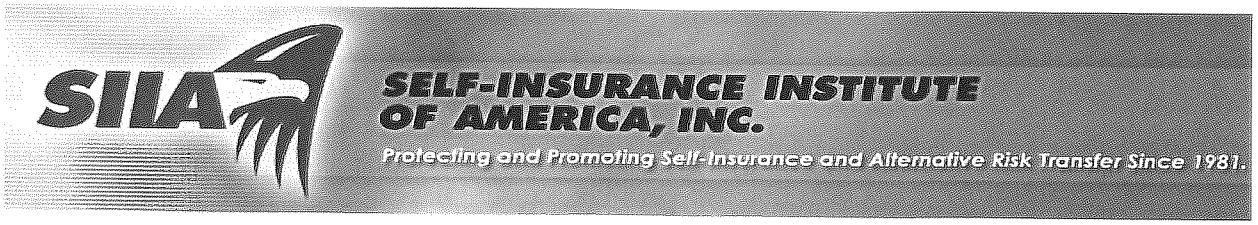

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Providing Access to Affordable, Flexible Health Plans Through Self-Insurance

Testimony Delivered By

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INTRODUCTION

Good morning Chairman Roe and members of the subcommittee, thank you for the opportunity to testify on the issue of self-insurance. My name is Mike Ferguson. I serve as President and CEO of the Self-Insurance Insurance Institute of America, Inc. (SIIA).

SIIA is a national trade association that represents companies involved in the self-insurance marketplace, including self-insured organizations and their business partners, mostly in the small and midsized market segments.

My written testimony will address six general areas relating to self-insurance.

- What is Self-Insurance and How Does it Differ from Traditional Health Insurance
- Who Self-Insures
- The Advantages and Disadvantages of Self-Insurance
- Federal Regulation of Self-Insured Group Health Plans
- Stop-Loss Insurance Overview and Marketplace Demographics
- What Congress Can Do to Help Protect the Self-Insurance Marketplace

WHAT IS SELF-INSURANCE AND HOW DOES IT DIFFER FROM TRADITIONAL HEALTH INSURANCE?

Should an organization wish to sponsor a group health plan for its employees or members, it has two basic options. The first option is to purchase a traditional group health insurance policy from a licensed health insurance carrier. Under this arrangement, the organization pays the insurance carrier a fixed premium and the carrier provides health care coverage to the group in accordance with specified policy terms. By choosing the traditional insurance option, the organization transfers the health care-related financial and legal risk to the carrier.

The other option is to retain the financial and legal risk through the use of a self-insured group health plan. This is also known as self-funding. Under this arrangement the organization pays eligible health care claims as they are incurred, either directly like other business expenses or through a separate trust. Self-insured employers typically outsource claims administration functions, and often times retain stop-loss insurance as a financial backstop for catastrophic claims.

WHO SELF-INSURES?

According to the 2013 Kaiser Employer Health Benefits Survey, 61% of covered workers in private employer plans receive coverage through self-insured arrangements. Interestingly, 16% of small employers with 3-199 workers are self-insured. In 2012, this number was 15%.

It is important to note that there are about 1200 Taft-Hartley health plans – sponsored jointly by labor and management – serving a variety of industries. More than half of these plans are self-insured. And, many of these self-insured Taft-Hartley plans are small, with as few as 50 to 100 members.

Given these statistics, it's clear the topic of self-insurance is important to labor and management. And it's also clear that self-insurance is not simply a privilege for large organizations.

DISADVANTAGES OF SELF-INSURANCE

Now that we have established the size and diversity of the self-insurance marketplace, it would be useful to discuss the advantages and disadvantages of self-insurance in order to better understand what must be considered as part of the evaluation process.

It's important to state right up front that self-insurance is not the right option for all organizations. Smaller organizations, in particular, should carefully consider what it means to be self-insured.

Financial Liability

The primary consideration is that once self-insured, the organization is responsible for paying all eligible health care claims incurred by plan participants. While stop-loss insurance provides for a limited reimbursement mechanism for higher cost claimants, the self-insured organization accepts all financial liability for the group health plan. Simply stated, if an organization is not prepared to cut checks to pay providers, the organization should not be self-insured.

Legal Liability

In addition to accepting financial liability, self-insured plan sponsors also subject themselves to significant legal liability. Plan fiduciaries (normally organization executives) are subject to civil and criminal penalties under the Employee Retirement Income Security Act (ERISA) to the extent that plans are not administered in the best interests of the participants. Again, if an organization is not prepared to understand and ensure compliance with applicable federal law, the organization should not be self-insured.

Time and Focus Commitment

While self-insurance allows plan sponsors more flexibility to deliver quality health benefits in a more cost effective way, sponsors must commit to the necessary time and focus to design and manage their plans in order to achieve the desired results. So, the final simple statement is, if an organization is not willing to make this commitment, the organization will likely be better off in a traditional, fully-insured arrangement.

