1. How common is the use of stop loss insurance in connection with self insured arrangements? Does the usage vary (and, if so, how) based on the size of the underlying arrangement or based on other factors? How many individuals, if known, are covered under stop loss insurance (either nationally or on a state-specific basis)? What are the trends? Are past trends expected to be predictive of future trends? Is the Affordable Care Act expected to affect these trends (and, if so, how)? ***In Maryland, about 14% of employees of small firms (fewer than 50 employees) were self-insured in 2009/2010 and the trend has been flat. Various studies indicate that the ACA will increase the incentive to self-insure in the small group market. (Refer to Exhibits 1 and 2 in the attached Issue Brief for more detail).***

2. What are common attachment points for stop loss insurance policies, and what factors are used to determine these attachment points? What are common attachment points by employer size (e.g., for plans with fewer than 50, between 50 and 100, or between 100 and 250 employees, and how do these compare to attachment points used by larger plans)? What are the lowest attachment points that are available? What are the trends? ***One national insurer indicated that common employee-level attachment points for stop loss insurance policies for large employers (50 or more employees) range from $100,000 to $500,000. A prominent Third Party Administrator (TPA) indicated it is selling stop loss insurance policies to small businesses with as few as 5 employees. Under Maryland law (Insurance Article § 15-129, Annotated Code of Maryland), medical stop loss insurance must have a specific attachment point of at least $10,000 or an aggregate attachment point of at least 115% of expect claims.***

3. Are employee-level (‘‘specific’’) attachment points more common, or are group-level (‘‘aggregate’’) attachment points more common? What are the trends? What are the common attachment points for employee-level and group-level policies? ***According to one large Maryland carrier, specific attachment points are more common than aggregate attachment points. Currently, specific attachment points range from about $125,000 to $150,000. Trends are about $10,000 to $11,000 per employee.***

4. How do insurers work with small employers to integrate stop loss insurance protection with self-insured group health plans? What kinds of options are generally made available? Are policies customized to meet the needs of different employers? ***Yes***. How are the attachment points for a stop loss policy determined for an employer? Do self-insured group health plans purchase stop loss insurance anticipating that they will purchase it every year? ***Yes, until they have a major loss. Current small group market rules allow a small employer to purchase with no pre-ex limitations.***

5. For a given attachment point, what percentage of total medical costs incurred by the employees is typically paid for by the employer and what percentage is typically paid for by the stop loss insurance policy? How much do the relative percentages vary for different attachment points? What are the loss ratios associated with stop loss insurance policies? No information

6. What are the administrative costs to employers related to stop loss insurance purchased for the employers' self insured group health plans? How do these costs compare to the administrative costs related to purchasing a health insurance policy from an issuer? ***MHCC does not have any data on costs. When employers self-insure they also avoid broker commissions, so it is possible that costs to a firm with a young healthy workforce could see much lower costs by self-insuring. As noted previously, small group rules permit the employer to purchase insurance with no pre-ex, etc. The small group protections coupled with the low attachment points provide incentives for gaming.***

7. Is stop loss insurance more prevalent in certain industries or sectors? Are there any minimum employee participation requirements for a small employer to be offered stop loss insurance? ***Stop loss insurance is more prevalent among larger employers; small employers that purchase stop loss insurance tend to be retail.***

8. What types of entities issue stop loss insurance? How many small entities issue stop loss insurance policies? ***Stop loss insurance policies are typically offered by national insurance companies, as well as by specific stop loss insurers.***

9. Do stop loss issuers increase fees for groups below a certain size or exclude those groups? If so, how? ***No information available on pricing.***

10. How do stop loss insurers evaluate the plans seeking coverage and how is this evaluation reflected in the coverage or premiums offered? Does the profile of the plan have an effect on the attachment points available?

11. How do States regulate stop loss insurance? In States that are regulating this insurance, what are the licensing processes and standards? Have States proposed laws, regulations, or best practices with regard to stop loss insurance? Do such proposals focus on attachment points, size of the group, percent of total claims paid by the stop loss insurer, or other criteria? What are the issues States face in regulating stop loss insurance? ***Under Maryland law (Insurance Article § 15-129, Annotated Code of Maryland), medical stop loss insurance must have a specific attachment point of at least $10,000 or an aggregate attachment point of at least 115% of expect claims. Maryland attempted to regulate stop loss insurance in the small group market but it failed in court.***

