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Small Firm Self-Insurance Under the Affordable Care Act

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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.

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OVERVIEW

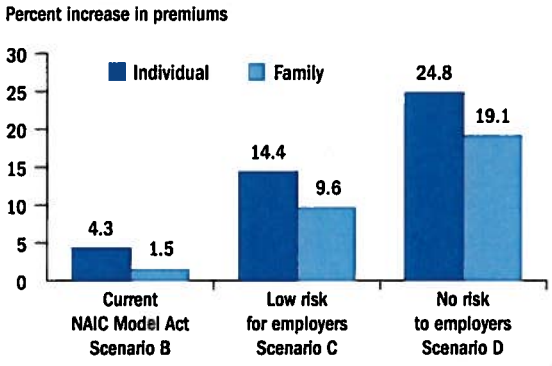
The Patient Protection and Affordable Care Act will substantially change the organization and market rules of the small-group insurance market, beginning January 1, 2014. Reforms focus on improving access to and adequacy of coverage, while increasing transparency and accountability of insurance products, 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

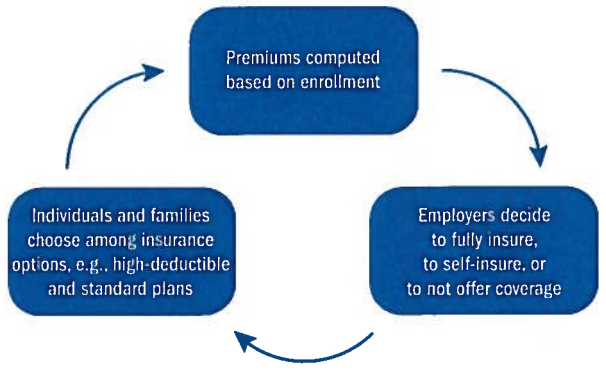
by the actuarial subgroup of the NAIC requires a self-insured employer to take on much higher risk than many stop-loss policies currently offered to small firms. Note that the results shown here assume implementation of the Affordable Care Act. Provisions such as the insurer fee do not currently exist, 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.

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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.

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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

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Georgetown University's Health Policy Institute

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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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.SIf-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.