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Self-Funding: Myths vs. Facts

1. Myth: Self-funded plans are exempt from market reform changes under the Affordable Care Act (ACA).

Fact: Self-funded plans are subject to the substantive ACA market reforms, as well as numerous other Federal laws, including (but not limited to) the Employee Retirement Income Security Act of 1974 (ERISA) (P.L. 93-406), the Health Insurance Portability and Accountability Act (HIPAA) nondiscrimination rules (P.L. 104-191), HIPAA privacy and security (P.L. 104-191), the Americans with Disabilities Act (P.L. 110- 325), the Mental Health Parity Act (P.L. 104-204), COBRA continuation coverage (P.L. 99-272), IRS nondiscrimination rules prohibiting benefit differences based on employee status (P.L. 95-600).

ACA Market Reforms Applicable to Self-Funded Plans

>> Prohibition on Lifetime and Annual Limits (PHSA §2711)

>> Prohibition on Preexisting Condition Exclusions (PHSA §2704)

>> Prohibition on Rescinding Health Coverage after coverage begins (PHSA §2712)

>> Coverage of Dependents up to age 26 (PHSA §2714)

>> Summary of Benefits and Coverage and Uniform Glossary of Coverage and Medical Terms (PHSA §2715)

>> Tax on Plans to Fund Temporary Reinsurance Program>> Wellness Incentives (PHSA §2705)

>> Employer/Plan Information Reporting (IRC §6055 and §6056)>> Automatic Enrollment (ACA §1511)

>> Out of Pocket Maximums* (PHSA §2707)

>> Coverage of Preventive Care without Cost Sharing * (PHSA §2713)

>> Claims Appeal and External Review Requirements* (PHSA §2719)

>> Limitation on Waiting Periods * (PHSA §2708)

>> Nondiscrimination Based on Health Status* (PHSA 2705)

>> Patient Protections (choice of primary care provider and emergency services without prior authorization)* (PHSA §2719A)

>> Prohibition on Discrimination against Providers* (PHSA §2706) >> Coverage of Clinical Trials* (PHSA 2709)

* Grandfathered plans, whether self-funded or fully insured, are not subject to certain market reforms. Most

self-funded plans will have lost grandfather status by 2014.

2. Myth: Self-funded group health plans are unregulated.

Fact: Self-funded group health plans are regulated by a myriad of Federal agencies including the Department of Labor, the Department of Treasury, the Department of Health and Human Services, and the EEOC. Most self-funded plans (other than government and church plans) are subject to ERISA, which imposes strict disclosure rules, fiduciary financial management controls, claims and appeal rules, government reporting and potential civil and criminal penalties. States have the authority to regulate non-federal governmental plans and many States have developed rules reflecting the needs of their respective constituencies.

3. Myth: Stop-Loss coverage is virtually unregulated.

Fact: State Insurance Departments regulate all insurance companies and their products. Stop-Loss is one of the many regulated products, with at least 30 states addressing Stop- Loss insurance in law, regulation or by Bulletin.

4. Myth: Stop-Loss insurance is just like health insurance.

Fact: Stop-Loss insurance does not insure plan participants. Stop-Loss insurance insures employers against excess loss. Small and mid-sized self-funded employers retain Stop-Loss insurance to provide a financial buffer to guard against catastrophic claims. Stop-Loss reimburses the plan sponsor or the plan for health payments in excess of a pre-determined level, commonly known as an “attachment point." The role of Stop-Loss is essentially the same for self-funded employers as reinsurance is for insured health plans - a financial risk management tool.

5. Myth: Some employers are too small to self-fund.

Fact: The economic condition of the employer, their financial risk tolerance, the desire for flexibility in designing a benefit plan to meet the needs of a group, and the significantly lower administrative costs are the factors determining whether an employer will self-fund. The notion that employer size should be a threshold issue in the decision to self-fund is misplaced. Smaller firms that have more robust cash flows can be better suited for self-funding than larger firms with restricted cash flows. Employers, regardless of size, are in the best position to evaluate their unique situations and select an appropriate method to finance the risk of a health benefit plan.

6. Myth: Small employers with healthier workers will disproportionately self-fund, creating adverse selection in the fully insured markets (including the SHOP) and increasing premiums for the small employers who continue to fully insure.

