Health Reform Road Map for Cities and Villages

By Josh Brown, Esq.

Weekly Update 3 – May 17, 2013

Subject: More Detail on the Self-Insurance Option

What is Self-Insurance?

Under a self-insurance plan the employer itself agrees to pay for its employee's healthcare. The employer may run its plan like a health insurance company, making risk assessments, assigning and collecting premiums, and making payouts. In fact, an employer can even hire an insurance company to administer the plan. Further still, an employer can limit its own liability by having an insurance company pay claims above a certain amount (this is called stop-loss coverage).

There are several benefits to self-insurance and I will discuss a few here. First, the employer has more control and flexibility in providing coverage. Self-insurers are exempt from certain laws, as discussed below. Second, employers have more access to information that could make coverage more effective. Finally, the employer gets to keep all the money that is not paid out. Under regular insurance, your overpayments are lost. So let's say you have $35 million in assets and $32 million in liabilities for a given year. If you self-insure, you get to keep the difference. However, keep in mind, if the numbers are flipped and your liabilities exceed your reserves, you have to eat the $3 million difference.

Why does it Matter?

I am going to be frank with you about this…self-insurance is widely acknowledged to be a loop-hole in the health insurance regulatory system. However, the loophole is tolerated because most self-insured plans do not suffer from the major problems that regulations protect against. Self-insured plans do not have to comply with most of the ACA or most state regulation. The ACA specifically does not apply to self-insurance, for the most part. State regulations do not apply to self-insured plans (for the most part) because, as an employee benefit, they are regulated by ERISA. ERISA preempts most state regulation.

Here are some particular rules that apply to self-insured plans:

1) Self-insured plans are not subject to the ACA's:
    a. risk adjustment requirements of section 1343;
    b. risk pooling requirements ;
    c. essential benefits requirements;
    d. minimum loss ratio requirements;
    e. requirement to justify "unreasonable" premium increases[1];
    f. do not have to pay the ACA's excise tax on insurers;[2]

[1] Technically, self-insured plans do not have loss ratios or premiums since they are not insurance.

[2] Jost, Timothy S., and Mark A. Hall, *Self-Insurance for Small Employers Under the Affordable Care Act: Federal and State Regulatory Options*, NYU Annual Survey of American Law, forthcoming; Washington & Lee legal Studies Paper No. 2012-14 (June 1, 2012).

    g. review of medical-loss ratios that indicate where premium dollars are spent.
2) There is no prohibition against small group plans self-insuring.
3) Self-insured plans are mostly not subject to state regulation.[3]
4) A plan still qualifies as self-insured, even if it has stop-loss coverage.[4]
5) Prohibited from discriminating in favor of highly compensated employees.
6) May be administered by an insurance company, as long as the risk is not transferred to the insurance company.
7) These parts of the ACA do still apply to self-insurers:
    a. Limitations on annual and lifetime limits
    b. Guaranteed access to internal and external appeals.

Large Cities and Self-Insurance

Often, self-insurance has been viewed as the realm of large employers, because running such a system requires sophistication and significant investment. Further, the city also has to have the kind of cash on hand necessary to cover possible claims. The best example I have been able to discover is the City of Columbus. They are totally self-insured. This makes sense for them, because they have the resources.

They also have some particular needs that self-insurance allows for. For example, insurance companies are prohibited from giving their customers certain claims data. That data can be helpful in reducing claims and managing safety and risk, by helping craft safety or wellness programs. But keep in mind, we are not discussing workplace claims here, which are covered by Ohio's monopoly worker's compensation system (although, some large employers will self-insure for worker's compensation as well).

There is only one option that is available to large employers that would not be available to small employers, and this is only because of practical reasons, not legal. This is the "naked" self-insurance option, meaning that they city makes itself fully liable for all claims, with no stop-loss. This option is only available to cities that have large cash reserves and a strong capacity for bonding to raise cash if necessary. Other than this, the options I discuss below are available to both large and small municipalities.

Small (and Large) Cities Options for Self-Insurance

Small employers have been getting into the game lately through group self-insurance. Presumably, a small village or city does not have the resources to naked self-insure alone. Different employers may get together to create the group self-insurance. The funds come from each of the employers involved. O.R.C. 9.833 (B)(4) explicitly allows for political subdivisions to maintain "joint self-insurance programs." The language is very broad. Municipalities are also authorized to enter into these arrangements with any "political subdivision," not just other municipalities.

