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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.

<u>Financial Liability</u>

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-insuring, 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.

Rating Rules – As non-profit entities, plans have no financial incentives to rate participants unfairly. For fully-insured plans, there is both the profit margin incentive as well as a history of abuse in rating practices.

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.