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# **ACA and Self-Insurance for Small Employers**

A White Paper for Employers and Their Brokers



**HPM INSTITUTE**  
HEALTHCARE PERFORMANCE MANAGEMENT

## Introduction

In response to major uncertainties in the commercial insurance market due to the sweeping new health reform law, many mid-sized and smaller employers—as well as their brokers and consultants - are seriously considering a shift to self-insurance even before the new law's costly benefit mandates become effective.

The aggregate impact of the Affordable Care Act (ACA) on the insurance market; including, impending yet undefined large premium increases; delays in issuing implementing regulations; a congressional focus on ACA amendments; and possible changes in the national political landscape, have left plan sponsors, insurers, regulators and consumers with few clear answers about ACA's future implementation.

In light of widespread uncertainty, many employers are considering an early switch to self-insurance prior to the 2014 effective date. This will help employers to not only take advantage of favorable incentives in ACA to exempt self-insurance from many requirements imposed on insurers, but also to avoid many of the ACA's costly benefit mandates and requirements.

Concurrent to introducing a wide range of expensive new federal mandates into the commercial insurance marketplace, Congress also made a policy decision in ACA not to disrupt self-insurance (viewed as working well) by exempting self-funded arrangements from many of the new law's costly requirements.

The health reform law makes self-insurance particularly attractive to small employers concerned about independent projections that the ACA will add significant new costs and mandates to already soaring premiums in fully insured plans.

With major, disruptive changes looming in the U.S. health insurance system, many employers and their brokers are taking a closer look at the self-insurance alternative not only as a strategic move in light of the uncertainty in the insurance marketplace, but also as a more effective way to mitigate health risk and manage their health plans in the long run.

This report discusses ACA's new federal benefit mandates and distinguishes their impact on insured vs. self-insured plans, tracks positive trends in self-insurance for employers of all sizes and outlines a new model for data-driven self-funding programs.

## ACA Treats Self-Insurance Favorably

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While ACA requires both insured and self-insured plans to meet a significant number of new requirements, the new law introduces several mandates applicable only to health insurers nationwide.

Overall, self-insured plans are exempt from many of ACA's requirements. In this section, we examine some of the key differences applicable to insured vs. self-insured plans under ACA.

Effective January 1, 2014, ACA makes a number of substantial changes in the insurance market applicable to private health insurance plans, including the requirement that, as a minimum, insurance plans must include a package referred to as "essential health benefits."<sup>i</sup>

Self-insured plans are not required to offer the package of essential health benefits, which must include:

- Ambulatory patient services, such as doctor's visits and outpatient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

While the ACA requires coverage for each of these benefit categories, the law does not define the specific services that must be covered or the amount, duration or scope of services. The HHS Secretary will define in regulations the specific benefits within each of these categories and how much discretion to leave insurers in coverage decisions.

For example, if the Secretary determines that physical therapy to treat lower back pain is a covered benefit, he/she could determine the minimum number of physical therapy sessions that must be covered to treat the condition, or he/she could leave that to the discretion of the insurers.

Currently, insurers must also cover certain benefit mandates as requirements of state law. As the ACA allows states to continue to mandate health benefits, insurance plans will have to abide by federal law in addition to relevant state laws and regulations.