Another factor that makes self-insurance available to small employers is "stop-loss" coverage. As you saw in footnote 3 the courts have been clear that stop-loss coverage does destroy the status of a self-insured plan. Stop loss insurance kicks in at a "attachment point." For example, let's say Employee Smith has a $70,000 claim, while City A is self-insured, with stop-loss insurance, that kicks in at an attachment point of $15,000. Here, City A would pay $15,000 for the employer's claim and the stop-loss insurance company would pay the remaining $55,000.

[3] *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990). Interpreting: Section 514(a) of ERISA.

[4] *Bill Gray Enters. V. Gourley*, 248 F.3d 206, 209 (3d Cir. 2001); *Thompson v. Talquin Bldg. Prods.*, 928 F.2d 649, 653 (4th Cir. 1991); *United Food & Commercial Workers v. Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986).

Policy Side-Bar: The Problem of "Adverse Selection"

Stop loss coverage with low attachment points has been a thorny issue in Washington D.C.. This is because the option is very attractive to small firms with a relatively young healthy population. The ACA dictates a policy of "guaranteed issue," which means that insurance companies must cover people with preexisting conditions who do not qualify for Medicaid, Medicare, or CHIP (generally speaking). To pay for these added costs, the ACA also instituted the "individual mandate," requiring most people to have coverage. Ultimately, young healthy people were supposed pay premiums and have little pay outs. Those premiums were supposed to go to pay for the added costs of those taking advantage of guaranteed issue. However, if the young healthy premium payers find a way out of the system (e.g., through self-insurance) then there may not be enough money in the system to cover those taking advantage of the guaranteed issue rule. To further complicate this problem—while the healthier population moves out of the private market, into self-insured plans—it is widely speculated that many employers with high risk populations, who are currently self-insured, will actually move into the health care exchanges to take advantage of guaranteed issue. This could further exacerbate the balance-sheet-problem.

I added the policy side-bar above for two reasons. First, to make the point about adverse selection, which many commentators have lamented about, saying it will undermine the ACA's balance sheets. Second to illustrate a non-political point: that the self-insurance option may be more attractive to small employers with a less risky (i.e., healthier, younger) employee population.

Under a self-insured plan, employers can offer lower premiums, have greater flexibility in which benefits to offer, and manage their cash flow more easily (since funds are not drawn until after the claims process). These options are especially important to young employees who are unlikely to have major claims in the near future. For an employer with a low-risk employee population who can expect few claims, self-insurance, stop-loss coverage with a low attachment point might make sense.

Another issue for healthier populations is the strategic pricing that insurance companies must engage in. Insurance companies are collecting premiums from widely diverging groups of people. They will always act in their own self-interests, not necessarily the interests of any particular customer or group of customers. The risk associated with any particular group is spread out (or aggregated) across their entire spectrum of customers.

In other words, some small healthy groups of customers are sick of paying higher premiums to cover the risks associated with other customers. The best example of this is happening currently. It has been widely reported the insurance companies are currently raising their premiums, because they are preparing to face the uncertainty that will come next year when many ACA provisions kick in. This is perfectly logical and fair, because they have no idea what to expect next year. However, the problem is that customers are paying higher premiums to cover insurance company speculation. What if insurance costs decrease (as was the intention of the ACA) instead of increase (which is the expectation of some commentators)? Well, those customers are not going to get the additional money back. With self-insurance, very generally speaking, you have more flexibility in deciding what risks are right for your organization, and you do not have to cover aggregate risks outside of your own pool; or at least you minimize this phenomenon.

However, the case might be different if you have an employee population that is higher risk. Even stop-loss coverage, although it caps your case-by-case liability, may still require you to pay out a large number of claims in a short time. You do not want to be driven to bonds if you don't have to be. However, some insurance companies may offer aggregate-based stop-loss coverage. In which case, it may mitigate the risk of this type of coverage, in the high-risk environment.

This final point is one I want to stress—**there is some scamming going on in this industry.** Several "insurance companies" have scammed several clients in the past. This has been well-documented. If you consider self-insurance, you must coordinate with professionals in the field to make sure you are dealing with reputable insurance companies.

