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Congress of the United States

U.S. House of Representatives

Committee on Small Business

2361 Rayburn House Office Building

Washington, DC 20515-0315

Memorandum

To:	Members, Subcommittee on Health and Technology
From:	Committee Staff
Date:	November 12, 2013
Re:	Hearing: "Self-Insurance and Health Benefits: An Affordable Option for Small Business?"

Introduction

At 10:00 a.m. on November 14, 2013, in Room 2360 of the Rayburn House Office Building, the Subcommittee on Health and Technology will meet for the purpose of receiving testimony from industry leaders and small business owners regarding the trend of small businesses choosing to self-insure their employees health care coverage rather than purchase health insurance from insurers. The hearing will also examine whether changes to the health care marketplace, including the implementation of the new health care law,[1] are influencing these decisions.

Background

In the United States, there are generally four means of paying for the health care products and services that individuals consume: they can pay for the services out of pocket, they may qualify for means-tested or retirement-age health programs such as Medicaid and Medicare, they can individually obtain private insurance from an insurance carrier; or they can receive health benefits as non-cash compensation through an employer. The most common source of health care financing is through some type of health benefit provided through an employer, unless the individual is eligible for Medicare or Medicaid. The source of these employer-sponsored benefits may be a fully-insured health benefit or a self-insured health benefit. Before discussing the topic of the hearing, it is necessary to provide differences between fully-insured health benefits and self-insured health benefits.

The typical purpose of insurance is to indemnify individuals against economic loss resulting from unanticipated or unforeseen events. It transfers the risk that an individual may experience an economic loss from the individual to the insurer. The insurer is willing to take the risk because the insurer receives premium payments from the insured.

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[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2011) (hereinafter the "health care law" or the "law").

While health insurance provides similar indemnification protection against potentially catastrophic health expenses, it also often pays for routine and customary health care products and services.[2] Thus, what many people consider health insurance is in actuality part indemnification insurance and part a means of receiving routine health care products and services they may consume.[3]

The purpose of this hearing is to discuss employer-sponsored health benefits. Therefore, the rest of the memorandum will discuss employer options for sponsoring health benefits for their employees. Currently, there are two such options: purchasing a fully-insured health benefit plan or sponsoring a self-insured plan.

Fully-Insured Health Plans

Of the two health benefits options available to small businesses, the most common option has historically been a fully-insured plan purchased from an insurance company. Under a fully-insured plan, the insurance carrier charges the employer[4] a fee, typically in the form of a premium,[5] for coverage of the benefits specified in the insurance contract. To control for their own risks and potentially make health insurance costs more manageable and predictable to their small business customers, insurers typically pool their small business plans into a common-risk pool. This is known as the small-group market.

Fully-insured plans allow the sponsoring employer to transfer the risk that claims paid by the plan exceed the premiums the business (and beneficiaries) pay. For example, if a covered employee unexpectedly develops an illness and requires costly medical treatments, any costs in excess of premiums paid to the plan are the responsibility of the insurer. In addition, an insurer's risk pooling helps make the month-to-month cost of sponsoring coverage predictable to the employer, thus assisting the employer in managing its expenses and cash flow.

Self-Insurance

In contrast to a fully-insured plan, an employer can choose to assume all or a portion of the costs and risks associated with sponsoring the benefits plan. Under a self-insured arrangement, an employer forecasts how much it is likely to spend on health benefits in a given year and then decides whether or not it makes practical or economic sense for that employer to pay those costs out of pocket (self-insure) or purchase a fully-insured product. To protect against the possibility

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[2] For example, an individual purchases automobile insurance to indemnify themselves and their vehicles from loss or damage caused by theft or an accident. However, auto insurance does not pay for such routine vehicle ownership expenses such as oil changes or replacing the vehicle's brakes. Health insurance, in contrast, may pay for routine health expenses, such as an annual physical in a physician's office, even though such visits don't normally constitute an unforeseen or economically harmful event.

[3] Note, not all health insurance products provide so-called "first dollar coverage" of benefits. Some plans require individuals to spend-up to a deductible amount before the insurer assumes the additional costs of these benefits.

[4] Technically, the employer would be referred to as the "plan sponsor" but for clarity, this memo uses the colloquial term of "employer".

