings to cover the "run out."
16. This is consistent with observations made by experts analyzing the market. See, for example, Jost and Hall.
17. Similar to captive property/casualty programs, medical stop-loss captives allow self-funded employers to pool part of their excess medical claims costs with other like-minded companies and then purchase commercial stop-loss coverage at higher attachment points. PEOs contract with client organizations to provide human resources management, including services such as payroll, access to benefits packages, and workers' compensation and unemployment insurance claims.
18. After interviews were completed, state legislators in some study states, including Minnesota and Rhode Island, introduced legislation to further regulate the sale of stop-loss coverage to small employers. See 2013 MN HB 647 and 2013 RI HB 5459.

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113TH CONGRESS
1ST SESSION

H. R. 3462

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 13, 2013

Mr. CASSIDY (for himself and Mr. ROE of Tennessee) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and the Workforce and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to exclude from the definition of health insurance coverage certain medical stop-loss insurance obtained by certain plan sponsors of group health plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Self-Insurance Protection Act".

SEC. 2. CERTAIN MEDICAL STOP-LOSS INSURANCE OBTAINED BY CERTAIN PLAN SPONSORS OF GROUP HEALTH PLANS NOT INCLUDED UNDER THE DEFINITION OF HEALTH INSURANCE COVERAGE.

(a) PHSA.—Section 2791(b)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(b)(1)) is amended by adding at the end the following new sentence: "Such term shall not include a stop loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop loss policy obtained by such plan or sponsor.".

(b) ERISA.—Section 733(b)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191b(b)(1)) is amended by adding at the end the following new sentence: "Such term shall not include a stop loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or

sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop loss policy obtained by such plan or sponsor.".

(c) IRC.—Section 9832(b)(1)(A) of the Internal Revenue Code of 1986 is amended by adding at the end the following new sentence: "Such term shall not include a stop loss policy obtained by a self-insured health plan or a plan sponsor of a group health plan that self-insures the health risks of its plan participants to reimburse the plan or sponsor for losses that the plan or sponsor incurs in providing health or medical benefits to such plan participants in excess of a predetermined level set forth in the stop loss policy obtained by such plan or sponsor.".

○

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
EXECUTIVE VICE PRESIDENT
GOVERNMENT AFFAIRS

1615 H STREET, N.W.
WASHINGTON, D.C. 20062-2000
202/463-5310

November 20, 2013

The Honorable Bill Cassidy
U.S. House of Representatives
Washington, DC 20515

The Honorable Phil Roe
U.S. House of Representatives
Washington, DC 20515

Dear Representatives Cassidy and Roe:

The U.S. Chamber of Commerce, the world's largest business federation representing the interests of more than three million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations, and dedicated to promoting, protecting, and defending America's free enterprise system, thanks you for introducing H.R. 3462, the "Self-Insurance Protection Act." This legislation would ensure that the definition of health insurance coverage will not improperly encompass certain medical stop-loss insurance used by self-insured health plans and plan sponsors of group health plans as a form of financial protection.

Many businesses decide to offer their employees health benefits through self-insured plans. Employers that self-insure, particularly small to mid-sized businesses, purchase stop-loss insurance to protect the plan and plan sponsor in the event of unexpected catastrophic losses. H.R. 3462 would guarantee that employers may continue to have this effective option of providing quality health benefits by limiting further regulation of self-insurance. Providing this clarification to the law will make certain that federal regulators cannot redefine stop-loss insurance as traditional health insurance.

The U.S. Department of Health and Human Services has shown interest in the possibility of regulating stop-loss insurance which raises concerns that future regulations may make the administration of self-insured plans more burdensome and expensive for employers who choose this option. In addition to making self-insurance coverage less appealing, including stop-loss insurance in the definition of health insurance coverage could effectively force many self-insured entities using stop-loss insurance to discontinue their plans. In light of this tumultuous and highly transitional time for our country's private sector health insurance system, it is critical to ensure that businesses continue to have a variety of accessible options to offer their workers quality health care coverage.

The Chamber continues to support health care reform that builds on and reinforces the employer-sponsored system and looks forward to working with you and your colleagues to enact this important legislation to protect the American workforce and the businesses that drive our nation's job creation.

