

A hand is shown in the bottom right corner, pouring a variety of pills from a yellow plastic container. The pills are scattered on a blue, textured background. The pills include white round tablets, red oval tablets, green round tablets, and two red-and-white capsules. The lighting is dramatic, with strong highlights and shadows.

# The Case For Self Insurance: **Overcoming Common Myths**

by George J. Pantos, Esq.



In today's changing healthcare landscape, the political discourse on Capitol Hill and in many state legislatures is replete with misstatements, charges, and claims about the so-called problems, shortcomings and risks faced by employers – primarily medium-sized and small employers – who choose to self insure health benefits for their workforce population.

As a four decade long journeyman in the ERISA legal trenches, this is one man's attempt to set the extensive record straight with documented responses to the most common myths advanced by critics of self-insurance.

### **Myth: Federal preemption is a major ERISA “loophole”**

**Response:** To call preemption a major “loophole” belies the historical record of self-insured plan growth under ERISA and ignores the explicit wording by Congress which distinguishes between employer-sponsored self-insurance and commercial insurance.

Nearly 80 million individuals – a record all-time high – received their health benefits through a self-insured ERISA plan in 2010. According to the Kaiser annual survey of annual employer trends, that's 60 percent of working individuals under age 65.<sup>1</sup> The number of workers in small firms (3-199 workers) alone increased to 15 percent in 2012-- up from 10 percent in 2003.<sup>2</sup> Conducted in conjunction with the National Opinion Research Center and the University of Chicago, the annual Kaiser Survey is the most comprehensive U.S. look at national trends in employer sponsored health coverage.

ERISA's preemption provisions reflect a national purpose in federal law to facilitate the administration of

uniform benefits across state lines. By enacting ERISA's “deemer” clause Congress prohibited states from deeming employer sponsored benefit plans to be insurance companies. Congress thus gave life to a clear and explicit statutory exception to the insurance “savings” clause by exempting self-insured plans from the threat of often costly and conflicting state laws. With more than half of working Americans covered by self-insurance over the nearly forty years since passage of ERISA, congressional intent in distinguishing between self-insurance and commercial insurance has proven to be sound policy.

With few exceptions, the courts have interpreted ERISA's preemption clause very broadly and the distinction between self-insurance and commercial insurance has been upheld repeatedly by the U.S. Supreme Court for nearly four decades.<sup>3</sup>

### **Myth: Self-Insurance provisions in ACA are a major “loophole” that will cause adverse selection against health insurance exchanges**

**Response:** Similarly, there is no rational or historical basis to assert that self-insurance under ACA will cause adverse selection in future state health insurance exchange pools. As with ERISA, Congress explicitly chose in ACA to distinguish between self-insured and insured plans. In other pre-ACA federal laws such as HIPAA, both self-insurers and insurers are prohibited from covering only healthy employees.<sup>4</sup> ACA also bars discrimination by both self-insurers and insurers against plan participants based on health status.<sup>5</sup> In a 2011 study conducted for the DOL under ACA, RAND CORPORATION concludes that self-insured plans “do not pose a threat of adverse selection in the small group market once the new law is implemented.”<sup>6</sup>

A later 2012 U.S. Department of Labor Report to Congress confirms that self-insured plan membership mirrors a cross-section of workforce risk.<sup>7</sup> Employers that self-fund health benefits cover a broad cross-section of participants with low, medium and high risks. As self-insured and insured plans have similar membership characteristics, there is no rational basis for highly speculative assertions that self-insured plans “cherry pick” by enrolling healthier employees and may cause adverse selection.

