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Re: Request for Information Regarding Stop Loss Insurance

Thank you for the opportunity to provide information on the use of stop-loss insurance. We recognize that stop-loss insurance is an important product for many group health plans that self-insure. We also recognize that many large employers provide comprehensive health benefits to their employees through self-insured health plans. We are concerned, however, with early indications, including internet advertisements, that insurers and benefits advisors are aggressively marketing stop-loss insurance to small employers as a means to evading consumer and market protections imposed on insurers under the Affordable Care Act. The undersigned organizations and individuals are extremely concerned about the increase in the use of stop-loss insurance with low attachment points by self-insured small employer plans and the potential that it will undermine important requirements of the Affordable Care Act (ACA). While we do not have access to data that would allow us to respond to many of the specific questions raised in the Request for Information, we would nevertheless like to express our deep concern about this issue and respond in part to questions 2, 11, and 13. We also attach a report by Deborah Chollet of Mathematica further discussing this issue.

We will be entering a new world in 2014 as the ACA continues to re-shape the rules of the road for health insurance, particularly through reforms for the individual and small group markets. Many small employers will purchase new, more affordable options offered by the SHOP exchanges. Other small businesses may be enticed by the recent marketing efforts of stop-loss insurers, which increasingly sell low-attachment point coverage as a way to circumvent the ACA consumer protections, including coverage of essential health benefits, guaranteed issue, and modified community rating. The widespread availability of stop-loss coverage with low attachment points could cause extensive adverse selection. Small groups may self insure when they have a good risk profile and return to the fully insured market when they do not.

Stop-Loss Insurance is Actively Marketed to Small Businesses [Question 2]

Employee benefits advisors and stop-loss insurers are openly touting self-insurance for small employers.[1] Our recent search on the internet discovered a number of promotions for stop-loss coverage aimed at small businesses. The following is a small sampling from websites we viewed in May 2012:

- "AMF can provide stop-loss on groups with as few as 10 eligible employees. . . . . Stop-loss limits of $10,000+ are available, depending on state law."[2]

- "We underwrite coverage for employers with as few as 11 participating employees, and with specific retention levels from as low as $5,000."[3]

- "IAC specializes in small group plans . . . with "stop-loss numbers" ranging from as low as $10,000 to as high as $25,000."[4]

- "CIGNA offers . . . administrative services for self-funded health plans . . . for employers with as few as 25 employees."[5]

- "Our goal is to bring a self insured product that best fits the below components of a self insured program to meet your needs. . . . Who is eligible? 10 - 50 Employee Businesses."[6]

- "In today's stop-loss market, employers can find coverage with attachment points as low as $10,000."[7]

- "I have recently heard about one of our competitors doing [self-funding] for small groups sized 5 and up."[8]

Further confirming this evidence, of the 474 self-insured groups CCIIO granted "mini-med" waivers to impose annual limits lower than those required by Affordable Care Act

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[1] See, e.g., United Benefit Advisors, Small Businesses Blaze a New Trail with Self-Funding (2011), http://wn.ubabenefits.com/Download.aspx?ResourceID=7630; Self-Insurance Institute of America, Companies of All Sizes Can Operate Viable; Self-Insured Group Health Plans (2011), http://www.avalonbenefits.com/news_story.php?file=2011-02-14_150657.txt; George J. Pantos, PPACA: Small Business And Self-Insurance: Dispelling Some Myths (2011), http://georgegjp.wordpress.com/2011/05/09/ppaca-small-business-and-self-insurance/; Michael Turpin, A Case for Self Insuring Small Business (2011), http://thehealthcareblog.com/blog/2011/04/08/a-case-for-self-insuring-small-business/.

[2] http://www.amfrms.com/smallgroup.htm

[3] http://www.img-stoploss.com/about-img-stop-loss/IMG-sl-advantage.aspx

[4] http://www.sbisvcs.com/iac_group_advantage.htm

[5] http://www.cigna.com/grouphealthplans/index.html

[6] http://healthexchangeforselfinsurers.com/About_Self_Insurance.html

[7] Joanne Wojcik, Smaller firms try self-funding benefits, Business insurance (2011), http://www.businessinsurance.com/article/99999999/NEWS050101/399999918#

[8] http://www.actuarialoutpost.com/actuarial_discussion_forum/showthread.php?t=211409

regulations of July 15, 2011, almost one quarter (109) had fewer than 50 enrollees, and ten percent (47) had fewer than 25 enrollees.[9]

The only contrary indication comes from an econometric projection by the RAND Corporation, which predicts no substantial increase in small employers that self-insure.[10] That study, however, assumed that "most stop-loss policies" have attachment points "exceeding $75,000," and the authors noted that their analysis might differ if the ACA "induce[s] stop-loss insurers to offer more-attractive policies geared specifically toward small firms that wish to avoid regulation."[11] Clearly, this is already happening.

Increasing Self-Insurance of Small Groups Reduces Benefits to Workers and Threatens the Stability of the Fully Insured Market [Question 13]

Self-Insured Status Avoids Essential Health Benefits Requirement

One of our particular concerns is that self-insuring small employers could offer their employees coverage that does not meet the essential health benefit (EHB) requirements that apply to certain plans beginning in 2014. All new health plans selling coverage to individuals and small groups—both in and outside of the new Exchanges—must offer benefits within at least the 10 broad categories of services. Some of the services included in the EHB standard, such as maternity, mental health and habilitative services, are currently extremely limited in the small group market, unless required by state law. Other federal requirements that govern group health plans do not apply to certain small employers. Specifically, the Pregnancy Discrimination Act and Americans with Disabilities Act do not apply to employers with fewer than 15 employees, the Age Discrimination in Employment Act does not apply to employers with fewer than 20 employees, and the Mental Health Parity Act does not apply to employers with fewer than 50 employees. This leaves potential gaps for some employers to not provide certain essential health benefits such as maternity care or mental health services or to provide benefits that would not comply with the non-discrimination requirements of the EHB standard.