Sincerely,

R. Bruce Josten

R. Bruce Josten

Mr. Chairman,

I want to thank you for holding this hearing and highlighting the value of self insurance as an affordable option for small businesses seeking to provide their employees with quality health care.

As a former Chairman of the Self Insurance Institute of America (SIIA), a former senior executive of two large Blue Cross health plans and a former owner and current operator of a third party administrator, I can tell you that self insurance is an important model that is being adopted rapidly all over the country. Given my extensive experience owning and operating third party administrators (TPAs), I can tell you that not only do self-insured plans provide businesses with an opportunity to generate significant savings but they provide employers with more flexibility to customize health care benefits for their employees.

The commercial health insurance market has been steadily moving from fully insured to self insured for over three decades. Today 61% of all employers in the U.S. self insure and the small group health insurance market is looking to self insurance as a more attractive method of providing health benefits to employees. According to the Kaiser Family Foundation, 16% of small businesses currently self insure their medical benefits. Many industry consultants believe that the cost advantage of self insuring will drive the small group market to over 50% self-insured.

As a former senior executive of health plans, I can attest that the trend toward self insurance is undesirable for the large national health insurance carriers. The reason for this is that these large health insurance companies make much more money from fully insured clients than self insured clients. In many cases, I have seen that these companies make 300% to over 500% more profit on fully insured books of business compared to self insured business. Fully insured small employers with less than 500 employees are generally the most profitable groups for the insurance carriers. Needless to say, they have a strong financial interest in deterring smaller employers from making the switch to self insurance.

Traditionally, self insurance is about 4–10% cheaper than buying a fully insured health policy, and given the costs of Obamacare that self insured plans avoid, this savings advantage is projected to grow to over 15%. Yet despite these significant savings, many states are trying to limit access to smaller employers. Add to this that some health insurance carriers, through pervasive market practices, are artificially inflating costs for self insured plans.

In an attempt to protect their profits, some plans use tactics to block their self insured clients from enjoying free and open choice of vendors for their health plan, even though when an employer self funds, they should have full control of how their dollars are spent. Since the insurance company is only providing administrative back office services like claims processing for self funded groups, not taking risk, this practice is very restrictive.

For example, some carriers block independent specialty service companies from offering medical cost saving solutions that would make self insurance even more financially attractive. Specialty

companies focus on driving cost savings and quality improvements within a particular type of medical service such as pharmacy, vision, dental, mental health, radiology, oncology, fertility, transplant management and physical therapy.

Further, many states ban smaller group self insurance or create limitations by artificially forcing larger deductibles on reinsurance for these smaller employers. These regulations amount to a restraint of trade designed to perpetuate the state tax revenue derived from fully insured plans. While many states claim they limit small employer self insurance because they want to protect those constituents, statistics show that small employers can benefit from this alternative insurance and strengthen their financial outlook.

Several large carriers will refuse to release the claim experience for their insured smaller employers so that these customers cannot get competitive self insurance proposals. This practice is common and reflects further restraint of trade by these dominant insurers while protecting their bottom lines.

These regulations and business practices have impaired the self insured market, making it much less cost effective than it would otherwise be under a truly free and open competitive market. I felt it important that the Small Business Committee is made aware of these detrimental market practices and I encourage further investigation. I appreciate your consideration of my testimony.

Sincerely,

Lawrence Thompson
Regional President
POMCO Group

House Committee on Small Business
Subcommittee on Health and Technology Hearing

November 14, 2013

Self-Insurance and Health Benefits: An Affordable Option for Small Business?

Statement for the Record
Rep. Bill Cassidy (LA-6)

Chairman Collins, Ranking Member Hahn and members of the committee. Thank you for the opportunity to submit my statement for the record. Over 100 million Americans are currently covered under self-insured health plans. The trend towards self-insurance has been increasing for years, with 61 percent of the commercial health insurance market currently covered under self-insurance. Therefore, it is imperative to understand that self-insurance market and protect it as an option for businesses throughout the country.

Self-insurance provides employers with the flexibility to customize their employee health benefits to best meet the needs of their workforce. Self-insurance also helps control costs because employers can more directly manage programs such as wellness programs, which save money and make people healthier.