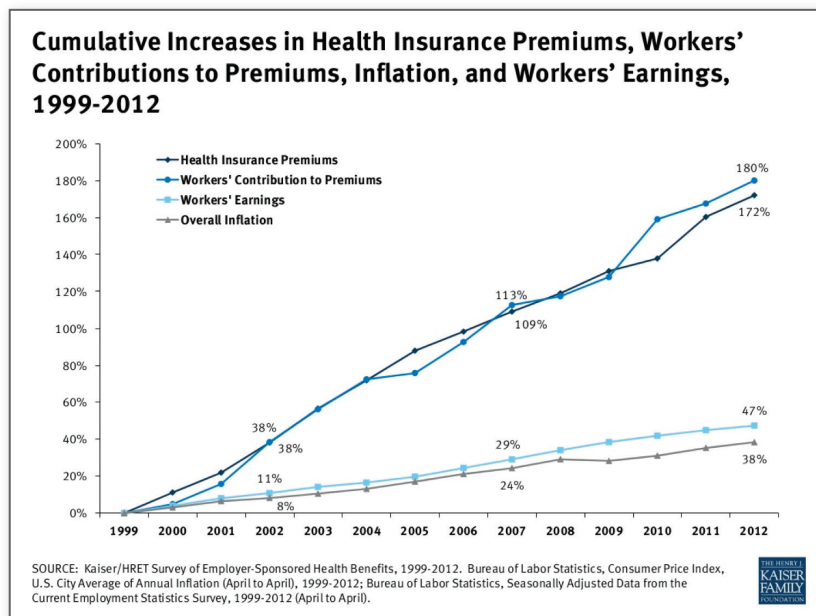
In addition, the following key provisions in ACA, applicable to insured plans, do not apply to self-insured plans:

- Annual limitation on deductibles
- Subject to jurisdiction of state ombudsman
- Guaranteed issue of coverage
- Guaranteed renewability of coverage
- Community rating with tighter age bands

In sum, while ACA imposes a variety of detailed new requirements on self-insured plans, such as: automatic enrollment, coverage of defined preventive health services, and the obligation to pay certain fees; in comparison to insured plans, fewer requirements are imposed on self-insured plans.

## Projected Costs

New surveys, as well as testimony before a House subcommittee examining the impact of the new law on insurance premiums, indicate the ACA will exert substantial upward pressure on premiums.



While most national surveys project insurance premiums to rise 9 percent in 2014 in the absence of ACA due to rising health costs, a new Milliman survey estimates the added cost of the “essential health benefits” required by ACA alone will increase premiums by 22.2 percent in California.<sup>ii</sup>

According to a survey of health insurance executives released in March 2013 by Munich Health North America, a subsidiary of Munich Re, a majority of

health executives surveyed said they expected insurance premiums to increase in 2014, with 42 percent estimating a premium increase of more than 25 percent, 40 percent estimating an increase of between 10 and 25 percent and only 11 percent saying premiums will go up by 10 percent.<sup>iii</sup>

Munich Health surveyed 326 executives representing health plans, health maintenance organizations and disease management firms, as well as health insurance brokers and agents regarding the extent to which the Patient Protection and Affordable Care Act will influence decision-making related to employee health benefits.

Among those surveyed, 82 percent have experienced a growing level of interest among employers in self-funding their group health insurance plans over the past 12 months, with nearly one-third, or 32 percent, reporting that interest has increased “significantly,” Munich Health noted.

“The trend away from providing group health insurance towards self-funding is due to employers’ wanting to maintain a level of flexibility and control in the design and financing of their employees’ health benefits,” said Richard Phillips, president of Munich Health North America’s reinsurance division.<sup>iv</sup>

“A properly designed self-funded health plan can allow a company to directly reap the benefits of their cost containment and wellness activities as opposed to having to pay a monthly premium based on an arbitrary set of rating restrictions,” Phillips said. “As companies struggle with the growing cost of providing quality benefits, we expect self-funding to continue to grow in popularity.”<sup>v</sup>

Echoing this view in testimony on ACA’s impact on insurance premiums, Douglas Holz Eakin, president, American Actkon Forum and former director of the Congressional Budget Office, said, “The requirements faced by insurers will be such that market forces will push premiums higher and health costs will be inclined to grow faster, rather than slower, as a result of the law.”<sup>vi</sup>

## **New Costs Added to Already High Insurer Costs**

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Higher insurance premiums are driven by higher costs for medical services, as well as a combination of higher insurer administrative costs, reserves and stockholder dividends--factors that do not apply to self-insurance.