Although we do not have data about the breadth of the ways in which coverage is lacking in the small group market, we do know that there are small group plans that currently do not cover all of the essential health benefits:

- Certain essential health benefits are sometimes sold as riders. According to an Issue Brief by ASPE, "[s]ome small group market plans sell riders for benefits such as maternity, mental health, substance abuse, and prescription drugs."[12] This coverage would only be sold as a rider if there are employers that choose not to offer the benefit.
- Habilitative services are not commonly a part of small group market plans.

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[9] Center for Consumer Information and Insurance Oversight. Self-insured employers: approved applications for waiver of the annual limit requirements [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2011 Jul 15 [cited 2012 Jan 18]. Available from: http://cciio.cms.gov/resources/files/employer_07152011.pdf

[10] C. Eibner, C. Price, R. Vardavas, et al., Small Firms' Actions in Two Areas, and Exchange Premium and Enrollment Impact, 31 Health Aff. 324 (2012). The study also projects that prohibiting self insurance would cause a net decline in small-firm workers covered by employer-sponsored insurance.

[11] Id. at 326.

[12] http://aspe.hhs.gov/health/reports/2011/IndividualMarket/ib.pdf (Footnote 4)

- Pediatric dental and vision are often sold as part of a separate excepted benefit, rather than being provided as part of the small group market plan.
- Recently, an insurance company in Washington State filed a request to remove all prescription drug coverage from the company's small group market products.[13] This suggests there is a market for small employer plans without certain essential health benefits, including prescription drugs. (The request was denied by the state insurance commissioner.)

The EHB standard will help correct the gaps in current law that leave employees of small businesses without adequate health protections. However, an increased use of self-insurance made possible through low attachment point stop-loss insurance for small employers could undermine these important protections.

Extensive Use of Stop-Loss Insurance Threatens to Undermine Insurance Reforms Inside and Outside the Exchange

Under the ACA, small group policies must be offered without regard to pre-existing conditions (guaranteed issue) and using modified community rating. An increased use of self-insurance could seriously undermine the small group market and severely damage the underpinning of the ACA: getting the largest and broadest possible risk mix possible in the insurance market. Small groups with younger, healthier employees are likely to prefer to pay the actual predicted cost of their lower-risk employees through self-insurance, exiting the ACA risk pools which would, in turn, cause prices to rise in the ACA-covered plans. And when a group's risk profile changes and it is no longer advantageous to self-insure, groups can rejoin the fully insured market without penalty, further increasing prices. This type of market segmentation is exactly what the ACA seeks to avoid.

In the small group market today, the key problem is affordability. Overall, health coverage costs more for small groups than for large; small groups with disproportionately older or less healthy employees face even higher costs. Thus, small employers often find the cost of providing health insurance prohibitive and decline to offer it.

The ACA includes a number of requirements intended to remedy this situation in the small group market. These steps include requiring that small group policies to use guaranteed issue and modified community rating. In an attempt to create the broadest risk pools possible, the ACA also bars insurers from splitting their individual and small group business in each state into smaller risk pools. In addition, the SHOP exchanges are intended to increase the market power of small employers and reduce their administrative cost and the complexity of the market they face, thus reducing the cost of insurance, by creating a one-stop shop for small businesses to purchase private insurance, with tax credits.

Although many of the ACA reforms apply to all the major market sectors—individual, small group and large group—and to fully insured and self-insured plans, this is not uniformly the case. Some reforms that are most vital to consumers, *and key to systemic improvement*, do not apply to self-insured plans. These include covering essential health benefits, discussed above;

[13] http://www.insurance.wa.gov/news/2012/5-1-12a.shtml

limits on factors that may be considered in setting rates; risk pooling and risk adjustment requirements; medical-loss ratios; and rate review and justification for "reasonableness." In addition, self-insured plans are not subject to additional state law protections. Nor are stop-loss plans that insure self-insured plans covered by the ACA's guaranteed issue or renewal requirements, restrictions on unreasonable rate increases, or underwriting limits. Thus, stop-loss plans can raise their prices dramatically for self-insured groups or refuse to insure altogether if the risk experience deteriorates significantly. Finally, stop-loss insurers are arguably not subject to the fee imposed on insurers under ACA section 9010, and thus can offer coverage to self-insured groups for less than fully insured coverage.

One example of how stop-loss coverage is being offered to small groups to evade ACA requirements can be seen in the stop-loss coverage marketing of Cigna. Among the major insurers, Cigna has been one of the most aggressive marketers of stop-loss insurance.[14] Their stop-loss business grew by 17% between the first quarter of 2011 and 2012, and accounted for over $400 million in revenue in the first quarter of 2012.[15]

In presentations to small businesses, benefit managers have promoted the following benefits of self-insurance (with Cigna stop-loss coverage):

"Who Are the Ideal Candidates?