12. What effect does the availability of stop loss insurance with various attachment points and other particular provisions have on small employers' decisions to offer insurance to employees? ***In Maryland, about 14% of employees of small firms (fewer than 50 employees) were self-insured in 2009/2010 and the trend has been flat. Various studies indicate that the ACA will increase the incentive to self-insure in the small group market. (Refer to Exhibits 1 and 2 in the attached Issue Brief for more detail).***

13. What impact does the use of stop loss insurance by self-insured small employers have on the small group fully insured market? ***See answer to question 1 above.***

SPOTLIGHT ON
MARYLAND

MARYLAND HEALTH CARE COMMISSION

A Profile of Maryland's Self-Insured Small Group Health Insurance Market

One mission of the Maryland Health Care Commission (MHCC) is to develop timely and accurate information for policymakers, purchasers, providers, and the public, in order to promote informed decisionmaking.

Introduction

Employers that offer health insurance benefits can do so by offering fully insured commercial plans, for which the insurer is liable for the health care expenses, or self-insured plans, for which the employer pays for the employees' health care directly or through a trust. Self-insured plans, which are exempt from state regulation by federal law, can be less expensive for employers than commercial plans, especially if their employees are healthier than the general population of employees. Self-insured plans are also exempt from state health benefit mandates and premium taxes and enable multistate employers to offer uniform benefits across state lines.

Because employers that self-insure assume financial risk for health care claims, it has been much less common for small employers to self-insure than large employers, which are able to spread the risk of unanticipated, large health expenditures across many enrollees. Small firms that choose to self-insure are generally different from other small firms: "the ratio of expected health spending to wages is 50 percent lower at self-insured small firms compared to fully insured small firms"[1], indicating that their employees tend to be healthier, higher income, or both.

The Affordable Care Act's (ACA's) Small Business Health Options Program (SHOP) creates a health insurance exchange for small employers that should be functioning at the start of 2014. The SHOP exchange is designed to increase the number of employees in small firms with health insurance. However, the insurance protections in the ACA provide incentives for some small employers to self-insure[2]. Whether they purchase health insurance inside or outside the exchange, fully insured small businesses must offer plans that reflect the essential health benefits package, "include their enrollees in a single risk pool, offer the same premiums without regard to health status, and offer coverage tiers"[2] (bronze, silver, gold, and platinum). Self-insured businesses are not subject to these requirements and are exempt from the ACA's minimum medical loss ratio requirement and insurer fee. Additionally, the risk of self-insuring for small employers will be reduced under the ACA. If an employer's enrollee risk profile increases, the employer can easily switch to a commercial insurer thanks to the ACA's guaranteed issue requirement and ban on health status underwriting and pre-existing condition exclusions.[2]

Insurers are well aware of the self-insurance incentives under the ACA and have begun actively marketing self-insured products to small employers.[1,2] These products incorporate administrative services and medical "stop-loss" coverage—a type of reinsurance that protects firms against higher than expected enrollee spending—with a low attachment point.[3] "Adverse selection"—an increase in the number of small employers with healthier employees who choose to self-insure to avoid the cost of the ACA changes—in the small group market after the ACA is fully implemented has the potential to drive up premiums in the SHOP exchanges. Consequently, it seems prudent for states to closely monitor the self-insurance rate of change in the small group market prior to and after 2014. This brief discusses small group health insurance market regulation in Maryland, trends in self-insurance in this market, and how trends in Maryland compare to trends nationally.

Maryland small group health insurance market regulation

Small employers in Maryland have had access to a standard health benefit plan since 1995. All carriers that elect to offer group coverage in the fully insured market in Maryland must sell the standard health benefit plan to small firms (those with 2 to 50 employees). Coverage must be offered on a guaranteed issue and guaranteed renewal basis.

