

The American Association of Payers, Administrators and Networks provides a look at the vital role the self-funded insurance market plays in the U.S. healthcare system and the challenges and opportunities presented in an evolving marketplace. Part One takes a look at the significant role that the self-funded market plays overall in the healthcare arena, current statistics including the substantial increase in self-funding since the enactment of ACA and the benefits of self-funding. Part Two examines the role of the TPA in administering self-funded plans, and Part Three outlines the business practices of the stop-loss carrier in providing coverage for self-funded plans.

PART ONE: The Self-Funded Market

In today's marketplace, 61 percent of all individuals with health coverage are covered by self-funded plans as employers and employees alike welcome the options and control they provide to beneficiaries. Competitive pressures to provide attractive employee benefits have always been a driving force for employers to consider alternatives to fully funded plans. But never has that been truer than now as employers begin to come to terms with the realities of health care reform which is making self-funded insurance an attractive alternative more than ever.ⁱ

Yet, even as self-funded insurance is gaining in popularity with employers, the self-funded market is increasingly vulnerable due to the regulatory implementation objectives of the Affordable Care Act (ACA). State and federal policy makers, in an attempt to avoid adverse selection away from exchange benefit plans, are considering policies that could limit employer access to the self-funded market, depriving them of this needed alternative.

After holding steady as a percentage early last decade, a substantial increase in self-funding occurred after the enactment of the (ACA). As we move into the second year of ACA Exchanges, one implementation factor in this trend is still looming – the 2016 implementation of the employer mandate to employers of 50 to 99 employees. As nearly 70 percent of American employees are employed by small firms, the pending implementation of the mandate is driving small employers to look at all options.ⁱⁱ

Traditional benefits of self-insuring

A number of features have made self-insurance an attractive option for employers.

1. They can tailor a policy to the current (and projected) needs of their workforce, rather than paying for benefits employees are unlikely to use. They may also have a greater range of provider network options.ⁱⁱⁱ
2. They retain access to and control over current and historical employee health claims data, which can help in ensuring that plan resources are cost-effective while meeting employee needs.^{iv}
3. They retain, invest and earn investment income on their health plan reserve dollars, and capture cash flow by not prepaying for services employees may or may not use. They also avoid the added expense of state taxes on employer-paid insurance premiums.^v
4. They avoid dealing with complex state regulations,^{vi} freeing up cash and time, especially for companies with employees in multiple states, that can be invested in operations, expansion and job creation.



The ranks of self-insurers are large and growing

Most people with employer-provided health insurance are in self-funded plans. The percentage of covered employees in completely or partially self-funded plans grew from 49 percent in 2000 to 61 percent in 2013. As of last year, 83 percent of workers in large firms (200 or more employees) that have health care coverage are currently in self-insured plans, according to a Kaiser Family Foundation estimate.^{vii}

An estimated 59 percent of these employees are in plans that are covered by stop-loss insurance. The average attachment point for large firms surveyed by Kaiser in 2013 is \$317,000. The average attachment point for smaller surveyed firms is about \$96,000.^{viii}

Companies are increasingly moving to self-insurance

Sixteen percent of firms with fewer than 200 employees surveyed by Kaiser in 2013 are self-insured, up from 13 percent in 2011. This level, however, remains below 2001's 17 percent rate of self-insurance among small employers.^{ix}

The ACA may be spurring small employers to consider self-insurance, as some ACA mandates do not apply to self-insured plans. The mandated essential health benefits package included in the ACA, for example, applies to traditional insurance plans but not to self-insured ones.^x While Jost and Hall of Washington & Lee University (2012) cite stop-loss plans with attachment points as low as \$10,000 targeted at small employers as increasing the number of small employers considering self-funding,^{xi} the \$96,000 average attachment point cited by Kaiser supports the position that other factors are leading employers towards self-funded insurance.

Ultimately, the decisions determining the benefits and access to health care services employers provide to employees will be based at some level on price. While lower stop loss attachment points may make self-funding achievable for some small businesses, the effect is simply to provide an employer with an additional option to find the best fit for health care coverage for employees.