### **Myth: Enrollees in self-insured plans are deprived of important ACA consumer protections.**

**Response:** Not true. Self-insured plans are subject to most of the same ACA coverage requirements and protections that are imposed on commercially insured plans. With minor exceptions, ACA protections – enacted by Congress to remedy what were called “abusive insurance industry practices” – also apply to enrollees in self-insured plans. Among many provisions that apply to both self-insured and insured plans, ACA prohibits coverage exclusions based on pre-existing conditions, prohibits discrimination based on health factors, requires dependent children to remain under parent plan coverage until age 26, eliminates lifetime and annual caps, requires first dollar coverage for preventive service, requires uniform explanation of plan benefits, requires internal and external claims procedures and limits out-of-pocket spending.<sup>8</sup> Certain provisions such as medical loss ratios (MLRs), rebates, and community rate rules labeled by critics as “loopholes”, in reality, are intended properly by Congress to apply only to commercial insurers.

Beginning in 2012, MLR rules require commercial insurers who collect premiums and are in the “business of insurance” to use premium revenues to meet specific

minimum benefit payment standards rather than excessive administrative costs, such as for executive salaries and marketing expenses – or make refunds to customers. The Commonwealth Fund has found that, for some small employers, as much as 30 percent of premium payments go to administration.<sup>9</sup> In this regard, 16 million consumers and businesses received about \$1.3 billion in rebates from insurance companies in 2012, including \$377 million in the small employer market.<sup>10</sup>

### **Myth: Regulations should be enacted to limit the ability of small groups to self-insure health benefits.**

**Response:** While self-insurance is not for everyone, annual insurance premium increases have accelerated the trend by small employers to consider self-insurance as a viable alternative to commercial insurance. Ever increasing health care costs are one of the most important challenges impacting small business firms which are the backbone of the U.S. economy. Studies show that small firms pay 18 percent more for health coverage than larger firms, while firms with 10 to 24 workers pay 10 percent more.<sup>11</sup> And the cost of U.S. healthcare services is expected to rise 7.5 percent in 2013, more than three times the projected rate of inflation and economic growth.<sup>12</sup>

Eliminating the ability of small employers to self-insure would not only add to already spiraling health costs, but may even create higher levels of uninsured employees. Limiting small employer ability to self-insure would be associated with a “decline in the total number individuals enrolled in health insurance coverage,” according to RAND.<sup>13</sup>

Employers must be able to meet sound actuarially determined financial standards to demonstrate they are capable of self-insuring. Under existing laws, employers of all sizes who can meet recognized standards have the freedom to choose the most appropriate method to fund their health plans, including recognized alternative risk transfer (ART) methods such as self-insurance.

Eliminating the ability of small employers to self-insure would not only add to already spiraling health costs, but may even create higher levels of uninsured employees. The RAND study states that total enrollment in coverage is higher in the small market where self-insurance is allowed.<sup>14</sup>

Exacerbating the small employer cost problem, many insurers already have filed for double-digit premium increases, which HHS has criticized as unwarranted.<sup>15</sup> Reflecting these increases, private insurer financial reports to the Securities and Exchange Commission for 2010 through the first half of 2011 document that premium revenues have been well above payments for medical claims, with profit margins at historic highs and rapid accumulation of reserves well beyond state insurance requirements.<sup>16</sup>

### **Myth: Self-insured plans do not provide adequate value to enrollees.**

**Response:** As noted, in large part, the value of self-insurance as an alternative funding method is reflected in the large number of covered participants in self-insured plans of all sizes as reported in recent studies. According to the 2010 Annual Kaiser Survey, 57 percent of covered workers in firms with three or more workers were in self-funded plans in 2010.<sup>17</sup> This includes 26 percent of workers among smaller plans with 100 to 199

participants. Based on an analysis of the Kaiser data, RAND reports that the share of employee enrollment in self-insured plans rose from 52.6 percent in 2006 – up to 57 percent in 2010.<sup>18</sup>

The principal advantages of self-insuring for employers have been well documented; greater control over design of plan benefits and provider networks, costs based on their own claims experience, control over reserves, improved cash flow and uniform benefits to workers in different locations. Moreover, access to plan claims data provides self-insured employers with the ability to design wellness programs directly targeted to workforce health profiles that have proven successful in reducing costs.