ADVANTAGES OF SELF-INSURANCE

Notwithstanding these disadvantages, there are many reasons why organizations should consider self-insurance as an alternative health plan financing option.

More Cost Effective Than Fully-Insured Plans

A well run self-insured health plan is generally less expensive over time compared to traditional, fully-insured options. The "over time" caveat is important because claims experience often varies from year-to-year.

Traditional insurance premiums must account for the carrier's marketing cost and profit margin, among other cost escalators that are not applicable to self-insured plans, as they are essentially not-for-profit health plans.

Plan Design Flexibility

Federal law provides self-insured plans greater flexibility in designing benefit packages that better meet the specific needs of their plan participants. For example, organizations with a predominately female workforce can structure their plans to incorporate more robust health benefits that would be utilized by female plan participants. Self-insurance plans can also structure more innovative reimbursement arrangements with health care providers.

Improved Cash Flow

Self-insuring allows claims to be funded as they are paid. Fully-insured premiums constitute a form of pre-payment. With self-insuring, a plan pays health plan costs only after the services have been rendered. Insurers set health insurance premiums at levels that anticipate projected increases in healthcare costs – usually well in excess of the actual rise in costs.

Ownership of Health Claims Data

Health claims data is extremely valuable for plan design purposes. But, under traditional insurance arrangements, carriers maintain that they own this data and employers cannot get access to it. By contrast, self-insured organizations have control over this data and can use it to help deliver benefits more efficiently and control costs.

ERISA Preemption of State Regulation

ERISA provides uniform regulatory stability to employers that operate in several states, so those companies do not have to adopt a patchwork of design variations to comply with various states' requirements. This is particularly important for multi-state organizations.

Incorporation of Value-Based Benefits and Wellness Programs

As medical costs have skyrocketed, self-insured plan sponsors have been taking steps to reduce medical costs by emphasizing prevention and maintenance care for chronic diagnoses. Employees have the flexibility to design and integrate into overall strategies, health risk assessments, prevention and wellness programs tailored to the employer's specific employee demographics and needs.

FEDERAL REGULATION OF SELF-INSURED PLANS

Some health care market observers contend that policy-makers should be concerned about employers switching to self-insured health plans and purchasing medical stop-loss insurance in order to "dodge" requirements and fees applicable to fully-insured health plans as provided for by the ACA.

They further argue that if an increased number of small employers self-insure, such actions will contribute to adverse selection, and therefore, compromise the viability of the ACA Exchanges (in particular, the SHOP Exchanges). SIIA believes these contentions are inaccurate based on a review of those ACA requirements applicable to self-insured plans, along with the recent findings of the RAND Corporation on this subject.

For purposes of our discussion, we will focus on non-grandfathered self-insured plans, which by definition include organizations that have switched to self-insurance since the passage of the ACA or have changed their plans since the enactment of the law. Importantly, non-grandfathered self-insured group health plans are subject to almost all ACA's health care market reforms, which means self-insured plans must:

- Eliminate all pre-existing condition exclusions for all participants.
- Eliminate waiting periods that exceed 90 days.
- Stop imposing annual and lifetime limits on the dollar value of "essential health benefit."
- Stop rescissions of coverage.
- Cover "adult children" up to age 26.
- Cover the cost of clinical trial participation.
- Provide coverage for certain preventive health services with no cost-sharing.
- Provide participants with a summary of benefits and coverage.
- Provide annual reports describing the plan's quality-of-care provisions.
- Include new internal and external appeals processes.
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.
- Provide direct access to emergency services.
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.
- Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014.

Of the few ACA health care market reforms that do no not apply to non-grandfathered self-insured health plans, there are specific reasons why:

Medical Loss Ratio – As self-insured plans are essentially non-profit entities with the fiduciary requirement to use plan assets for the exclusive benefit of the plan participants, there is no "profit margin" to regulate.

Rating Rules – As non-profit entities, plans have no financial incentives to rate participants unfairly. For fully-insured plans, there is both the profit margin incentive as well as a history of abuse in rating practices.

Review of Rate Increases – Again, as self-insured plans are non-profit entities and prohibited from using plan funds for any other purpose, sponsors have no incentive to increase rates any more than the rate of increase of medical claims and expenses.

Essential Health Benefits – Congress considered whether self-insured plans should be subject to the "essential health benefits" (EHB) requirement. But, because Congress understood that most, if not all, self-insured plans already provided coverage for the enumerated EHB medical services, Congress made the affirmative decision to only impose the EHB requirement on fully-insured individual and small group market health plans. It is important to note that self-insured plans sponsored by employers with 50 or more "full-time equivalent employees" must offer coverage that provides "minimum value" or face a potential penalty tax. Most observers agree that the "minimum value" test is a proxy for the EHB requirement, so in essence self-insured plans are indirectly subject to a requirement to provide comprehensive coverage.

Finally, although not considered when Congress drafted the law, the fact that HHS directed the states to develop their own "essential health benefits-benchmark plan" lends to the argument that the EHB requirement would be preempted under ERISA, and therefore, not applicable to self-insured plans.