- Level Funding
- The "losers" under Obama Care (Young, healthy, favorable industry)
- Wants to benefit from good claims experience
- Needs greater control and flexibility
- Needs consistent plan across multiple markets
- Wants better reporting & transparency
- Wants to participate in the health and wellness of their members
- Wants lower Premium Taxes
- Is accustomed to fully insured
- Needs predictable payments
- Needs low pooling level"[16]

Another major market participant is Assurant, which tells small employers that "Self-Funded Health Plans could be for you if you have 10 to 50 employees and are tired of paying high premiums for seldom-used benefits."[17] Assurant encourages market segmentation:

> "Self funding offers great advantages for many, especially those groups whose members have relatively few ongoing, high-cost medical needs. But self funding is not the best choice for all. If your group includes members with serious, ongoing health conditions,

[14] A preliminary scan of major insurers' earnings reports for recent quarters indicates a steady decline in both individual and small group markets. This, coupled with vigorous promotion of stop-loss coverage for small employers, is further evidence of the beginning of a possible shift of more small employers to self- insurance.
[15] http://www.cigna.com/assets/docs/about-Cigna/Investor%20Relations/CignaCorp_1Q12QFS.pdf. at 6. During the same period, their traditional "guaranteed cost" revenue fell 3%.
[16] Powerpoint presentation by Rogers Benefit 2010.
[17] http://www.assuranthealth.com/corp/ah/HealthPlans/SESelfFunded.htm

you're less likely to benefit from self funding."[18]

We are particularly concerned about the practice of "lasering," which we understand is common in the stop-loss market. Under this practice, a stop-loss insurer offers a low attachment point for most members of the group, but a very high specific attachment point (as high as $100,000 to $400,000) for a specific member of the group with health problems. Although not specifically illegal in many states, this practice runs squarely contrary to the prohibition of health status discrimination not only in the ACA but also in HIPAA and renders Americans with health problems highly vulnerable to employment discrimination.

State Regulation of Stop-Loss Insurance [Question 11]

Approximately 20 states regulate stop-loss insurance for small employers either by banning it altogether, which makes self-insuring infeasible for small employers, or requiring it be subject to the same laws that apply to regular insurance. New York and Oregon prohibit the sale of stop-loss insurance to groups with 50 or fewer employees, and Delaware bars it for firms with fewer than 15 employees. North Carolina prohibits insurers from serving as third-party administrators for self-funded employers.

The majority of the state laws that have addressed this issue are based on the NAIC's Stop-Loss Insurance Model Act, which sets minimum individual and aggregate attachment points defining what constitutes legitimate stop-loss insurance. The level recommended by the NAIC in 1995 for an individual attachment point was $20,000. The NAIC recently commissioned Milliman, Inc., to make recommendations to update the model law. On June 6, 2012, three levels of NAIC actuarial groups voted to approve Milliman's report, and the report has been sent to the NAIC ERISA Working Group for further action on its recommendations.

The Milliman report suggests that substantial increases in attachment levels in the Model Act are necessary to reflect current market and economic realities. The NAIC Health Actuarial Task Force Working Group has concluded based on the report that it is appropriate to raise the attachment levels as follows: the annual individual specific attachment point must not be lower than $60,000 (rather than the current $20,000); the annual aggregate attachment point for groups of 50 or fewer, must be no lower than the greater of (i) $15,000 times the number of group members (up from $4,000); (ii)130% of expected claims (up form 120%); or (iii) $60,000. Milliman explained that they were most concerned about very small plans shifting to self-insurance and noted that low individual and aggregate attachment points shift most of the risk to the stop-loss insurer.

As the NAIC pursues improvements to its Model Act, a number of states fail to meet even today's low standard by allowing attachment points as low as $10,000. This is, of course, grossly out of step with NAIC's new actuarial update to the attachment points in its Model Act. Some states do not regulate attachment points at all.

One logical reference point for minimum attachment points is the level typically purchased by employers of sufficient size to be genuinely self-insured. For instance, in 2011 the average

[18] https://www.groupselffunded.com/groupdetails.aspx

attachment point for employers with 50-200 workers was $73,824 and for groups of 200-1000, it was $136,710. Based on this, a California bill SB 1431 (De Leon) was introduced that would have banned the sale of stop-loss with an attachment point less than $95,000. Recent amendments to that bill, which is now in the second house of the legislature, however, removed the specific attachment point number, leaving for further legislative debate the appropriate level for that state.

Apart from attachment points, and short of banning stop-loss insurance, other states choose to impose some or all of the same requirements on stop-loss insurance sold to small employers as those that apply to normal small-group health insurance. For instance, New Jersey's insurance commissioner ruled recently that it constitutes an unfair trade practice for insurers to refuse to sell stop-loss insurance to small employers based on health risk or conditions.[19] By statute, North Carolina requires that stop-loss insurance sold to small employers comply with all of the underwriting, rating, and other standards of its small group health insurance reform law.[20]

Federal Authority to Regulate Stop Loss Coverage

The ACA uses the term "self-insured" repeatedly, without definition, and the Secretary of Health and Human Services has full authority to promulgate regulations defining the term.[21] Moreover, the Secretary has authority to define the term "health insurance issuer," which also is used throughout the ACA to describe entities subject to the ACA insurance reforms.[22] The law broadly defines this term as "an insurance company, insurance service, or insurance organization . . . which is licensed to engage in the business of insurance in a State . . . ."[23] This obviously describes stop-loss insurers, and so the Secretary has authority to clarify which stop-loss insurers qualify as "health insurance issuers." The definition is key, as a number of important provisions of the ACA, such as the essential health benefits requirement, apply only to "issuers," and thus impliedly not to self-insured plans.

Federal regulations drafted by HHS should be developed in coordination with the Department of Labor, which has authority to promulgate regulations defining terms under ERISA,[24] and the Department of the Treasury, the one agency that currently has regulations defining "self-insured," which were promulgated to implement the provisions of the Internal Revenue Code prohibiting discrimination by self-insured plans in favor of highly-compensated employees, as noted above.[25] Federal definitions of self-insured and of issuer should recognize that a plan is not self-insured unless the plan sponsor in fact bears substantial risk for claims for which the plan is responsible. Such a definition would build on the Internal Revenue Service's current regulation, which defines a self-insured plan as one that "does not involve the shifting of risk to