Fact: Self-funded plans cover a wide range of employee risk, including participants with high-cost chronic and non-chronic conditions. Historically, self-funded plan participants have not had more favorable health risk profiles than fully insured plan participants. Since the inception of HIPAA in 1997, small employers (in most states those with fewer than 51 benefit eligible employees) have participated in an insurance market with features comparable to the ACA. These features have included guaranteed issue requirements, and in many states, a limited ability to price based on the group’s actual experience. During this 17-year history, a trend has not emerged of small employers moving into or out of insurance primarily on the basis of known employee health factors.

There are significant transition costs and barriers to switching between benefit funding methods, and the health status of employees is only one of many factors considered when an employer selects a benefit funding approach. Employers will not abandon one method simply because of employee health status changes. The adoption of self- funding in lieu of insurance also introduces additional compliance, financial and Plan management obligations for employers. This will continue to deter many from choosing this option. And for

employers with fewer than 25 employees, SHOP participation may generate an employer tax credit, a feature that self-funding cannot offer.

The premise that small employers with healthier workers will disproportionately utilize self-funded plans is unsubstantiated. Each employer that decides to provide benefits weighs a number of elements in choosing a method; population health is but one of those.

7. Myth: Self-funded plans will adversely impact state health insurance marketplaces.

Fact: The statement that self-funded plans contribute to adverse selection and will lead to the decline of the health insurance marketplace has no basis in fact. In particular, the RAND Corporation concluded the exact opposite. According to a Technical Report published by the RAND Corporation in 2011 ("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") that predicts firms' decisions to self-insure using a microsimulation model, "the option to self-insure does not lead to substantial adverse selection in the exchange market." http://www.rand.org/pubs/technical_reports/TR971.html

8. Myth: Regulating Stop-Loss attachment points will protect small employers.

Fact: Minimum Stop-Loss attachment points would deprive small businesses of cost- effective health care options and the flexibility to choose the best coverage option for their employees' needs. Many small businesses will choose not to offer coverage if their options are limited, rather than purchase a fully insured policy. According to the RAND Technical Report noted above, "eliminating the option to self-insure also leads to a decline in the number of people with insurance, because some firms opt not to offer coverage (and some offered workers choose not to enroll)."

Lower attachment points are accompanied by higher Stop-Loss policy costs. The economic surcharge of low attachment points functions as a deterrent for small employers in selecting this option. Small employers, aided by their benefit advisors, are skilled in weighing the risks and rewards associated with varying Stop-Loss coverage levels.

9. Myth: Small employer decisions to self-fund their benefit plans are based on incomplete information about the arrangement they are entering.

Fact: Providing information about risk exposure and ERISA fiduciary duties is a common business practice for brokers, agents and third party administrators (TPAs) who work with employers in reaching their decisions about the appropriate methods to use in financing their health care benefits. Because brokers, agents and TPAs seek a long-term relationship with an employer client, they have strong motivations to ensure that employers make financially sound choices. The decision to self-fund should be made by a well-educated employer no matter what the size. There is no reason to believe that small employers are less educated in their decision than larger ones.

State Insurance Departments impose varying professional conduct standards on brokers, agents and TPAs. States have the authority over these standards and require brokers, agents and TPAs to provide additional education materials to small employers on self- funding.

10. Myth: Stop-Loss policy terminations occur frequently.

Fact: Stop-Loss policy terminations are rare events. Guaranteed renewable coverage is available.

11. Myth: Stop-Loss lasers (specific deductible levels that vary by a particular risk from the general level offered to the employer plan) are frequently a problem for small employers.

Fact: There are many sources of Stop-Loss coverage that offer employers numerous options, far greater than

the choices available in the fully-insured market. No-laser renewal products are commonly offered and effectively provide employers with a guaranteed renewable product.

12. Myth: Stop-Loss contract lasers change or eliminate actual plan coverage for individual participants in a group health plan.

Fact: If utilized, lasers are a financial tool feature of the Stop-Loss contract between the employer/plan and the Stop-Loss carrier that help to minimize the fixed cost of the Stop-Loss coverage, and place no condition on, or change in, the plan's coverage provision to individual participants.

In addition, the HIPAA final regulations on nondiscrimination (29 CFR 2590.702) prohibit a group health plan from denying an individual eligibility for benefits based on a health factor and from charging an individual a higher premium than a similarly situated individual based on a health factor. Health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. Brokers, agents and TPAs assist employers in locating products that permit their plans to comply with this Federal law.