**Small Employers Already Pay Higher Premiums.** New ACA costs will be added to already high annual premiums paid by small employers for health insurance who have long said that high health plan cost is their number one problem. During the 10 years from 1999 to 2009, overall insurance premiums increased 131 percent, or four times higher than prices, while wages have grown 38 percent and inflation has grown 28 percent, according to the Kaiser Family Foundation.<sup>vii</sup> Studies show small firms already pay 18 percent more for health insurance premiums than larger employers.<sup>viii</sup>

**Insurers Have Higher Overhead.** Exacerbating the cost issue, a recent Congressional Budget Office (CBO) study found that small businesses pay significantly more on average for insurance administrative services such as marketing, enrollment and premium collection.<sup>ix</sup> The Commonwealth Fund found that, for some small employers, as much as 30 percent of premium payments collected by insurers go to administration.<sup>x</sup> In this regard, 16 million insurance consumers and businesses received about \$1.3 billion in MLR rebates from insurance companies in 2012, including \$377 million in the small employer market.<sup>xi</sup>

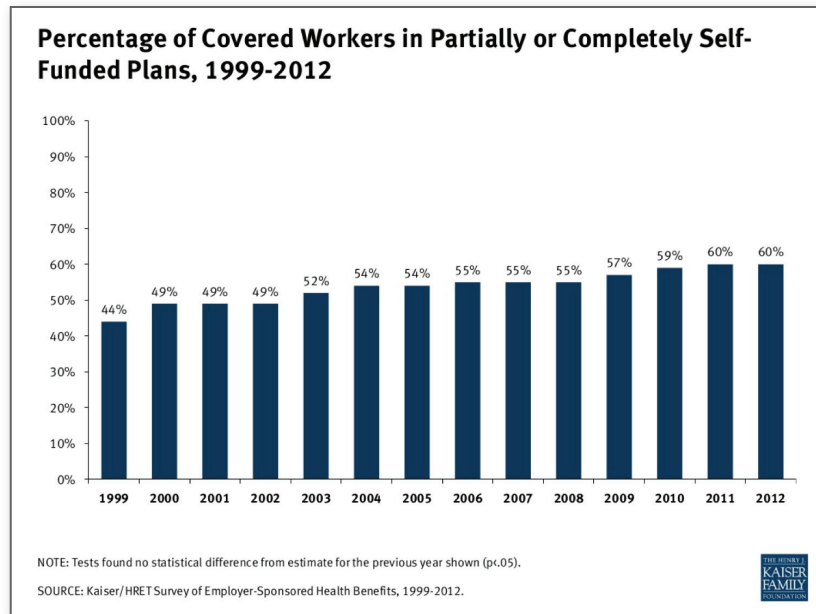
**Insurer Reserves and Profit.** Compounding the small employer cost problem, many insurers already have filed for double -digit premium increases, which HHS has criticized as unwarranted.<sup>xii</sup> Reflecting these increases, private insurer financial reports to the Securities and Exchange Commission for 2010 through the first half of 2011, document that premium revenues have been well above payments for medical claims, with profit margins at historic highs and rapid accumulation of reserves well beyond state insurance requirements.<sup>xiii</sup>

## Switch to Self-Insurance

ACA's new mandates are expected to accelerate the switch by many employers from insured health plans to self-insured arrangements.

While not for all companies, self-insurance has long been on the upswing with employers of all sizes. Self-funded plans increased from 41 percent in 1998 to 58.5 percent in 2011, according to the Employee Benefit Research Institute.<sup>xiv</sup>

While larger employers are most likely to offer self-insured plans—nearly 80 million covered individuals, a record all time high—the number of workers in small firms (3-199 workers) alone increased to 15



percent in 2012—up from 10 percent in 2003.<sup>xv</sup>

Conducted in conjunction with the National Opinion Research Center and the University of Chicago, the annual Kaiser Survey is the most comprehensive U.S. look at national trends in employer sponsored health coverage.

Despite the lower penetration, as recently as 2009, only 13 percent of companies with fewer than 100 employees offered coverage through self-

insured plans.<sup>xvi</sup> Clearly, small firms represent the fastest growing segment of self-funded plans as they choose self-insurance as a cost-effective alternative to commercial health insurance.