PART TWO: Third Party Administrator and Self-Funded Employer Partnership

Self-insurance allows companies to pay for their employees' medical costs by paying providers directly and/or reimbursing employees rather than paying a fixed premium to an insurance company, as it would under a fully insured plan. But that does not mean that they are acting alone. Employers of all sizes who seek to self-insure frequently employ experts to help them with the day-to-day mechanics of the administration of providing health benefits to their employees - from assisting with benefit design, choosing a network, enrollment, and paying claims to providing many additional benefit services to meet the needs of their employees. Central to this process are services provided by Third Party Administrators (TPAs). Today more than 70 million Americans^{xii} benefits are administered by TPAs.

The Role of the TPA

TPA services are broadly used throughout the private insurance market. Whether as independent entities or as an affiliate or subsidiary of a health insurance carrier, TPAs are active in all 50 states and are licensed or registered in 43. Their value has been recognized at the national level since 1977 by the National Association of Insurance commissioners (NAIC), which has been instrumental in providing TPA guidance to states, in the group health context as well as in the Worker's Compensation Insurance market.^{xiii}

Furthermore, Maryland has recognized the positive role of the TPA in presenting options to employers pursuant to the Affordable Care Act (ACA). Maryland has certified TPAs to present SHOP exchange options to employers and guide them to solutions that make sense for their employees^{xiv}, integrating TPAs into the State Health Benefit Market alongside their function in the self-insured market.

While TPAs are often viewed as claim processors specializing in administrating the transactions between providers and payers, it is very important to understand the depth of the services they perform and how the services they performed are valued by employers and many other payers as well. While utilization of a TPA's specialization occurs in the self-insured market for the benefit of an employer, all types of payers use TPAs for their efficiency and expertise in comprehensive and specialty administration of a variety of programs and services including:

- Workers' Compensation
- Dental/Vision
- Retirement Plans
- Long Term Disability
- COBRA
- HIPAA
- Taft Hartley
- Government Sponsored
- PBM
- Wellness
- Utilization Review
- Human Resources



Accordingly, TPAs are seen as reliable entities central to providing guidance to employers seeking to address the administration of many different types of benefit plans and programs. In Deloitte's 2013 Survey of U.S. Employers, Third-Party Benefit managers and independent consultants including TPAs were seen by both large and small employers as more trustworthy sources of guidance for health care services than federal and state government agencies.^{xv} The longer a TPA works with a particular employer, the more its specialized programs and services can be tailored to positively impact the employer's bottom line. Many employers and municipalities depend on their TPA for ongoing benefit design, using previous years' utilization data and analytics to recommend benefit changes that still provide a solid benefit for employees but reduce health care costs for employers.

TPAs Provide Employers Value and Choice

Large and small employers employ specialized experts to assist them in efficiently running their businesses, particularly in areas beyond their core competencies. This is particularly true for employers who have specific needs to attract and keep highly trained employees, or attend to employees that are in remote areas of the country. While some have noted that self-insurance would become too burdensome for small employers^{xvi} without TPA services, this is true of any critical service an employer chooses to outsource. Employers rely on outside accounting firms, payroll companies, logistics operators, and a myriad of other companies to address critical needs central to the success of their businesses. Another example of this outsourcing is coordination of benefits and subrogation services for an employer. TPAs frequently provide subrogation services identifying claims attributable to third parties or appropriately directed to workers' compensation. This service cannot easily be accomplished in house, but can be delivered efficiently by specialized TPA programs.

Placing a burden on small and large employers' ability to self-fund or prevent access to the experts to support their choice to self-fund places an unwarranted limitation on their right to operate their businesses in an efficient and flexible manner.

PART THREE: Self-Funded Employer and the Stop-Loss Carrier Services

When employers, large or small, choose to self-fund their health plans, they take on risk that will require them to plan and budget for the potential medical claims their employees incur during the plan year. A self-insured employer normally sets up a special trust fund that will pay for incurred medical claims.^{xvii, xviii} Some employers choose to partially self-insure, using self-insured plans to augment rather than replace the insurance-carrier benefit plans they offer.^{xix} In either event, employers desire the flexibility to design and manage the health benefit plan that they offer their employees while predictably managing their paid claims. For fully self-insured employers that actively seek to mitigate the risk of unusually high medical expenses for one or more employees, most choose to utilize stop-loss insurance.