Unlike traditional health insurance, self-insured employers take on the risk for their employees. It is impossible for the employer to precisely predict the amount of health claims they must provide from year to year. In order to limit the employer's exposure, they often buy stop-loss insurance. This financial tool is important to provide certainty to employers.

Moreover, the Obama administration has recently expressed interest in regulating stop-loss insurance. As recently as August 22, 2013 in a letter to Congress, HHS Secretary Kathleen Sebelius confirmed that the department is interested in how regulating stop-loss insurance could affect the risk pools in the fully insured market. It is concerning that the administration is considering limiting access to the stop-loss financial tool for businesses. Stop-loss insurance has always been a state-regulated insurance tool. Limiting it would have a detrimental effect on the self-insurance market.

In order to protect the self-insurance market, I introduced H.R. 3462, the Self-Insurance Protection Act (SIPA). The legislation would clarify that federal regulators cannot re-interpret stop-loss insurance as traditional health insurance for the purpose of regulating it. This clarification would protect this important financial option and provide certainty for thousands of businesses across the country. The legislation is supported by the Self-insurance Institute of America (SIIA) and the U.S. Chamber of Commerce.

Again, thank you for the opportunity to include this statement for the record. Also included are H.R. 3462, and a letter of support by the U.S. Chamber of Commerce.

Sincerely,

Rep. Bill Cassidy (LA-6)

WOODLAND TRUCK LINE, INC.

WE ♥ FREIGHT

November 21, 2013

To Whom It May Concern:

Jim & I have owned Woodland Truck Line, Inc. since 1967. We are a small union carrier with 29 trucks and 40+ employees. We have survived many changes in the economy, energy prices, and regulations. These latest changes could be the straw that breaks the camel's back. Woodland Truck Line, Inc. has never made a big profit but we usually have not lost money, however, since this law we have had losses every month.

The new hours' rule allows drivers to take only one 34-hour restart a week and requires that restart to have two 1 a.m. to 5 a.m. time periods within, and 168 hours in between restarts. It also requires that drivers take a 30-minute break after eight hours on-duty hours. The 100 air mile exemption does not help a small carrier like Woodland Truck Line, Inc.. It really just helps UPS and FEDEX. Also with serving just Washington, Oregon, BC and a little of Idaho our drivers usually do not drive 8 hours straight because they are stopping to make pickups or deliveries. From the driver's side, all this does is put more drivers on the road and reduces the driver's pay. From the Company's side, productivity per employee and truck is reduced which adds greatly to costs especially if that company provides any employee fringes, which we do (like family medical with dental and vision and a pension plan).

Our drivers hate the new rules because it keeps them away from home longer with no extra compensation. With a small carrier, flexibility is our main advantage over the big guys and this law takes that away. **Making the 34-hour restart conditional is wrong,** and the current rule penalizes night shift drivers. A day shift driver could restart after as little as 34 hrs, whereas a night shift driver with a shift ending between 1:00 a.m. to 5 a.m. could add an additional 24 hours. That is not fair for a night shift driver. Some of our drivers prefer this shift because their shifts go easier with less of the public on the road. This also reduces peak hour congestion.

Additionally, if a driver wanted to take two days off during the week (which he used to be able to do) he could make up the time by working on the weekend. Not so, with the new conditional 34 rule.

If you really think about it, 34 hours off is 34 hours off regardless of restart time.

According to our accident investigations and our drivers we would see no increase in safety, in fact the opposite is true because this rule decreases drivers' flexibility.

This downward pressure on driver pay would hinder safety when more experienced and qualified drivers choose to do some other job instead of losing pay. Carriers would be

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WOODLAND TRUCK LINE, INC.

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left with less experienced and qualified individuals to replace them. Which is what is currently happening in our country.

It is frustrating for us that the same city, county, state and federal agencies that are responsible for, but have failed to provide adequate road capacity, are sometimes the same agencies that regulate our industry.

As stated earlier, currently the trucking industry is showing a good safety record under the old rules. If it is not broke do not fix it.

Thank you,

Darlene Johnson
President
Woodland Truck Line, Inc.

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