According to CFO.com, shifting risk from insurers to small firms is a legitimate concern, but the shift is prompted by factors that include ever-increasing health premiums and differing state to state benefit mandates that affect many firms that operate with employees on a multi-state basis.<sup>xvii</sup>



In a narrative description of a typical self-insured small employer, Tim Doherty, managing director of health and welfare benefits, Pinnacle Financial Group writes in CFO.com:

“A CPA and business consulting firm with 77 employees embarked on self-funding when its fully insured policy renewal came in with a 15 percent increase in rates and no data to support the increase. In spite of the firm’s frustration, it was still concerned it was too small for self-funding to make sense, so it looked at its maximum expense on a self-funded plan relative to the renewal. With a self-funded plan, the maximum cost turned out to be 5 percent below the fully insured renewal, so the firm decided to take the plunge. The self-funded plan ultimately came in not 5 percent below the fully insured policy renewal rate, but 10 percent below that rate. After the second year,

costs continued to run well and are a convincing 19 percent below a comparable fully insured plan. A significant corollary benefit for small employers that implement a self-funded plan is that because they gain access to all their claim data, they are able to gauge much more accurately what future healthcare costs may be.”<sup>xviii</sup>

## The Self-Insurance Advantage

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In the post-ACA world, small employers who choose to self-insure health benefits for their employees will do so for the same reasons larger employers self-insure. According to the Self-Insurance Institute of America (SIIA),<sup>xix</sup> the key reasons employers choose this approach are:

- The ability to customize health plan benefits to the specific needs of the workforce
- Employer control over the health plan and its reserves
- Better cash flow because coverage does not have to be prepaid
- Exemption from often conflicting and costly state benefit mandates
- Exemption from state insurance premium taxes (usually 2 or 3 percent of premium dollar value)
- Freedom to contract with any provider or provider network
- Option to administer claims in-house or contract with a TPA
- Purchasing stop-loss insurance to protect the plan sponsor from catastrophic claims

“While self-insurance may not be a viable option for many smaller employers because their balance sheets are not strong enough or due to workforce instability, an increasing number of smaller employers are operating successful self-insured group health plans,” said SIIA’s Michael Ferguson, in recent testimony before the California legislature. “These plans provide cost containment advantages and they are often customized to meet the specific needs of plan participants.”<sup>xx</sup>

Because self-insurance is regulated under the federal Employee Retirement Income Security Act (ERISA), self-insuring firms with employees in multiple states can offer uniform benefits to workers across state lines. Furthermore, costs are based on the employer’s own claims experience and are not pooled with others, as they might be for smaller firms purchasing fully insured plans in the commercial market. While smaller firms with a younger workforce may find self-insurance advantageous, national studies report that the demographics of self-insured plans mirror the composition of larger firms.

“Increasing medical costs and willingness to assume more risk are driving many employers, including small employers, to shift to self-insured health plans,” according to Sheri Sellmeyer, vice president of analysis for Health Leaders InterStudy, a leading provider of healthcare market intelligence.

## The WellNet Model

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To better understand how self-insurance works in the alternative marketplace, we examine an innovative model developed by WellNet, a nationwide provider of services for the medium-sized and smaller market in the post-ACA world. The WellNet model incorporates the elements recommended by SIIA as enhanced by principles of Healthcare Performance Management (HPM).

The four pillars of HPM, combined with self-insurance that empower small employers to take control of their plans and reduce costs, include: Measure, Manage, Engage and Automate.

**Measure**—*Data-driven analytics and predictive modeling allow organizations to measure risk and assess the health profile of a plan population and better understand the key risk and cost drivers.*

Under this model, a small employer that self-funds is able to quickly gain more control over costs associated with employee health benefits. Working with their professional advisors, employers who don't know much about the health of their workforce—and what is driving costs—now can utilize innovative technology, including analytics, metrics and predictive modeling, to help employees improve healthy lifestyle choices and reduce healthcare costs.