Related Consideration – Other Federal Laws Regulate Self-Insured Plans
Self-insured group health plans (grandfathered and non-grandfathered) are highly regulated by other federal laws such as ERISA, HIPAA and COBRA that existed prior to the ACA. Consumer protection requirements/mandates under these laws include:

- Prohibited from denying coverage based on preexisting conditions
- Prohibited from discriminating on cover based on health status
- Mandated internal review procedures
- Privacy protections
- Plan fiduciary standards
- Prohibited from rescinding coverage for non-fraudulent purposes
- Continued access to coverage post job termination

STOP-LOSS INSURANCE OVERVIEW AND MARKETPLACE DEMOGRAPHICS

Stop-Loss Insurance Overview
As referenced earlier in this testimony, smaller and mid-sized self-insured organizations typically retain stop-loss insurance to provide a financial backstop to guard against catastrophic claims. In this regard, I believe it would be useful to clearly explain what stop-loss insurance is and how it differs from traditional health insurance, as it is more closely related to liability insurance products than health insurance products.

Quite simply, stop-loss insurance provides financial reimbursements to self-insured organizations for health care payments that exceed pre-determined levels, known in the industry as "attachment points." Stop-loss policy attachment points can either be for specific plan participants and/or for total claims incurred by the plan, known as "aggregate."

Unlike health insurance, stop-loss insurance does not cover individuals nor pay health care providers regardless of attachment point levels. Stop-loss insurance can only reimburse the sponsor or the plan for health payments in excess of the attachment point.

Stop-Loss Insurance Marketplace Demographics

Milliman released a report last year commissioned by the Self-Insurance Educational Foundation (SIEF), highlighting key policy characteristics found in the U.S. employer medical stop-loss (ESL) market. The underlying policy data was provided by eight of the largest stop-loss carriers which collectively represent approximately 50% of the market. Milliman therefore assumed that the data is a reasonable approximation of the entire ESL market. A summary of this data revealed the following:

- Employers with 100 or fewer covered employees represent approximately one-quarter of the ESL market if the market is measured by count of employers. If measured by covered employees, however, that same segment represents only 2% of the ESL market.
- Most ESL purchasers obtain both specific and aggregate stop-loss. However, employers with over 1,000 employees are more likely to purchase specific stop-loss without aggregate. Very few employers found in the underlying data purchased aggregate coverage without specific stop-loss.
- The data included employers that purchased specific deductibles ranging from $5,000 to $2,000,000. However, 81% of employers purchased deductibles of $50,000 or greater.
- The median specific deductible found in the calendar year (CY) 2012 data across all plans was $80,000. For groups with 50 or fewer covered employees, the median deductible was $35,000. For groups of 51-100 employees, the median was $45,000.
- Less than 0.2% of specific stop-loss policies had specific deductibles of $10,000 or less. About 0.3% of specific stop-loss policies were written with specific deductibles of less than $20,000.
- The data included employers that purchased aggregate corridors ranging from 110% to 200% of expected claims. By far, the most common corridor (found on 90% of policies with aggregate coverage) was 125% of expected claims.

WHAT CONGRESS CAN DO TO PROTECT THE SELF-INSURANCE MARKETPLACE

Despite the many positive advantages of self-insurance described in this testimony, SIIA is concerned that the Administration may make this option more difficult by restricting the availability of stop-loss insurance. Specifically, it is believed that the Federal agencies may "interpret" the definition of health insurance coverage to include stop-loss insurance based on attachment point levels.

The Administration first signaled its interest in regulating stop-loss insurance in May of 2012 through a tri-agency request for information (RFI) about stop-loss policies. Then, a letter to Congress dated August 22, 2013 by HHS Secretary Kathleen Sebelius confirmed that the Department is "interested in the possible effects of self-funded arrangements with stop-loss insurance on the risk pool and premiums in the fully-insured small group market."

Most recently, the final Health Insurance Tax Rule, published on November 26, 2013, included a section on stop-loss insurance that does not rule out the possibility that future guidance may specify, "Under what circumstances stop-loss coverage constitutes health insurance."

Based on these observations, SIIA strongly supports H.R. 3462, known as the Self-Insurance Protection Act (SIPA). This simple, three-page bill amends the definition of "health insurance coverage" under the Public Health Services Act (PHSA) and parallel sections of ERISA and the Tax Code to clarify that stop-loss insurance is not health insurance in order to prevent overly creative interpretation of the federal statute by regulators.

It is important to note that the legislation does not amend the ACA. As a result, SIIA does not view SIPA as a partisan bill. Rather, the bill essentially establishes guardrails around a segment of the employer-based health care system that is working well. We therefore ask members on both sides of the aisle to support this sensible public policy objective.

CONCLUSION

In conclusion, I would like to thank the committee again for this opportunity to provide input on the increasingly important topic of self-insurance, and I look forward to addressing any questions you may have. Additional information about self-insurance can be accessed on-line at www.siia.org