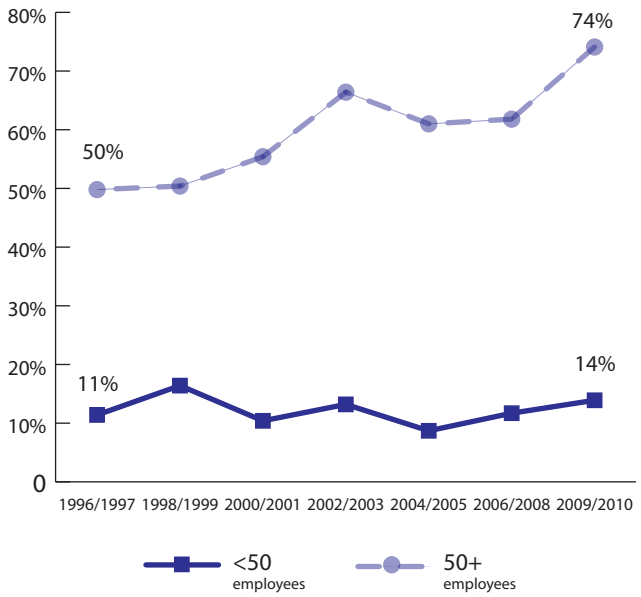
Carriers must establish a community rate for plans offered in the small group market and are allowed to adjust the community rate +/- 50 percent, based on the average age of the group and the geographic location of the business only. For new groups entering the fully insured market, carriers are allowed to further adjust the community rate for health status by +/- 10 percent, +/- 5 percent, and +/- 2 percent, respectively, during the first three years of enrollment. Pre-existing condition limitations are prohibited except for certain individuals that are new to this market. Although not stricken from the regulations, carriers are not using these additional rate adjustment options. Carriers never implemented the complex tiered premium option because of the impending ACA requirements and were asked by the Maryland Health Care Commission (MHCC) to not implement the pre-existing option, or to terminate use of that option if in force. (Only one carrier had used the pre-existing option and agreed to discontinue its use.)

The comprehensive standard health benefit plan (CSHBP) sold in the fully insured small group market is defined in regulation by the MHCC with the approval of the Maryland Insurance Administration. The average cost of an individual policy under the standard health benefit plan can be no more than 10 percent of the average annual Maryland wage ($51,742 in 2010). Employers are permitted to purchase riders that reduce deductibles, coinsurance, or copayments for medical or pharmacy benefits. Carriers report, anecdotally, that almost all small employers purchase one or more such riders. Consistent with the concept of a standard health benefit plan, negative riders that reduce benefits are not permitted. To keep the program affordable, the MHCC has the authority to exclude any of the existing 45 state mandates from the standard health benefit plan. Currently, 41 of the 45 state mandates are included in the plan. The excluded mandates include treatment for in vitro fertilization, coverage for hair prostheses after cancer treatment, smoking cessation treatment, and coverage for amino acid-based elemental formula.

Use of Self-insurance in Maryland

In Maryland, the percent of enrolled workers in small firms (<50 employees) with health insurance through self-insured plans is relatively low and has not changed much over time (Exhibit 1). In contrast, the percent of enrolled workers in larger firms (≥50 employees) with a self-insured plan is relatively high and has increased over time.

Exhibit 1: Percent of Enrolled Workers in Maryland in Self-insured Plans by Firm Size



Notes: In order to increase the precision of the estimates, data was pooled over two years. The 2007 data is not available because the Medical Expenditure Panel Survey-Insurance Component changed from retrospective to current collection in 2008.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component tables, as analyzed by SHADAC.

Use of Self-insurance in Maryland and Nationally

Both nationally and in Maryland, the percent of small employers that self-insure is relatively small and the trend is flat (Exhibit 2). This is also true for the percent of enrolled workers in small firms with a self-insured plan. For small employers, there are no statistically significant differences between the different time periods or between the U.S and Maryland within the same time period.

There are some differences for larger firms (50+ employees). In the 2009/2010 period there was an increase over the previous time period in the percentage of enrolled workers in larger Maryland firms that were in self-insured plans. Not only is the difference between the two time periods (2009/2010 & 2005/2006) statistically significant, but there is also a statistically significant difference between Maryland and the U.S. in 2009/2010.

Exhibit 2: Trends in Self-insurance, by Firm Size, Maryland and U.S.

	Maryland			U.S.		
	2001/ 2002	2005/ 2006	2009/ 2010	2001/ 2002	2005/ 2006	2009/ 2010
Among employers that offer health insurance, percent with a self-insured plan:						
Fewer than 50 employees	11.4%	12.9%	12.1%	12.5%	13.0%	13.0%
50 or more employees	63.2%	54.4%	62.2%	59.1%	61.6%*	62.9*
All firm sizes	33.8%	29.0%	33.0%	31.4%	33.6%*	35.5%*
Percent of enrolled workers in self-insured plans:						
Fewer than 50 employees	12.4%	11.6%	13.9%	12.4%	12.0%	12.1%
50 or more employees	58.0%	61.0%	74.1%*^	58.6%	63.0%*	66.7%*
All firm sizes	49.2%	50.0%	62.5%*^	49.5%	53.1%*	56.8%*

*Indicates a statistically significant difference from the previous time period within the geographic area at the 90% level.
*^Indicates a statistically significant difference from the U.S. within the time period at the 90% level.

Note: In order to increase the precision of the estimates, data was pooled over two years.

Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component tables, as analyzed by SHADAC.