Using data on deductibles, copayments and other out-of-pocket expenses to measure the relative generosity of health plans, RAND researchers concluded that there is little difference in plan generosity between fully insured plans when comparing plans of the same size, including small plans with 3 to 199 workers.<sup>19</sup> In the study conducted for HHS in collaboration with the U.S. Labor Department, RAND found that self-insured plans offered by small and mid-sized firms covered approximately the same proportion of medical expenses as fully insured plans.<sup>20</sup>

RAND reports that the state regulatory environment, exacerbated by the excessive prices employers must pay for administrative services in commercial plans, plays a major role in employer decisions to self-insure health benefits.<sup>21</sup> Studies show that of the \$95 billion paid by consumers and employers in premiums to U.S. commercial insurers in 2007, about 7.5 percent was paid for insurance administration – the highest share in the world.<sup>22</sup> These costs were paid for advertising, sales commissions,

underwriting, and other administrative functions as well as net additions to insurer reserves, rate credits and dividends and profits.<sup>23</sup>

While state mandates provide added protection to some consumers in commercially insured plans, they impose additional costs that most often are passed along to employers in the form of higher premiums. By contrast, in addition to greater cost efficiency and lower administrative expenses, self-insured employers add value by retaining for their own investment purposes that portion of premiums collected by insurers to fund insurer reserve requirements and profits. Self-insured employers add additional value-based plan design by tailoring benefit packages to meet specific workforce needs rather than costly mandated state benefits.<sup>24</sup>

Other important factors which add value include greater plan autonomy and plan control and the flexibility under ERISA for employers operating across state lines to offer uniform benefit packages. While not always covering certain state benefits mandated in fully insured plans, self-insured plans are no less generous overall, and in many instances provide even more generous benefits, according to interviews conducted for the RAND study.<sup>25</sup>

### **Myth: State regulation of stop loss attachment points is needed and legislative proposals calling for higher attachment points should be supported.**

**Response:** Several states and the NAIC have attempted to regulate stop-loss attachment points which they contend “could” pose a threat to state exchanges coming on line in 2014. In proposing higher stop-loss attachment points, state legislators

have poorly masked their real intent to curb the self-funding method for small employers.

In proposing extremely high individual attachment points (\$45,000), legislation such as California’s SB 161, and similar state legislative proposals, are designed to negatively impact the decision of most otherwise financially qualified small employers to self-insure health benefits. By mandating that small employers assume greater financial risk, such proposals would have the effect of eliminating the entire cash funding reserves of most self-insured small employers.

Such state legislative proposals raise the legal issue of federal preemption and the bounds of permissible state insurance regulation under ERISA. Many states do not have minimum requirements for stop-loss and only three states have passed laws based on NAIC’s 1999 “model” stop-loss act recommending a minimum attachment point of \$20,000 per person.<sup>26</sup>

However, federal courts have held that states cannot regulate stop-loss insurers in a manner that influences the structure or administration of the underlying self-insured plan, such as by regulating attachment points.<sup>27</sup> Courts also have held that states cannot define at what point a self-insured plan bears so little risk (due to generous stop-loss attachment points) that the plan is no longer self-insured and the stop-loss carrier is a primary health insurer.<sup>28</sup> Thus, if enacted into law, proposals such as SB 161 clearly would be subject to a preemption challenge under ERISA’s federal provisions.

### **Myth: A federal definition of self-insurance is needed**

**Response:** Calling for a federal definition of self-insurance assumes that small employers need to assume more risk for health benefits in order to qualify as qualified self-insured plan sponsors. Without defining “significant, critics propose that self insured plans should bear “significant risk,” and that stop-loss attachment points be set at a “significant level.” This unrealistic approach is not only inconsistent with ERISA and other federal laws relating to insurance regulation, but also ignores the historical nature of stop-loss insurance as a class of indemnification coverage for employer catastrophic losses.

