Testimony of Robin P. Frick
on behalf of the National Association of Health Underwriters before the
U. S. House of Representatives Small Business Committee
Health and Technology Subcommittee
Hearing on
"Self-Insurance and Health Benefits: An Affordable Option for Small Business?"
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Good Morning. My name is Robin Frick and I am a licensed professional health insurance agent from Slidell, Louisiana. I serve the health coverage needs of my clients by helping them purchase, administer, service and utilize health insurance policies and other related benefits. I have spent my entire career helping businesses design and implement self-funded benefit plans for their employees. Many of the clients I have worked with are very large employers, but many are also employers that would fall under the jurisdiction of both this committee and the United States Small Business Administration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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