[5] The decision on how to divide the cost of the premium between employers and employees is up to the business owner.

of catastrophic costs, these plans may also purchase a stop-loss policy[6] from a third-party insurer to pay for these excess claims. Therefore, in deciding which option works best for the business and their employees, employers must take into account how much they will spend on employee health benefits, their willingness to assume all or a portion of the risk that claims will exceed these projections and the cost of a third-party stop loss policy.[7]

Traditionally, larger firms have utilized the self-insurance option at a greater frequency than smaller firms. In 2013, sixteen percent of covered workers at smaller firms (3–199 workers) and 83 percent of covered workers at larger firms are enrolled in plans which are either partially or completely self-funded, similar to 2012 (15 percent and 81 percent).[8] Six percent of firms offering fully-insured plans report that they intend to self-insure because of the health care law.[9]

Irrespective of whether a business decides to obtain insurance from an insurer or self-insure, the provision of employer-provided health insurance will be affected by the requirements of the health care law. The requirements of the law are a necessary prerequisite for understanding the parameters of the decision whether to self-insure is made.

The Health Care Law's Requirements

The health care law was signed by the President on March 23, 2010. Although many people agreed that our health care system needed reform, the debate that resulted in the comprehensive health care law was a contentious one, culminating in a decision by the United States Supreme Court that largely upheld the law.[10]

The law requires individuals and employers with more than 50 employees to purchase and maintain qualified health care coverage[11] or, with certain exceptions not relevant for this hearing, pay a penalty for not doing so.[12] The law has remained controversial, raising questions about the access, affordability, and delivery of health care.[13] Small businesses that fall within the

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[6] Reinsurance, or stop-loss coverage, is a policy that details the conditions under which the reinsurer will pay a portion of the health care claims incurred by the employer's 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.

[7] Firms that self-insure typically contract with third-party administrators to duties such as plan enrollment, employee contribution collection, and customer service, among other tasks. In general, and for a more detailed description of self-insured plans, see SELF-INSURANCE INSTITUTE OF AMERICA, INC., UNDERSTANDING SELF-INSURED GROUP HEALTH PLANS, SOLUTIONS FOR CONTAINING COST WHILE PROVIDING QUALITY BENEFITS (2013) (on file with committee staff), and GEORGE PANTOS, HEALTHCARE PERFORMANCE MANAGEMENT INSTITUTE, ACA AND SELF-INSURANCE FOR SMALL EMPLOYERS (2013) (on file with committee staff).

[8] KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS, ANNUAL SURVEY, SUMMARY OF FINDINGS, 6 (2013), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8466-employer-health-benefits-2013_summary-of-findings2.pdf [hereinafter "KFF Survey"].

[9] *Id.*

[10] *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012).

[11] 26 U.S.C. § 5000A. The type of coverage that must be offered to employees is specified in 26 U.S.C. § 5000A(f)(2). Technically, the employer penalty only occurs if an employee enrolls in a plan for which the employee obtains a tax subsidy or when a cost-sharing reduction is allowed or paid. Id. *at* § 4980H(a)(2).

[12] *Id.* at § 4980H(c)(2)(A). This is commonly referred to as the "employer mandate" which has been postponed until January 1, 2015 where as the individual mandate is still scheduled to be enforced on January 1, 2014.

[13] KFF Survey, *supra* note 8, at 7-8.

employer mandate must determine how they will comply with the law and whether that compliance will avoid the imposition of statutory penalties.

Treatment of Self-Insured Plans vs. Fully-Insured Plans Under Federal/State Law

Given the possibility of business owners purchasing insurance or self-insuring to comply with the health care law, it is necessary to discuss how both options are regulated under federal and state law. Those distinctions may affect a business's decision to purchase health insurance or to self-insure their health benefits.

Under the McCarran-Ferguson Act,[14] states have primary authority over the regulation of all insurance products sold within their jurisdictions. This authority enables (but does not mandate) states to regulate health insurance (such as insurance purchased by employers to offer their employees) including, but not limited to: actuarial value of health insurance, coverage mandates, the adequacy of provider networks, exclusion or inclusion of pre-existing conditions, and the utilization of risk rating bands.