Availability of Self-Insurance Stop-Loss Plans With Low Attachment Points
The RAND Institute conducted a study recently, which concluded that these policies will be widely available over the coming years, particularly after several ACA provisions kick in during 2014.[5] A survey by the Center for Studying Health System Change concluded that such policies are already widely available. There are self-insurance associations and groups which make research tools available.

Employer's Options for Self-Insurance
If you are considering self-insurance, the first decisions you will have to make include:

1. whether to pay claims out of general revenue or a dedicated trust;
2. whether to hire a third party administrator (TPA) to handle enrollment, pay claims, collect premiums, provide customer service, and perform administrative duties—almost all self-insurers do, for legal privacy reasons under HIPAA;
3. if you do hire a TPA, the decision on which one to go with is paramount;
4. funding of claims arrangements:
    a. totally self-insure;
    b. mixed-insure; or
    c. fully insured.
5. Whether to partner with other political sub-divisions to pool your employees.

Group Health Plans
The law provides for several options if you want to create a group plan. I plan to do a future update on this subject. However, I will lay out a few basics here.

The health insurance regulatory scheme basically recognizes two types of plans: group plans and individual plans. Group plans are only employer-sponsored group plans, while individual plans are everything else.[6] You will find several types of group plans, which I will expand upon in a future update. The main thing you need to know, for purposes of self-insurance, is that many of these group plans may

[5] Eibner, Christine, et al., *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),* Technical Report, RAND Health, Santa Monica, Calif. (2011).

[6] Group Health Plan Definition under the ACA:

1. "Group Health Market" defined in terms of employer groups only
2. "Individual Market" defined as marketed to individuals other than through employer groups
3. "Group Health Plan" defined, by reference, as an employer plan.
4. HIPPA regulations also explicitly state that employee association health plans are regulated as individual plans.

* This suggests that a plan that markets coverage to individuals outside of an employee group is an individual plan.

self-insure. In the past, some entrepreneurs have marketed their insurance as being less costly because their plan is exempt from state and federal laws. Although it is true that some such plans exist, you have to be very careful and do your research to be sure. In some cases, the state does not have to recognize a plan as being fully-insured, until the federal government "deems" it to be. In some cases, a plan needs to be recognized as an "employee welfare benefit plan," before it is exempt from certain requirements. In some cases, the marketers are simply lying to potential customers.

A Few Things to Look Out For
Below is a list of issues to be aware of. This is not comprehensive, but merely is intended to put you on notice of a few issues that may be important to look at. You should contact an experienced professional in this area for a comprehensive list of issues to investigate before self-insuring.

First, you have to choose a company to administer your plan. Generally, for legal privacy reasons under HIPAA, you have to contract out for administrative services. Issues in choosing a company to administer your self-insured plan include:

1. Subrogation Services
Many of the claims that you will have, will be against third parties. You will need a team of lawyers who can pursue these claims. This is called subrogation services. When you self-insure, you must be sure you are strong in this area.

2. Steerage or Repatriation Services
One of the biggest costs you will run into is sending your claimants to the right provider. Usually, plans have contracts with a network of healthcare providers. You will need a good team of people to get people to the right place.

3. Hospital Bill Audits
You do not want to just accept and pay a hospital's bills. Large bills must be audited by a professional team of auditors to determine whether all expenses billed should be paid or challenged.

4. Professionalism
The company you hire should have updated software, a good team of lawyers who keep up with latest laws, an ability to access their own insurance (in case they run out of money), and adequate errors and omissions coverage. You should also look at how fast they tend to process claims, answer questions (such as when you call them directly), and what laws they think they are exempt from if any.

Other issues to look out for:

4. Claims History
I wrote earlier about the differences in incentives for healthy and less healthy pools of people. You need to have a firm grip on what the claims history of your pool is. Of course, being self-insured helps establish this record. Having a reliable records of claims helps establish future needs.

5. Expected Future Claims
Knowing your past claims history is good, but having reliable estimates of future claims is great. It is helpful to establish wellness programs (which are subsidized under the ACA), safety programs, and other services, to help establish a lower-risk pool. This will make it easier to determine whether self-insurance is a good option for your community.

Josh Brown, Esq. is the Legislative Advocate and a Policy Analyst at the Ohio Municipal League.
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