The Role of Stop-Loss Insurance in the Self-Funded Market

Stop-loss, or excess, insurance protects a self-insured employer against unexpectedly high, catastrophic or unpredictable medical costs. A stop-loss policy transfers medical costs above an agreed upon threshold from the employer to the insurer. There are two types of stop-loss insurance – specific and aggregate. Specific stop-loss protects against a single unexpectedly high claim, while aggregate stop-loss protects against an unexpectedly high aggregate amount of claims in a contract period. Both forms of stop-loss policy pay any claim amounts that exceed an agreed-upon level, known as the attachment point.^{xx, xxi} Stop-loss insurance attachment points should be matched to an employer’s budgeted funds to pay medical claims, both in terms of yearly budgeted amounts, but also attuned to cash flow if reserves are depleted. An employer can match coverage to address both its exposure to claims on an annual or individual claim basis if a stop-loss carrier is permitted flexibility when setting attachment points.

While an employer will not know the precise amount beneath the aggregate stop-loss attachment point it will need to pay in claims, or when these expenses will occur, there are additional insurance products that allow employers to address their monthly risk. Many stop loss carriers offer a product called “monthly accommodation” for aggregate coverage. This product provides a monthly aggregate reimbursement to specifically address the employer’s potential high costs early in the plan year. The annual aggregate attachment point is calculated on a monthly basis and employer paid amounts in excess of the monthly aggregate attachment point are reimbursed the next month, following the employer’s reimbursement of claims in excess of the monthly aggregate attachment point. A final annual accounting is determined at the end of the policy year.

Another aspect of stop-loss policies are run-in and run-out provisions that protect both the employer and employees if claims are made outside of a plan year but were incurred within a plan year. Run-in and run-out policies operate similarly, addressing claims that occur outside of the plan year, but for differing circumstances. While run-in policies may be necessary for plan changes between self-funded plan years to address a change in stop-loss carriers or other changes, for an employer moving from a fully insured plan this would be largely unnecessary as claims from the previous plan year would still be covered. In contrast, run-out provisions protect employers when they move back into a fully insured plans and protect employees from employer or plan insolvency.



Both monthly accommodation and run-in and run-out provisions demonstrate that the stop-loss insurance market has anticipated or responded to employer concerns addressing any financial uncertainty of self-funding in the short and long term. This is expected from a mature market responding to consumer demands. Unfortunately, this can be lost in discussions that view the self-funded market as a series of potential problems to be solved, rather than a rational exploration of viable options for employers seeking to provide their employees with health care benefits. What makes the self-funded market so attractive to employers is the flexibility they have to adapt existing and robust health care networks and services to their specific needs. To restrict this flexibility would force employers to make decisions far removed from what would provide the best coverage to their employees.

State Attempts to Regulate Stop-Loss Insurance

Recent efforts by states to regulate stop-loss insurance have focused on establishing mandatory minimum attachment points or increasing existing ones. Several state legislatures considered stop-loss legislation during their 2013 sessions, with four of the six states considering legislation enacting new minimum specific attachment points. Most of those states adopted attachment points at or below those recommended by the National Association of Insurance Commissioners (NAIC). Colorado, North Carolina, and Rhode Island adopted new minimum attachment points at the \$20,000 level recommended in the NAIC's existing 1999 model language. Utah also adopted a new minimum individual attachment point at a lower \$10,000 level. The highest minimum attachment points enacted this session were in California. The state set its minimum individual attachment point at \$35,000, which is scheduled to rise to \$40,000 in 2016. The California aggregate minimum attachment point has been set to 120 percent of expected claims. While this is higher than the current NAIC recommendations, it is still lower than the revised numbers considered by the state last summer.

As states examine increased regulation of self-insured plans, the current structure of their health insurance markets will be the primary driver of new policy. Particularly for states without a state operated insurance exchange, the benefits to employees and employers of the current self-insurance regulatory setup may be significant, and the risks may be relatively small. While North Carolina did consider and pass new minimum stop-loss attachment points, no other jurisdiction without a state-based exchange moved forward with this legislation. Even those exchange states that raised the minimum levels limited them to relatively conservative levels. The reason for this is that any perceived adverse selection threat to state exchanges are theoretical at this point. Small businesses moving from fully insured plans to self-funded plans may not move into the exchange even without the option of a self-funded plan.