At its core, stop-loss insurance programs are forms of excess liability protection designed to indemnify employer plan sponsors for health care expenses above predetermined dollar amounts. While stop-loss carriers are subject to state insurance regulation as insurers, this is not the same as regulating health insurance



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carriers that bear health risk loss for individuals. Varying by state, specific regulation of stop-loss insurers generally covers solvency and licensing requirements and regulation of investments. More closely resembling property and casualty insurance, stop-loss is a form of catastrophic insurance coverage that reimburses an employer for unforeseen and abnormally high plan expenses. The protection offered by comprehensive stop-loss coverage reflects its value in helping plan sponsors including small employers to manage catastrophic plan events. Since stop-loss insurance does not bear financial responsibility for individual plan participants there is no rational basis to classify stop-loss insurance as health insurance or to define self-insurance based on federally regulated attachment points. ■

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<sup>1</sup>Kaiser Family Foundation and Health Research & Education Trust, 2012 Employer Health Benefits Survey

<sup>2</sup>Ibid.

<sup>3</sup>See *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985) (discussing ERISA's "savings" and "deemer" clauses).

<sup>4</sup>Health Insurance Portability and Accountability Act (HIPAA), Pub.L. No 104-191, 1996.

<sup>5</sup>Affordable Care Act (ACA) P.L. 111-148 (2010).

<sup>6</sup>RAND CORPORATION, *Employer Self-Insurance Decisions and the Implications of PPACA*, Report to U.S. Department of Labor (2011).

<sup>7</sup>Secretary of Labor, *Annual Report to Congress on Self-Insured Group Health Plans* (2011) and (2012).

<sup>8</sup>See note 6.

<sup>9</sup>S. Collins, "Medical Loss Ratio Regulation Good For Consumers", *Commonwealth Fund Blog* (Nov. 2010).

<sup>10</sup>Kaiser Health News, "Insurer Rebates Under Medical Loss Ratios for Consumers" (Nov. 2010).

<sup>11</sup>J. Gabel, R. McDevitt et al., *Commonwealth Fund Health Affairs*, May-June 2006 25(3) 832-43.

<sup>12</sup>Pricewaterhouse Coopers Research Institute, available at [www.pwc.com/us/en/health-behind-the-numbers/keyfindings](http://www.pwc.com/us/en/health-behind-the-numbers/keyfindings).

<sup>13</sup>See note 6.

<sup>14</sup>See note 6.

<sup>15</sup>See note 6.

<sup>16</sup>R. Abelson, "Health Insurers Making Record Profits as Many Postpone Care", *New York Times*, May 3, 2011.

<sup>17</sup>Kaiser Family Foundation and Health Research & Educational Trust, 2010 Employer Health Benefits Survey.

<sup>18</sup>See note 6.

<sup>19</sup>Ibid.

<sup>20</sup>RAND CORPORATION, *Report to U.S. Department of Health and Human Services in collaboration with U.S. Department of Labor; Report to Congress On Study of Large Group Market* (2011).

<sup>21</sup>Ibid.

<sup>22</sup>The Commonwealth Fund, *Issue Brief "How Health Care Reform Can Lower the Costs of Insurance Administration"*, (July 2009).

<sup>23</sup>Center for Medicare and Medicaid Services, Office of the Actuary, *National Health Expenditure Accounts*, available at [www.cms.gov/NationalHealthExpendData/downloads/dsm-o7.pdf](http://www.cms.gov/NationalHealthExpendData/downloads/dsm-o7.pdf).

<sup>24</sup>Healthcare Performance Management Institute, *Governance, Risk and Compliance Management Strategies for Self-Insured Health Plans*, White Paper (2011).

<sup>25</sup>See note 20.

<sup>26</sup>NAIC Model #92: Stop Loss Insurance Model Act (Only Minnesota, New Hampshire and Vermont have adopted the model law).

<sup>27</sup>*American Medical Security v. Bartlett*, 111 F.3d 358, (4<sup>th</sup> Cir. 1997) cert denied, 118 S.Ct. 2350 (1998).

<sup>28</sup>*Brown v. Granatelli*, 897 F.2d 1351 (5<sup>th</sup> Cir. 1990, cert. denied 498 U.S. 848 (1990)).