Self-funded employers can access their own plan clinical and Rx prescription claims data, without an insurance company standing in the way. Working with professional advisors, employers can leverage HIPAA-compliant claims data that unveils a real-time snapshot of plan health risk. They are able to gain insight into potential costly catastrophic conditions in the workforce before high-cost claims are filed. With this information, employers can adopt actionable plan design changes and employee outreach prevention campaigns to mitigate risk.

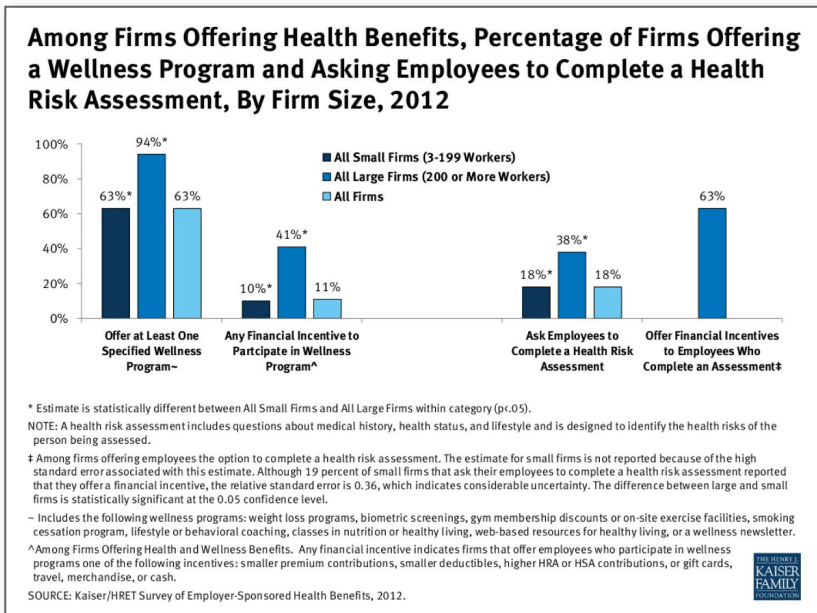
“As a leader in data-driven health management solutions for small- and mid-size plans, Bethesda-based WellNet has been instrumental in helping my small employer clients better manage and control health costs,” said Jerel Levenson, a broker at CG Benefits Group, Manalpan, New Jersey. “Utilizing a unique cloud-based technology, a firm like WellNet Health Plans works closely with small firms to identify potential expensive health trends in advance and implement tailored care management campaigns that are working with my clients to control costs.”

Based on advanced technology and data analytics, many of the high-cost, high-risk chronic conditions of an employee population are predictable and preventable, regardless of employer size. Software can be applied to analyze plan claims data, including Rx, medical claims and lab data, to proactively identify chronic conditions such as diabetes and cardiovascular risks and other health risks before they occur. Self-reported health assessment and biometric screening data are additional sources of information that assist in identifying population risk. Relying on high-speed tools, plan sponsors can use a desktop computer dashboard to unveil a real-time snapshot of workforce demographics and the population health risk profile. By gaining an overview of healthcare trends and utilization patterns, plan sponsors are better able to adopt proactive strategies that can improve plan performance.



**Manage**—Powerful analytics technology provides guidance for designing and managing actionable health and wellness strategies and campaigns that improve employee health outcomes, enhance their quality of life and reduce costs.

A significant aspect of HPM is the integration of data, workflow, and best practices to target care, lifestyle and disease management issues in advance. In a 2012 survey sponsored by Pitney Bowes and conducted by IDC Health Insights, health plans report investing in technologies and practices to create actionable campaigns that focus on opportunities for improved outcomes, health and costs. This approach can uncover the real drivers of high health costs and the beneficial opportunities for integrated care management.



The goal is to manage employee health through prevention-focused health coaching. Population healthcare management including highly interactive, risk-specific health improvement programs (preventative care, health coaching, wellness and disease management) are critical components of this HPM pillar. Concierge-like member relationship campaigns include mobile, text, e-mail, and member engagement and decision support software tools.