At the same time, employer-sponsored health insurance is subject to the regulatory requirements of the Employee Retirement Income Security Act (ERISA),[15] the federal law that sets minimum standards for private pension plans and the responsibilities of pension plans fiduciaries. ERISA was not enacted to specifically regulate health insurance but does so as a consequence of the fact that most individuals receive such insurance as an employee benefit.[16] Despite the potential breadth of ERISA on the regulation of health insurance by the states as a consequence of it being offered as an employee benefit, ERISA has a savings clause,[17] which permits states to continue the regulation of health insurance under the authority of state statutes recognized by the McCarran-Ferguson Act.[18]

The health care law contains features that have the potential to promote state authority in the form of additional state regulations on health insurance-related products and services.[19] Regulation of health insurance plans under state law, as a result of ERISA's "savings" clause is not extended to those businesses which self-insure. Since the Supreme Court has determined self-insurance is not insurance[20] the "savings" clause does not apply to self-insurers.[21] As a result, self-insurers that provide health care coverage to their employees are subject to the full requirements of ERISA.[22]

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[14] 15 U.S.C. §§1011-1015.
[15] 29 U.S.C. §§1001-1461.
[16] *See Aetna Healthcare Inc. v. Davila,* 542 U.S. 200, 211-14 (2004) (discussing the impact of employee benefit on state insurance regulation).
[17] 29 U.S.C. § 1144(a)-(b).
[18] Brendan Maher & Radha Pathak, *Enough About the Constitution: How States can Regulate Health Insurance Under the ACA,* 31 YALE L. & PLY'Y REV. 275, 285-88 (2013) [hereinafter Maher & Pathak"].
[19] *Id.* at 307.
[20] *FMC Corp. v. Holiday,* 498 U.S. 52, 61 (1990).
[21] Maher & Pathak, *supra* note 19, at 289.
[22] *Id.* at 290-291.

Despite the differing regulatory regimes between self-insurance and that purchased from insurers, the health care law mandates certain requirements that all providers of health insurance must offer, including: coverage of dependents up to age 26,[23] coverage of emergency services,[24] the right to external claims denial review,[25] coverage of preventative health services;[26] prohibitions against the imposition [27] of any annual and lifetime benefit limits.

Despite similar requirements for both fully and self-insured plans, the health care law imposes more requirements on insurers than on those that self-insure. For example, the law mandates that insurance spend a certain amount of premiums on claims (termed the medical loss ratio)[28] that are not applicable to self-insurers. As a result, the additional requirements imposed on insurance companies may play a factor in an employer's decision to self-insure rather than purchase a plan from an insurer.

Additional decisional criteria involve potential benefits and risks of self-insurance. It is to those factors that we know turn.

Self-Insurance Benefits and Risks for Small Businesses.

While there are advantages to self-insuring, the disadvantages and additional risk could outweigh the advantages. One of the most prominent advantages of a self-funded insurance plan is that it can increase positive cash flow. In a fully insured plan, employer health care costs are often fixed by the requirement that they pay an established monthly premium, regardless of whether the plan experiences claims in any given month. Self-funded plans, by contrast, only expend funds as claims actually occur.[29] Therefore, if claims during a particular month are lower than anticipated, that adds to the reserve and small business owners have the option to re-invest the additional cash into the business, or leave it in an interest bearing account, creating a long-term financial benefit.

The fact that employers are directly paying for health insurance claims also makes wellness programs and other incentive programs more relevant. With fully-insured plans, wellness plans generally do not result in immediate reductions in a firm's health insurance costs.[30] In most cases, prevention and wellness programs involve upfront costs in exchange for lower future spending on health care claims. As the financial rewards for wellness and prevention may not be immediate, an insurer may decide not to invest significant resources in a program if there is a possibility that their customer may move their business to a competitor to achieve lower-cost premiums. A business that self-insures may have a greater incentive to institute wellness

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[23] 42 U.S.C. § 300 gg-14.
[24] *Id. at* § 18022.
[25] *Id. at* § 300gg-19.
[26] *Id. at* § 300gg-13.
[27] *Id. at* § 300gg-11.
[28] 42 U.S.C. § 300gg-18. Other requirements, such as the requirement to provide essential health benefits and the law's tax on health plans are also not applicable to self-insured plans.
[29] NATIONAL INSURANCE SERVICES OF WISCONSIN, UNDERSTANDING SELF-FUNDED VS. FULLY INSURED HEALTH PLANS 4 (2012), *available at:* http://www.nisbenefits.com/pdfs-sell%20sheets/NIS%20-%20Self-Funding.pdf [hereinafter "Self-Funded plans"].
[30] Id. *at 5.*

programs in order to reduce their future medical costs. Additionally, certain provisions of the health care law that are expected to raise the cost of fully-insured small-group policies, such as essential health benefit requirements, could become an added incentive for a small firm to self-insure and leave the small-group market.[31]

While there are benefits to self-insuring, there are also risks. For example, claims over a certain period of time could be higher than anticipated, leading to greater out-of-pocket costs for the business. While stop-loss coverage can protect employers from paying excessive claims in a given year, the future cost of that coverage is vulnerable to the same escalation in costs as firms in the fully-insured market. Finally, the administrative costs involved with self-insuring have the potential to be significant and may serve as an initial deterrent.[32]

Potential Impacts on the Small-Group Fully-Insured Market

A small firm's decision to self-insure may also have implications for the cost of coverage in the fully-insured small-group market. To understand how, it is necessary to learn some basic facts about how the small-group market for health insurance operates.