[19] BULLETIN NO. 11-20, http://www.state.nj.us/dobi/bulletins/blt11_20.pdf (2011).
[20] N.C. Gen. Stat. 58-50-130(a)(5).
[21] The Secretary has authority under ACA section 1311(a) and 42 U.S.C. 300gg-92 to define terms under the ACA and the Public Health Services Act.
[22] ACA 1311(a); 42 U.S.C. 300gg-92.
[23] 42 U.S.C. § 300gg-91(b)(2). The current regulatory definition simply repeats this definition. 45 C.F.R. § 144.103.
[24] 29 U.S.C. § 1135
[25] 29 U.S.C. § 1135

an unrelated third party."[26] Both the Department of Labor and federal courts have concluded that an arrangement in which a purportedly self-insured group plan purchases 100 percent stop-loss coverage is not self-insured, but rather an insured plan, subject to state regulation.[27] Federal courts also acknowledge that an employee benefits plan with 100 percent stop-loss coverage is an insured and not a self-insured plan.[28] Beyond this, federal courts have also recognized that even if the plan sponsor of an employee benefits plan retains risk, the plan can still be an insured rather than self-insured plan if too little risk is born by the plan itself.[29]

The federal agencies authorized to issue regulations and definitions under the ACA are capable, both legally and practically, of defining when enough risk is transferred to an insurer for a plan to be considered insured rather than self-insured. Federal agencies could set a minimum attachment point that is based on stop-loss policies typically purchased by larger employers.

Under such an approach, coverage that is not genuinely self-insured would become subject to all requirements of the ACA that pertain to issuers. Thus, insurers that sell to groups whose retained risk falls below the definitional threshold would have to comply with all requirements of the ACA that apply to health insurance issuers, regardless of whether the policy is nominally written as a stop-loss or insured plan. If an insurer writes "stop-loss" insurance for a group that does not qualify as self-insured, the insurer would, for example, have to comply with medical loss ratio requirements and justify unreasonable premium increases. These stop-loss policies also could not impose annual or lifetime limits, and would have to cover preventive services and, for small groups, the essential health benefits package.

A federal definition of "self-insured" that requires a self-insured plan to actually bear significant risk makes eminent sense from a public policy perspective. As noted at the outset, a major goal of the ACA was to ensure consumer protections and end risk underwriting in the small group market. Requiring a group plan sponsor to actually bear significant risk by limiting stop-loss attachment points to a substantial level, would ensure that employees of small employers would enjoy the protection intended by the ACA. It would also protect the exchanges and the small group market generally from the risk of adverse selection. Large plans could still self-insure—nothing would be fixed that is not broken. But the badly broken small group market would not be broken further.

Conclusion

Among the most important reforms in the ACA are the improvements to the small group market that increase consumer protections, improve access to comprehensive coverage, and stabilize premiums for small employers. The ACA's new protections for small business turn on a crucial

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[26] 26 CFR 1.105-11 implementing IRC § 105(h).

[27] Advisory Opinion 2003-03A, http://www.dol.gov/ebsa/regs/aos/ao2003-03a.html; Advisory Opinion 92-21A, http://www.dol.gov/ebsa/programs/ori/advisory92/92-21a.htm.; McDaniel v. North American Indemnity, 2008 WL 1336832 (S.D. Ind. 2008).; *Home Health Care Affiliates of Miss., Inc. v. Am. Heartland Health Admins., Inc.*, No. 1:01-cv-00489-D-A, 2003 WL 24046753, at *6 (N.D.Miss. Mar. 21, 2003).

[28] McDaniel v. North American Indemnity, 2008 WL 1336832 (S.D. Ind. 2008).; *Home Health Care Affiliates of Miss., Inc. v. Am. Heartland Health Admins., Inc.*, No. 1:01-cv-00489-D-A, 2003 WL 24046753, at *6 (N.D.Miss. Mar. 21, 2003)

[29] 897 F.2d, 1351 (5th Cir. 1990).

distinction, however, between self-insured and insured plans. The ACA repeatedly uses the terms "self-insured" and "issuer offering group health insurance coverage," but nowhere does the ACA define the term "self-insured" nor clarify when an insurer claiming to offer stop-loss coverage is in fact an "issuer offering group insurance coverage." We urge the agencies to define these terms to ensure that a small group can only claim self-insured status if the plan itself bears substantial risk and that an insurer comply with the requirements of the ACA that apply to "issuers" if the insurer in fact is the primary risk bearer rather than the group health plan.

Consumers Union
Families USA
American Cancer Society Cancer Action Network
Service Employees International Union
American Federation of State, County, and Municipal Employees
National Women's Law Center
Community Catalyst
Women's Law Project (PA)
Sargent Shriver National Center on Poverty Law (IL)
Janet Varon, Executive Director, Northwest Health Law Advocates
Wisconsin Alliance for Women's Health
Health Care for America Now
Main Street Alliance
Alliance for a Just Society
Georgetown University Center for Children and Families
UHCAN Ohio
Legal Aid of Southwest Ohio, LLC
Toledo Area Jobs with Justice and Interfaith Worker Justice Coalition, Toledo,Ohio
North Carolina Justice Center
Colorado Consumer Health Initiative
Maryland Women's Coalition for Health Care Reform
United Food and Commercial Workers Local 1059
Alliance for Retired Americans in Ohio
Ohio Communities United
Ohio Consumers for Health Coverage
Asian Services in Action, Inc.

NAIC Consumer Representatives
Timothy Stoltzfus Jost
Marguerite Herman
Sarah Lueck
Bonnie Burns
Adam Linker
Birny Birnbaum
Stephen Finan
Elizabeth Abbott
Barbara Yondorf
Joe Ditre

Cynthia Zeldin
Carrie Fitzgerald
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SELF-INSURANCE AND STOP LOSS FOR SMALL EMPLOYERS

Deborah Chollet, Ph.D.
Mathematica Policy Research[1]

One result of the Employee Retirement and Income Security Act (ERISA), which protects employee benefit plans from state regulation, has been a bifurcation of the regulatory environment for employer-sponsored health insurance plans. While states may regulate the health insurance products that employers purchase for their workers, they may not regulate the employee benefit plan itself. This distinction has created a broad space for employers to develop self-insured plans exempt from state regulation or taxation, parallel to the commercial market where other employers purchase state-regulated insurance products.