Data Source and Precision of Estimates

All of the data in this brief is from the Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey-Insurance Component (MEPS-IC). The Insurance Component is a survey of employers that provides data on employer-based insurance. Because of the limited sample size in individual states, it can be difficult to detect statistically significant changes over time. For this reason, estimates for multiple years were combined to obtain more precise and stable estimates.[4] Combining years has the disadvantage of losing the ability to track changes by individual year, but by pooling just two years of data, the precision was increased sufficiently to allow for identification of changes over time without losing much in the ability to identify trends across time periods.

Summary

The percent of small employers, both nationally and in Maryland, that self-insure is relatively small (around 11% to 13%) and the trend has been flat. Although one study projected that adverse selection as a result of the increased incentive to self-insure in the small group market after the ACA is fully implemented would not be a "major threat"[5] to the success of the SHOP exchanges, the MHCC will continue to track self-insurance rates in the small group market and provide the information to state policymakers.

Differing Estimates of Small Employers and Their Offer Rates in Maryland

Different data sources yield different counts of small employers (fewer than 50 employees) and counts of those that offer health insurance to their employees, resulting in different estimates of the small employer offer rate (the percentage of employers offering health insurance) in Maryland.

The MHCC has historically reported two different estimates of the small employer offer rate in Maryland. One estimate—the MEPS-IC estimate—results from employer responses to the annual Medical Expenditure Panel Survey-Insurance Component (MEPS-IC) and counts of small employers produced by the U.S. Census Bureau.[a] The other estimate—the CSHBP estimate—results from counts of employers participating in Maryland's small group market insurance product, the Comprehensive Standard Health Benefit Plan (CSHBP), and estimated counts of small employers published by the state's Department of Labor, Licensing and Regulation (DLLR). Descriptions of the numerators and denominators used for each offer rate estimate are summarized in the chart below.

As a result of this comparison, the MHCC has concluded that the MEPS-IC offer rate estimate is more complete and consistent in that it includes both fully insured and self-insured small employers, and the numerator and denominator use consistent definitions. MEPS-IC is a national survey, making it possible to benchmark Maryland results against other states. For all of these reasons, the MHCC will rely on the MEPS-IC offer rate estimate in the future.

Comparing CSHBP and MEPS-IC Offer Rate Estimates for Private Sector Small Employers

	CSHBP Offer Rate	MEPS-IC Offer Rate
Establishment size having one employee included	Yes	Only if incorporated*
Employer Size	By establishment size	By firm size (all establishments)
Denominator	*More establishments*	*Fewer establishments*
Employers offering Health Insurance	Employers size 2-50 offering CSHBP	Employers size 1*-50 offering CSHBP or self-insured plan
Numerator	*Fewer establishments*	*More establishments*
Resulting Offer Rate	Lower	Higher
2010 Offer Rate	35.3%	47.2%

[a] The MEPS-IC survey is conducted by the U.S. Census Bureau for the Agency for Healthcare Research and Quality.

Sources: Maryland Department of Labor, Licensing and Regulation, the Agency for Healthcare Research and Quality, and MHCC.

Notes

[1] Eibner C, et al. Small firms' actions in two areas, and exchange premium and enrollment impact. Health Affairs (Millwood). 2012; 31(2):324-31.
[2] Jost T S, Employers and the exchanges under the small business health options program: examining the potential and the pitfalls. Health Affairs (Millwood). 2012; 31(2):267-274.
[3] The attachment point is the minimum level of expenditures per enrollee that an employer must pay before stop-loss insurance becomes effective. In Maryland's small group market, it can be as low as $10,000 per enrollee; the attachment point for large employers is typically much higher.
[4] The average relative standard error (se/estimate) for the combined years for the percent of small employers that self-insure in Maryland was 23% versus 32% if the years were not combined.
[5] Eibner C, et al. Employer self-insurance decisions and the implications of the Patient Protection and Affordable Care Act as modified by the Health Care Education Reconciliation Act of 2010 (ACA). Santa Monica (CA): RAND Corporation; 2011, xiii.

ACKNOWLEDGEMENT

The research and all analysis for this issue brief were conducted by the State Health Access Data Assistance Center (SHADAC). Their work was funded through a grant from the Robert Wood Johnson Foundation's State Health Reform Assistance Network.

MHCC is an independent, regulatory commission administratively located within the Maryland Department of Health and Mental Hygiene.

Marilyn Moon, Ph.D., Chair
Ben Steffen, Acting Executive Director

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Telephone: (410) 764-3460
Fax: (410) 358-1238
mhcc.dhmh.maryland.gov