“Availability of medical and Rx drug claims data provides information that helps customize care management and wellness programs to specific conditions,” says Gary Baker, a broker at Gary Baker Group working with small groups in southeastern Pennsylvania.

Plan data, translated into targeted wellness initiatives, can help manage employee health risk, particularly when combined with incentives that encourage employee engagement in their own health. According to national consulting firm Milliman, Inc. Medical, new lifestyle-based data sets and predictive modeling techniques are proving highly effective and that lifestyle analytics speed up the identification and reliability of disease prediction.<sup>xxi</sup> Through current disease and care management techniques earlier detection and action results in significant savings.

**Engage**—Backed with corporate endorsement, targeted risk-specific personalized outreach and healthcare management campaigns can be introduced within a health plan to foster employee engagement and emphasize healthy lifestyles.

HPM tools enable plan sponsors to intervene with employees before major health events occur. Campaigns featuring incentives and tested risk-specific engagement programs that manage health and lifestyle conditions are offered to employees on a voluntary basis. For example, if heart-related medical and Rx claims are a growing expense item, wellness programs could include blood pressure and cholesterol screening and education activities aimed at lowering blood pressure and total cholesterol.

With direction by health coaches who engage employees in “high-touch” wellness programs and activities, the HPM discipline produces above average participation and results in healthier employees, as well as reductions in healthcare costs. “One small employer client previously experiencing annual increases of 15 to 20 percent, after more than a year, was able not only to hold the line on costs, but also showed a substantial surplus,” said Baker.

In one study, the use of a \$100 financial incentive for health assessment completion achieved an 86 percent response rate. In contrast, within the same group, the request to complete a health assessment without an incentive produced a 10 percent response rate. In another example, the use of a \$50 incentive for completion of an online health coaching program produced a 30 percent response, while response rates without the incentives produced less than a 3 percent response, thus showing that incentives can drive high-level employee engagement in wellness and lifestyle behavior change programs.

**Automate**—*A cloud-based healthcare technology infrastructure and applications platform allows for unified data integration and management across disparate data silos that fosters the institutionalizing of care segment and healthy corporate lifestyle strategies.*

While health plan data is sent across corporate data silos—unmanaged, unfocused and frequently uncoordinated—this pillar facilitates an operational dashboard that connects all internal functions and teams on a single, secure HIPAA-compliant platform.

Cloud-based computing allows on-demand network access to a shared pool of technology resources such as networks, servers, and storage, as well as a suite of applications and services developed for the healthcare industry. With cloud computing, these resources can be accessed by small employer plans with minimal management effort and can help reduce the health cost curve while improving health outcomes.

## Conclusion

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In the post-ACA world, escalating costs will represent one of the most predictable outcomes of health reform for small employers. As small firms face higher costs and expanded legal requirements, many will switch to alternative risk transfer funding methods such as self-insurance to better manage their health plans and control costs.

While embraced by larger firms for years, self-insurance has become an increasingly popular option for many mid-sized and small employers as well. In the new post-ACA healthcare marketplace, these employers can be expected to adopt technology that empowers them to take greater control of their plans and reduce costs. Whether for financially qualified small employers considering self-funding as an alternative to fully insured coverage—or for employers with self-funded plans already in place—self-insurance is emerging as a viable solution to rising healthcare costs—even before the end of their current plan year.

## Endnotes

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## About the HPM Institute

The Healthcare Performance Management Institute (HPM Institute) is a research and education organization dedicated to promoting the use of business technology and management principles that deliver better and more cost-effective healthcare benefits for employers who cover their employees.

The Institute's mission is to introduce and develop a new corporate discipline called Healthcare Performance Management (HPM)—a technology-enabled business strategy that tackles the challenge of controlling healthcare cost and quality in much the same way that enterprises have optimized customer relations, supply chain management and enterprise resource management. Supported by its four key pillars—Measure, Manage, Engage and Automate—HPM provides organizations with visibility and control over their healthcare benefits spending trends and risk management postures, while protecting individual employee privacy.

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