Employers that sponsor self-insured plans for their workers carry the risk of health care claims directly and manage claims payments as cash flow. However, they often hire a third party administrator or administrative services organization to handle these payments. In addition, self-insured plans may purchase stop loss insurance to protect them from unexpectedly high claims. With a stop loss plan, the employer pays claims up to a specified threshold or "attachment point" (defined as a per-participant amount or an aggregate plan amount), after which the stop-loss policy pays any excess claims.[2]

Small employers' interest in self insurance has been increasing for a number of years, predating enactment of the Affordable Care Act (ACA). However, enactment of the ACA—coupled with the prospect of increasing insurance premiums in a difficult economy—appears to have intensified employers' interest in self-insurance. One recent Booz & Company study found significant interest among mid-sized companies in moving to self-insured products, largely to avoid the costs associated with premium taxes imposed by the ACA (Ahlquist et al. 2011).

With enactment of the ACA, concern about the potential impacts on employer decisions to self-insure, and in turn the impacts of those decisions on the market, have intensified. A number of policy analyses (Linehan 2010; Jost and Hall 2012) have observed that, in combination, guaranteed issue, elimination of waiting periods for coverage, and community rating for small groups could cause large numbers of small employers to self-insure, adversely selecting the new Small Employer Health Options Programs, or SHOP exchanges, as well as the small group insurance market more generally. Small employers that self insure pay the actual cost of their employees—and they would choose to self-insure if their annual self-insured costs are less than the average among all small groups in the market.

[1] The author wishes to thank Jill Bernstein for collaborating on an early version of this paper, as well as Timothy Jost and Mark Hall for their thoughtful comments and the Health Access Foundation for its financial support. Of course, any errors of commission or omission are solely the responsibility of the author.

[2] In some states, "minimum premium" plans also are marketed to employers as "self-insured" products. With a minimum premium plan, the employer self-insures a fixed percentage (as much as 100 percent) of estimated monthly claims and the insurer pays any excess claims. While some states (e.g., New York) regulate minimum premium plans as comprehensive insurance, equivalent to a conventional group product, others consider it a self-insured product not subject to that regulation.

However, if a self-insured group's risk worsens, it could move immediately back into either the insurance market or the SHOP exchange, raising average premiums for insured small-group coverage.

While self-insurance has played a major role in shaping health insurance markets, what constitutes a self-insured plan is not always clear in legislation or in practice—and the ACA does not define it (Jost 2012). Absent a clear definition, questions about the types of self-insured arrangements for which federal law preempts state regulation have been disputed for decades (Linehan 2010).

This paper summarizes the ACA's incentives for small employers to self-insure and what is known about the stop loss market that could facilitate the growth of self-insured small groups and in doing so, destabilize small group insurance markets in every state. The paper reviews the NAIC Model Act provisions that govern small group stop loss coverage and the recent NAIC proposal to increase stop loss thresholds for small groups. The paper then briefly considers emerging alternative insurance arrangements for small groups that seem equally poised to select low-risk employers and destabilize small group markets—and for which regulatory authority much less governing regulation are yet undefined. A brief summary is provided in the concluding section.

I. Small-Employer Incentives to Self-Insure

The advertisement for a recent webinar sponsored by a large administrative services company for self-insured plans succinctly states why employers and insurers might be interested in self-insurance:

> "Self-insured plans are subject to fewer regulatory requirements under the reform law. And while self-funding also offers greater plan-design flexibility and cost savings for employers, it comes with serious financial risk as well as a host of ERISA-related rules. For health insurers, self-funding could reduce per-member operating profit. [But, while] administrative services only (ASO) members might be less profitable on the surface, returns on capital can be very high. There also is less financial risk and uncertainty associated with members covered by a self-insured employer. And that could create new plan-design opportunities for health insurers" (Atlantic Information Services 2011).

The decisions for small employers to self-insure and for insurers to offer small-employer products supporting self-insurance are complex. However, the ACA clearly reinforces incentives for small employers to self-insure by offering self-insured plans some clear advantages over fully insured plans. Most important, self-insured plans are not subject to the law's essential benefit requirements, nor are they subject to its risk adjustment or risk pooling requirements.[3] In addition, they are not required to

[3] These exemptions contrast sharply with small group coverage in many markets, which (unless required by the state) commonly exclude or carve out maternity, mental health, prescription drug, pediatric dental, and habilitative services. These services are included in the ACA's essential benefits, which insured plans must cover. In addition, unless prohibited by state regulation, insurers may now price small group coverage to reflect the group's claims history and/or some proxy for expected claims (such as the employer's industry group or policy duration), as well as age, gender, and other factors. In contrast, the ACA allows insurers to vary premiums only by the average age of employees, the presence of a wellness program, and tobacco use.

pay the annual fee that insurers must pay on fully insured products[4] and likely will pass through to employers—although, like insurers, they must contribute to the states' reinsurance programs from 2014 through 2016.[5] Finally, self-insured plans (if willing to forego tax qualification) need not comply with IRS code prohibitions on discriminating in favor of highly compensated individuals, effective in 2011(Bender et al. 2011).[6] Noting that the ACA does not apparently govern reinsurance, a report prepared for the Maryland Health Care Commission observed that "it may be possible to design a "self-funded product with ultimate costs equal to or less than the fully insured premiums, as the self-funded insurers would be able to base the rates for any reinsurance on factors not allowed under the [ACA] such as gender, age, or medical status."[7]

II. Empirical Analyses of Small-Firm Self-Insurance

Reflecting the limits of available data, empirical analysis of self-insurance among small employers is rare. Much of the research literature has focused on how preemption from state benefit mandates and premium taxes influences employer decisions to self-insure; a small branch of the literature looks at impacts on market competitiveness, medical costs, and employer size and sector differences regarding self insurance.

