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TECHNICAL REPORT

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)

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Summary

Overview

The Patient Protection and Affordable Care Act as modified by the Health Care and Education Reconciliation Act of 2010, known as the Affordable Care Act (ACA), may create new incentives for small businesses to offer self-insured health care coverage. When a firm self-insures, it pays for enrollees' health expenditures out of general assets or through a trust and bears the risk for unexpectedly large claims. In contrast, fully insured firms pay a fixed premium per enrollee to a health insurance company, which then bears the risk for unusually high claims. While fully insured and self-insured plans serve the same purpose—providing health insurance to workers—they are subject to different regulations. In particular, self-insured plans are not subject to the small-group rating regulations, risk-adjustment policies, and essential health benefits provisions newly imposed by the ACA. Because the new ACA regulations will influence premium prices, the option to self-insure to avoid regulation may be attractive to some small businesses. Self-insured firms are also exempt from many state insurance regulations, such as state-specific benefits mandates and state premium taxes. Although the risk associated with self-insurance may reduce firms' incentive to self-insure to avoid regulation, self-insured firms may purchase stop-loss insurance (a type of reinsurance) to mitigate the risk associated with unexpectedly large claims.

The small-group regulations stipulated in the ACA are intended to assure that health insurance benefits offered to small-group enrollees meet specific standards and to spread risk across people with a wide range of expected expenditures. These regulations may tend to increase prices for lower-risk groups (i.e., groups that tend to have lower claims costs), while reducing premiums for higher-risk groups. As a result, lower-risk groups may opt to avoid the regulations by self-insuring. The differences in regulations applied to the fully insured and self-insured markets, as well as the potential for an increase in self-insurance following the full implementation of the ACA, raise many policy questions about the comparability of the two types of insurance. In addition, the option to self-insure to avoid regulation could lead to adverse selection in the health insurance exchanges, resulting in only firms with high-risk, potentially expensive workers choosing to enroll in exchange plans. In an extreme scenario, adverse selection could lead to "death-spiraling," where exchange premiums increase to the point at which the market becomes unstable.

This report examines the factors that motivate employers' decisions to self-insure and the ways incentives to self-insure might change after the ACA takes full effect. It also considers the consequences of self-insurance for enrollees in terms of benefit design, the probability of claims denial, financial risk, and recourse options in the event of denied claims. It investigates how

self-insurance influences employer solvency and whether self-insurance could lead to conflicts of interest between employers and their workers. Finally, we use the COMPARE microsimulation model to predict changes in employer self-insurance rates after the ACA takes full effect and to estimate the degree to which adverse selection might occur due to new regulations in the small-group market. The analysis is based on a combination of methods, including primary data analysis, literature review, discussions with stakeholders, and simulation modeling. The report addresses the congressionally mandated research questions raised in section 1254 of the ACA.

Key Findings

Overall, we find little evidence that self-insured plans differ systematically from fully insured plans in terms of benefit generosity, price, or claims denial rates. However, while relatively good data on plan benefits are available from the Kaiser Family Foundation/Health Research and Educational Trust (Kaiser/HRET) Annual Survey of Employer Benefits, data on claims denial and premiums are potentially less reliable. Stakeholders we spoke to expressed very little concern that claims denial is significantly different in self-insured and fully insured plans. While self-funding is perceived to be less expensive for firms than purchasing a fully insured product, employers that self-insure face higher financial risk. This risk can be mitigated by purchasing stop-loss insurance policies, which are regulated differently from fully insured health insurance products. There are no nationally representative data on the availability, prevalence, pricing, or contracting terms of stop-loss insurance, but stakeholders indicated that it is relatively common for self-insured small businesses to obtain stop-loss coverage. Sixteen states have regulations that prohibit insurers from selling stop-loss policies with attachment points below specified limits, which range from $5,000 to $25,000.

Stakeholders, including industry experts, consumer advocates, and regulators, remarked that self-insurance may leave consumers less financially protected in the event that their employers declare bankruptcy or face financial trouble. Financially strained firms might become unable to pay health care claims (in the case of self-insurance) or premiums (in the case of full insurance), leading to a loss of insurance in either case. However, failure to pay premiums would lead to a prospective termination of benefits to which consumers could be alerted in advance. Failure to pay claims, in contrast, could leave consumers financially responsible for claims that have already been incurred. Firms can help protect enrollees against this risk by establishing and paying claims through a trust, but there is no requirement to establish trusts, and few firms choose to do so.