- ⁱ Deloitte Development LLC, “Health care costs, benefits, and reform: What’s the next move for employers? Results of Deloitte’s 2013 Survey of U.S. Employers” http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Plans/us_lshc_2013employerstudy_111213.pdf
- ⁱⁱ Juliet Eilperin and Amy Goldstein, *Washington Post*, “White House delays health insurance mandate for medium-size employers until 2016” February 10, 2014 http://www.washingtonpost.com/national/health-science/white-house-delays-health-insurance-mandate-for-medium-sized-employers-until-2016/2014/02/10/ade6b344-9279-11e3-84e1-27626c5ef5fb_story.html
- ⁱⁱⁱ “Self-Insured Group Health Plans - Self-Insurance Institute of America, Inc.”
- ^{iv} Robin Gelburd, “The Importance of Data Analytics for Self-Insurers,” *The Self-Insurer*, September 2013, 5.
- ^v “Self-Insured Group Health Plans - Self-Insurance Institute of America, Inc.”
- ^{vi} *Ibid.*
- ^{vii} The Henry J. Kaiser Family Foundation, “Employee Health Benefits Survey 2013, Section 10,” *2013 Employer Health Benefits Survey*, August 20, 2013, <http://kff.org/report-section/ehbs-2013-section-10/>.
- ^{viii} *Ibid.*
- ^{ix} The Henry J. Kaiser Family Foundation, “Employee Health Benefits Survey 2013, Section 10.”
- ^x Maura Calsyn and Emily Oshima Lee, “The Threat of Self-Insured Plans Among Small Businesses,” *Center for American Progress*, June 19, 2013, 6, <http://www.americanprogress.org/issues/healthcare/report/2013/06/19/65790/the-threat-of-self-insured-plans-among-small-businesses/>.
- ^{xi} Jost and Hall, *Self Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, 7.
- ^{xii} Fleet, Samuel H., *Setting self-funding strategy: Small employers increasingly turning to self-funding to ease cost increases*, (Employee Benefit News, February 11, 2011) <http://ebn.benefitnews.com/news/setting-self-funding-strategy-2685025-1.html>
- ^{xiii} NAIC Guideline, *Registration and Regulation of Third Party Administrators*, 2011 <http://www.naic.org/store/free/GDL-1090.pdf>
- ^{xiv} Maryland Exchange TPA partnership program <http://marylandhbe.com/exchange-partners/third-party-administrators/>
- ^{xv} Deloitte Development LLC, “Health care costs, benefits, and reform: What’s the next move for employers? Results of Deloitte’s 2013 Survey of U.S. Employers,” 14, http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Plans/us_lshc_2013employerstudy_111213.pdf
- ^{xvi} T Jost and M Hall, *Self Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, Washington & Lee Public Legal Studies Research Paper Series (Washington & Lee University, June 27, 2012), 14, <http://ssrn.com/abstract=2070883>.
- ^{xvii} *Employer Self-Insurance Decisions and the Implications of the Patient Protection and Affordable Care Act as Modified by the Health Care and Education Reconciliation Act of 2010 (ACA)* (RAND Corporation, 2011), 3–4.
- ^{xviii} “Self-Insured Group Health Plans - Self-Insurance Institute of America, Inc.,” *Self-Insurance Institute of America*, c2012, <http://www.siaa.org/i4a/pages/Index.cfm?pageID=4546>.
- ^{xix} Dan Verel, “Smaller Employers Increasingly Explore Partial Self-funding,” *North Bay Business Journal - North San Francisco Bay Area, Sonoma, Marin, Napa Counties*, April 23, 2012, <http://www.northbaybusinessjournal.com/52827/employers-increasingly-inquiring-about-partial-self-funding-model/>.
- ^{xx} Deborah Chollet, “Self-Insurance and Stop Loss for Small Employers,” *Washington: Mathematica Policy Research* (2012): 1, http://www.naic.org/documents/committees_b_erisa_120626_chollet_self_insurance.pdf.
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