Both a Deloitte report (Brien and Panis 2011) produced for HHS and a RAND report (Eibner et al. 2011) produced for DOL addressed the potential for small employers to become self-insured in order to avoid broad risk pooling under the ACA. The Deloitte report analyzed the current scope and distribution of self-insured group coverage and reviewed the academic literature exploring employer decisions to self insure. Culling from the literature, it identified many factors (whether an employer is a single- or multi-state operation, the historical number and size of health insurance claims, attitudes toward risk, and financial assets and ability to cover unexpected costs) that might lead employers to move toward or from self-insurance. However, the report concluded that the literature offers no clear evidence about the relative importance of these factors in employers' decisions to self insure, nor evidence that can be

[4] ACA Section 1343.

[5] ACA Section 1341.

[6] Self-insured plans can offer differential benefits, but they will not receive the favorable federal tax treatment granted to tax-qualified plans, which must comply with non-discrimination rules under ERISA. Small employers value the ability to tailor benefits to the demands of their specific workforce might offer a nonqualified plan to highly compensated workers. In contrast, a small employer would, in general, pay significantly higher premiums if it offered separate fully insured plans to separate groups of employees, whether or not the arrangement is tax qualified.

[7] A Milliman study conducted for the state of Indiana also anticipated some possible changes to the small group market related to groups of 51-100 moving into the small group market or electing to self-insure. The analysis projected the number of Indiana residents with coverage from self-insured plans of all sizes could increase more than 10 percent, from 2.8 million in 2010 to as many as 3.1 by 2019 (Herbold and Houchens 2011).

used to generate robust predictions about how many or which small employers might choose to self insure over the next few years.[8]

The RAND study hypothesized that a number of factors might affect small employers' decisions to self insure—including regulation, financial risk, administrative service prices, and flexibility in benefit design—but pointed to the central importance of stop-loss coverage in employers' decisions to self-insure. The study's "lower risk alternative" scenario, which most nearly reflects the stop loss products currently marketed to small employers, predicts substantial erosion of fully insured coverage among small groups—that as many as one third of small employers with up to 100 employees might self-insure (compared with 8 percent of employers with 3 to 50 workers and 20 percent of employers with 51 to 100 workers in 2010) if stop-loss coverage with low attachment points is as widely available as it is already.[9] However, even this estimate may be conservative: the RAND study methodology appears to minimize the opportunity for favorable selection into self insurance and the reinforcing effect of self-insured plans' exemption from the ACA's essential benefits requirements. Both imply the strong potential for adverse selection and spiraling premiums for fully insured coverage in the small group market.

Taken together, the Deloitte and RAND reports identify significant information gaps related to products (like stop loss) that serve self-insured employer plans. Insurers are not required to report market-level data on the prevalence or structure of stop-loss insurance, so information is generally unavailable about the different types of stop-loss policies that insurers market, the terms of coverage, or the number of covered lives.

This information gap has forced analysts to make simplistic, essentially uninformed assumptions about both the current state of markets and how incentives to self-insure might change when SHOP exchanges are in place. It also has allowed stop loss insurers to minimize the prospects for self-insured plan growth under the ACA. Some view concerns about the role of stop loss in encouraging small firms to self-insure as simply uninformed, arguing that the lack of claims data is a major barrier for small groups seeking to self-insure (Ferguson 2011). Absent a credible claims history for the group, they argue, insurers cannot set a fair price for stop loss coverage and are unlikely to assume such risk, even if there are plausible reasons that a small employer would want to self-insure.

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[8] The Deloitte analysis relied on data from DOL Form 5500 reports, including employers that used a trust, maintained a separate fund to hold plan assets, or acted as a conduit for the transfer of plan assets. However, many employers—in particular small employers—are either not required to file Form 5500 at all or not required to file annually. Specifically, fully insured private-sector employers that cover fewer than 100 individuals and do not hold assets in trust do not file, nor do municipalities or other local governments, state governments, or religious organizations. Self-insured plans with fewer than 100 workers must file only every third year. As a result, small employers—especially those that are fully insured—are underrepresented in the Deloitte analysis.

[9] In contrast, the study's widely cited "baseline scenario" assumes that small employers can access stop-loss policies only with a specific attachment point of $75,000 and an aggregate attachment point of 125 percent of expected claims. Both are much higher than current NAIC standards ($20,000 and 120 percent of expected claims) and also much higher than indicated by industry reports, which commonly tout attachment points as low as $10,000 for small self-insured employers (Wojcak 2011).

These modest views, however, are belied by the stop loss industry's own advertising to small employers. Even a cursory review of insurance and benefits industry web sites turns up many instances of commentary and marketing of stop loss coverage to groups with as few as 10 employees. For example, announcing that "Stop Loss is a Go," one benefits trade paper recently described how, "Propelled in part by health care legislation, smaller companies are self-insuring more and buying more stop-loss coverage. The result is a bigger stop-loss insurance market—and more flexibility and customization for a wider variety and their workers" (Chase 2011). The article quoted an industry expert who predicted that "companies with fewer than 25 workers will be fully [insured], or will buy insurance through the exchanges", while "other firms will self-fund their employee benefits, using stop-loss insurance and wellness plans to get the healthiest workers they can—and the best possible return on their investments."

III. Focus on Stop-Loss

There is significant potential for stop-loss coverage to blur the line between fully-insured and self-insured plans. Stop loss coverage with a very low attachment point can appear very much like a conventional health plan with a high employee deductible.