Although data are limited, we found no evidence that claims denial rates are higher for self-insured firms. However, consumer recourse options in the event of a denied claim are generally more limited for self-insured than for fully insured enrollees. Both fully insured and self-insured plans are regulated by the Employee Retirement and Income Security Act of 1974 (ERISA), which establishes a right to an internal review of denied claims. Many states have extended consumer protections for enrollees of fully insured plans beyond ERISA; for example, 44 states and the District of Columbia have added a right to an external review of claims denials. The ACA expands federal requirements for internal review for enrollees in both fully insured and self-insured plans and establishes a right to external review for self-insured enrollees. However, details of how the regulations will be applied have not been fully determined,

and state protections will still differ for fully insured and self-insured enrollees. For example, the ACA does not preempt state internal and external review laws that offer stronger protections than the ACA provisions. Stakeholders argued that the different recourse options available to fully insured and self-insured enrollees are likely to be confusing and frustrating for consumers. Additionally, although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides privacy protection for personal medical information, some stakeholders remarked that internal reviews conducted by self-insured firms could raise privacy concerns, especially since such reviews may include other employees at the firm, including human resources representatives and managers.

Stakeholders expressed significant concern about adverse selection in the health insurance exchanges due to regulatory exemptions for self-insured plans. However, the COMPARE microsimulation model predicts a sizable increase in self-insurance only if comprehensive stop-loss policies become widely available after the ACA takes full effect, and the expected cost of self-insuring with stop-loss is comparable to the cost of being fully insured in a market without rating regulations. For all other scenarios, the change in self-insurance predicted by the model is small and reflects that even with stop-loss coverage, self-insurance remains risky for small firms. In scenarios where comprehensive stop-loss coverage is assumed to be available, increases in self-insurance are associated with slightly higher premiums on the exchanges. For example, for firms with 100 or fewer workers, the option to self-insure with comprehensive stop-loss coverage would result in a 3.3 percent increase in platinum-plan premiums. However, limiting small employers' ability to self-insure is also associated with a decline in the total number of individuals enrolled in health insurance coverage. These results are consistent with evidence regarding the impacts of state small-group regulatory reforms that were implemented in the 1990s. In general, it appears that regulatory reforms increase prices for lower-risk enrollees while decreasing prices for higher-risk enrollees. Because low-risk enrollees tend to have more-elastic demand for health insurance than high-risk enrollees, the net effect is a small decline in coverage and a small decline in exchange premiums. Our model predicts that allowing self-insurance mitigates this effect, so that total enrollment is higher in scenarios where self-insurance is allowed.

Conclusions

Our results do not point to major differences in benefit generosity between self-insured and fully insured plans or to a major threat of adverse selection in the small-group market after the ACA is fully implemented. Stakeholder interviews indicated that two significant concerns about self-insurance in the current market were the lack of financial protection for consumers in the event of employer bankruptcy or other financial problems at the firm and limited consumer recourse options in self-insured plans in the event of denied claims. The ACA partially addresses the second concern by creating a right to external review for self-insured enrollees, although regulatory differences governing recourse options between self-insured and fully insured plans may still be confusing for consumers.

Stakeholders also expressed real concerns about the potential for adverse selection if a disproportionate share of small firms with lower-risk (healthier) employees opted to self-insure after the law takes full effect. The results from our model suggest that adverse selection due to self-insurance is not likely to have a major influence on premium prices in the exchange. How-

ever, the model is an imperfect tool, and it cannot capture all the factors that influence firms' decisions. For example, the model cannot incorporate issues such as employers' idiosyncratic knowledge about employees' health status. The model is also constrained by data limitations, including lack of information on stop-loss policies and the absence of data linking employees, employers, and health expenditures.

Finally, our analysis pointed to two important data gaps that limit our ability to fully understand the market for self-insurance and the potential risk to consumers. First, no nationally representative data exist that enable a comparison of claims denials in self-insured and fully insured plans. Second, data are not available on the pricing, prevalence, availability, and contracting terms of stop-loss insurance policies. The availability of data on these issues could be important for crafting future policies. For example, it would be useful to better understand the terms of policies that are bought and sold in the current market before setting minimum standards for stop-loss insurance contracting terms.