In the fully-insured small-group market, as it exists prior to full implementation of the health care law, a firm's cost of insurance is not only a function of state and federal mandates, but also is directly related to their risk profile and previous claims experience. While insurers in many states are permitted to vary the premiums they charge small-group customers based on an individual firm's claims experience and risk factors, these individual small-group policies are pooled with the policies of other small firms and become part of a larger common pool. As a result, a firm's individual premium can be tied to the overall performance of the insurer's risk pools.[33]

Under the health care law, insurers are prohibited from separating insured populations into different pools.[34] In addition, the law modified community rating provisions prohibit insurers in the small-group market from taking a firm's previous claims experience into account when setting premiums.[35]

If a greater number of small firms with low projected health spending chose to leave the fully-insured market and self-insure, this could lead to smaller pools with a higher percentage of more costly individuals in the small-group market. In turn, the remaining firms, due to the higher risk, will face increased premiums thereby providing an incentive for the lower cost firms remaining

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[31] Mark A. Hall, *Regulating Stop-Loss Coverage May Be Needed To Deter Self-Insuring Small Employers From Undermining Market Reforms*, 31 HEALTH AFF. 316, 318 (2012).
[32] Self-Funded plans, *supra* note 29, at 5.
[33] Risk pooling is intended to help make costs predictable and manageable for consumers and insurers. In part, pools combine the policies of low utilization and high utilization users so that costs for high utilization users are affordable. KAISER FAMILY FOUNDATION, HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 5 (April 2008), *available at* http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7766.pdf.
[34] AMERICAN ACADEMY OF ACTUARIES, ISSUE BRIEF, HOW WILL PREMIUMS CHANGE UNDER THE ACA? 3 (2013), *available at* http://www.actuary.org/files/Premium_Change_ACA_IB_FINAL_050813.pdf.
[35] *Id.* at 5.

in the pool to leave.[36] In extreme cases, an adverse selection death spiral can occur when the insurer is no longer able to pay claims with collected premiums for the entire pool.[37]

Some health care industry researchers believe it is unlikely that the small group market would experience a significant incidence of adverse selection[38] as the law includes a number of provisions intended to reduce its occurrence.[39] Nevertheless, this adverse selection and increasing premiums may occur in the small-group market and it is a critical factor in the calculus to purchase or self-insure.

Conclusion

The health care law is likely to increase the cost of providing health benefits for both employers and employees alike. Self-insurance could be a more affordable means for employers to comply with the health care law's employer mandate but at a more affordable cost. However, small firms may find that the risks outweigh the benefits. The hearing is intended to expatiate on the costs and risks of self-insurance.

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[36] KATE GREENWOOD, SETON HALL UNIVERSITY SCHOOL OF LAW, THE AFFORDABLE CARE ACT'S RISK ADJUSTMENT AND OTHER RISK-SPREADING MECHANISMS: NEEDED SUPPORT FOR NEW JERSEY'S HEALTH INSURANCE EXCHANGE, 2 (2012), *available at* http://law.shu.edu/ProgramsCenters/HealthTechIP/HealthCenter/upload/affordable-care-act-risk-adjustment-9520.pdf.

[37] KAISER FAMILY FOUNDATION, HOW PRIVATE INSURANCE WORKS: A PRIMER 5 (2008), *available at* http://kff.org/health-costs/report/how-private-insurance-works-a-primer/.

[38] RAND CORP., EMPLOYER SELF-INSURANCE DECISIONS AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA) xi, (2012), *available at*: http://www.rand.org/pubs/technical_reports/TR971.

[39] JILL HERBOLD & PAUL HOUCHENS, MILLIMAN INC., *Individual and Small Group Premium Changes Under the ACA* 3, MILLIMAN, INC. (May 2011), *available at* http://www.in.gov/aca/files/Individual_SmallPremium_Increases.pdf.