In 1995, the National Association of Insurance Commissioners (NAIC) developed the Stop-Loss Insurance Model Act, establishing a minimum attachment point for stop loss coverage sold to small groups. The Model Act was intended to prevent insurers from avoiding health insurance market regulation by selling "stop loss" coverage with such low thresholds that purportedly self-insured plans actually retained little risk. As amended in 1999, the NAIC model specifies that for groups of 50 or fewer, aggregate stop loss may not be less that the greater of: (1) $4,000 multiplied by the number of members, (2) 120 percent of expected claims, or (3) $20,000 indexed for inflation. The NAIC identifies three states (Minnesota, New Hampshire, and Vermont) that have adopted the model regulation; as many as 18 others have regulations in some (but not consistent) ways reflecting aspects of the NAIC model (Linehan 2011; Milliman 2012).

In 2012, Milliman conducted an analysis for the NAIC, estimating the amount of risk small employers were expected to transfer to stop loss coverage under the thresholds established in the Model Act (Milliman 2012). Their analysis concluded that an employer with fewer than 51 employees that buys stop loss coverage with a specific (per member) stop loss threshold of $20,000 (as specified in the Model Act) would be expected to cede as much as 50 percent of claims to the stop loss carrier, depending on the benefit design of the self-insured plan. Employer plans that pay a higher percentage of covered costs would retain more risk (as much as 37.5%) with a specific stop loss attachment point of $20,000.

If that employer that also buys aggregate stop loss, it would cede a much larger proportion of risk to the stop loss plan. To retain half of the risk, an employer with 25 employees and specific stop loss that attaches at $20,000 would need to buy aggregate stop loss that attaches at 124 percent of expected claims, compared with the Model Act's small-firm minimum of 120 percent. With 10

employees, that employer would need to buy stop loss that attaches at 165 percent of expected claims—so is holding less than 50 percent of risk at the Model Act's minimum attachment point.

Milliman offers a number of other analyses that in general reach the same essential conclusion: at the minimum attachment points specified in the 1995 Model Act, a small employer can shed a significant share of purportedly self-insured risk, demonstrably blurring the line between a self-insured and insured health plan. The NAIC has proposed raising the minimum thresholds for small groups in order to brighten this line, aiming to place it so that small employers must cede the same minimum risk as they did under the 1995 Model Act. This proposal would raise the minimum specific attachment point for stop loss coverage to $60,000; and it would raise the minimum aggregate attachment point to be not less than the greater of $15,000 multiplied by the number of group members, $60,000 per employee, or 130 percent of expected claims. Roughly calculated from Milliman's analysis, this recommendation would reduce the amount of risk that a small employer could cede to stop loss coverage by about half and restore the distribution of risk between the self-insured small employer and the stop loss carrier approximately to that intended in the 1995 Model Act.

IV. Alternative risk arrangements for small groups

The potential for stop loss coverage with low attachment points arguably represents the most proximate risk to the stability of regulated small group markets and it is the central concern of this paper. However, other risk arrangements for small groups with the same potential are appearing in the wings and also warrant greater scrutiny from both federal and state regulators. Many recent news items, trade papers, and presentations point to interest in new products that that are (or will soon be) selectively marketed to small employers, allowing them to abandon small group insurance markets without self-insuring.

Two types of "alternative risk arrangements" illustrate this complex landscape:

- **Professional employer organizations (PEOs)**, which assume the human resources or employee benefit functions of employers, are not new, and they can be quite large. In at least some states, PEOs can "hire" their client employers' workers—paying and administering their benefits, and "leasing" them back to the firms where they actually work. PEOs can be virtually indistinguishable from AHPs: that is, they can purchase coverage for employers of varying sizes, including very small groups. DOL has determined that PEOs do not qualify as employee welfare benefit organizations and thus are subject to state regulation (Jost 2012). However, state regulation of groups that purchase coverage for small employers is often unclear or inconsistently applied. If PEOs that offer low-risk groups "alternative coverage" were to expand, they could destabilize both small group markets and the SHOP exchanges.

- **Group captives** provide a primary layer of medical stop-loss coverage that would be tapped before traditional stop-loss insurance. By grouping together and forming a captive to collectively purchase and risk-share one or more layers of stop-loss coverage, employers can take advantage of the increased underwriting credibility that larger numbers provide, and help

spread risk and stabilize loss volatility within the retained risk layer(s) of the captive.[10] Employers that participate in a group captive are individually underwritten but typically use a shared administrator and provider network, and may use either a standard or nonstandard plan design.[11, 12] As the owners of the group captive, the participating employers are the primary beneficiaries of any underwriting and investment profits generated by the assets and surplus held in the captive, helping to reduce the ultimate risk cost and potentially increasing the availability of commercial stop-loss coverage (Giles 2010). Group captives are subject to DOL scrutiny under ERISA.[13] Even when operating in a single state, group captives seem likely to be exempt from the state's stop loss insurance rules, if any—but would be subject to state rules governing captives, which can be much more favorable than those for commercial

[10] Self-funded employers that use a group captive for primary stop-loss coverage can also avoid "lasering," a practice in which stop-loss insurers set higher attachment points for certain plan members with costly pre-existing conditions. To protect the captive from a sizable claim that would otherwise be subject to a laser, the captive can purchase disease-specific coverage, such as first-dollar transplant coverage (which, for a group with 100 lives, can be less than $10,000 a year) (Wojcik 2011).

[11] Giles (2010) describes the basic structure of a stop-loss captive as follows: (1) The group participants select a common stop-loss insurer to provide coverage to all members. (2) Once a viable participation commitment (critical mass) has been achieved, each employer will establish and maintain an individual self-funded health care plan. This will include choosing the desired plan design and all related service components, such as third-party administrators (TPAs), provider networks, and the like. Although each employer's plan is designed and maintained separately, the size advantages of the group can be leveraged if related components are collectively obtained from common providers. (3) Each employer purchases specific and aggregate medical stop-loss coverage according to its own risk appetite. The stop loss is purchased from the common insurer or reinsurer that will provide coverage to each member of the captive. (4) The stop-loss insurer then cedes a portion of the collective stop-loss portfolio, attributable to all participating group members, to a captive owned jointly by all participating members. The most common arrangement is to have a captive participation layer above the specific deductible and below the maximum reimbursement limit of the policy. For example, the captive would assume risk participation within the $250,000, excess of $250,000 layer of a policy having a $1 million (or higher) limit. The actual captive participation level will be determined by the collective risk appetite of the insured members (with agreement from the ceding insurer), and could be structured either on an excess or quota-share basis. Individual member risk-sharing amounts within the captive are determined on a pro-rata basis according to the specific plan design and stop loss retention associated with each employer's participation.

[12] Like group captives that self-insure liability risks, benefits captives generally require participating employers to engage in loss-control activities such as health risk assessments and population health management. For example, the captive the Horton Group is assembling, which will be managed by Berkley Accident & Health L.L.C., a unit of Greenwich, Conn.-based W.R. Berkley Corp., requires that 80 percent of the employees of participating employers complete a health risk assessment as a condition of remaining in the captive (Wojcik 2011).

[13] ERISA's prohibited transactions rules govern the use of captives. If a benefit captive is able to meet certain requirements, showing that the interests of employees are appropriately protected, the DOL will provide an exemption allowing a captive owned by the plan sponsor to insure the benefit plan. Among the several requirements for exemption are that the benefit plan use an ''A'' rated insurer, and also provide a material enhancement of benefits or a reduction in participation costs to its participants. The Internal Revenue Service considers employee benefits placed into a captive to be third-party business, which increases the percentage of unrelated business required to help achieve tax deductibility of insurance premiums paid into the captive (Giles 2010).

insurance—including stop-loss insurance.[14] The trade press literature suggests that companies marketing group captives currently are targeting groups as small as 50 lives.[15]

V. Summary and concluding remarks

By regulating the small group market in ways that force greater risk pooling, the ACA seems likely to reinforce incentives for small employers to consider self-insurance and for insurers to offer small-employer products supporting self-insurance. Already protected by ERISA from state regulation, the ACA allows self-insured plans some additional advantages over fully insured plans: self-insured plans are not subject to the ACA's essential benefit, risk adjustment, or risk pooling requirements, nor are they required to pay the annual fee that insurers must pay on fully insured products.

The scant empirical research investigating small employers' propensity to self-insure has focused on how preemption from state benefit mandates and premium taxes influences that decision. While this literature is useful in illustrating the complexity of an employer's decision to self insure, it calls on very little actual information about small groups' access to stop loss coverage—either the amount of risk that stop loss carriers are willing to assume or the premiums they charge. Instead, analysts must rely on assumptions about the nature of current stop loss products and how these products might change in the future. The conservative views expressed by the industry (fundamentally, that stop loss for small groups is infeasible) is similarly ungrounded in data and directly conflicts with the industry's own marketing messages to employers.

The potential for stop-loss coverage to blur the line between fully-insured and self-insured plans is significant. Stop loss coverage with a very low attachment point can appear very much like a conventional health plan with a high employee deductible.

In 1995, the National Association of Insurance Commissioners (NAIC) developed the Stop-Loss Insurance Model Act, intended to prevent insurers from avoiding health insurance market regulation by selling "stop loss" coverage with such low thresholds that purportedly self-insured plans actually retained little risk. More recently, Milliman conducted an analysis for the NAIC, estimating the amount

[14] For example, in 1981, Vermont passed legislation providing a regulatory and taxation environment for captives with the objective of establishing a "business friendly climate" for companies forming captive insurance operations in Vermont. The law recognized association and group captives; established capitalization requirements that may be met with a letter of credit; exempted captives from approval of rates and forms, as well as minimum premium requirements; eliminated investment restrictions for pure captives; and established a favorable premium tax structure. In 2003, the entire body of Vermont captive law was recodified, adding employee benefits and life and health to permitted lines of business and, for the second time since captive law was adopted, allowing for a significant reduction in captive premium taxes. Other changes permitted reciprocal captives, gave pure captives the ability to insure controlled unaffiliated businesses, increased confidentiality of captive financial records, allowed branch captive formation, and permitted sponsored captives and the licensing of branch offices of offshore captives (Vermont 2011).

[15] See, for example: http://www.grouphealthcaptives.com/captive-insurance-advantages.php, accessed June 21, 2012. In the case of a group captive for medical stop loss, participation of at least five separate employers totaling 1,000 employee lives is generally considered the minimum needed to achieve sufficient underwriting stability and economic benefits (Giles 2010).

of risk small employers were expected to transfer to stop loss coverage under the thresholds established in the Model Act (Milliman 2012). Milliman offers a number of analyses that in general reach the same essential conclusion: at the minimum attachment points specified in the 1995 Model Act, a small employer can shed a significant share of purportedly self-insured risk, offsetting as much as half or more of the cost of a self-insured plan.

The NAIC has proposed raising the minimum thresholds for small groups in order to brighten the line between insured and self-insured plans to stabilize small group insurance markets. This proposal would raise the minimum specific and aggregate attachment points for stop loss coverage, restoring the proportion of risk a small employer could cede to stop loss to that envisioned in the original Model Act. Relative to expected claims costs today, this proposal would roughly halve the amount of risk that a small employer can cede under the standards established in 1995. The NAIC proposal seems to strike a reasonable compromise, protecting the small group market while allowing employer plans to self-insure when they are able to retain significant risk. The alternative, ever less distinct insurance and stop loss markets for small groups, can only encourage lower-risk small groups to abandon the insurance market and return when their cost experience worsens. This result could destabilize small group markets to the point of collapse and significantly erode the protections that regulated insurance provides for millions of employees and their families.

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