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PROVIDING ACCESS TO AFFORDABLE, FLEXIBLE HEALTH PLANS THROUGH SELF-INSURANCE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH, EMPLOYMENT, LABOR, AND PENSIONS

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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PROVIDING ACCESS TO AFFORDABLE, FLEXIBLE HEALTH PLANS THROUGH SELF-INSURANCE

Wednesday, February 26, 2014
U.S. House of Representatives
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
Washington, DC

The subcommittee met, pursuant to call, at 10:03 a.m., in room 2175, Rayburn House Office Building, Hon. Phil Roe [chairman of the subcommittee] presiding.

Present: Representatives Roe, DesJarlais, Bucshon, Brooks, Messer, Loebsack, Holt, Scott, Hinojosa, Courtney, and Bonamici.

Also present: Representative Kline.

Staff present: Andrew Banducci, Professional Staff Member; Janelle Belland, Coalitions and Members Services Coordinator; Molly Conway, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Benjamin Hoog, Senior Legislative Assistant; Nancy Locke, Chief Clerk; Daniel Murner, Press Assistant; Brian Newell, Deputy Communications Director; Krisann Pearce, General Counsel; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Alissa Strawcutter, Deputy Clerk; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Jody Calemine, Minority Staff Director; Melissa Greenberg, Minority Staff Assistant; Julia Krahe, Minority Communications Director; Megan O'Reilly, Minority General Counsel; Michael Zola, Minority Deputy Staff Director; and Mark Zuckerman, Minority Senior Economic Advisor.

Chairman ROE. A quorum being present, the Subcommittee on Health, Employment, Labor, and Pensions will come to order, and good morning. I would like to welcome our guests and thank our witnesses for being here on this snowy day—sort of a surprise this morning.

Rising health care costs remain a significant challenge for workers and job creators nationwide. According to a survey released by the National Small Business Association, 91 percent of employers reported higher costs at their most recent health insurance renewal; one in four experienced cost increases of 20 percent or more. In a report released last Friday, the nonpartisan actuaries at the Centers for Medicare and Medicaid Services estimated roughly two-thirds of small businesses will face higher insurance premiums as a result of the President's health care law.

Promoting policies that will lead to affordable health care coverage is more urgent than ever. Today we will examine how self-insured plans help provide quality health care to millions of Americans at a more reasonable cost and discuss why we should reject any effort that undermines this important health insurance option.

Employers who manage a self-insured health plan bear the financial risk of providing health benefits to workers. Employers will often work with a third-party administrator to process claims and benefit payments. Many self-insured employers also purchase a product known as stop-loss insurance, a risk management tool that protects employers against catastrophic claims and high costs.

We have with us today a panel of witnesses who possess a wealth of knowledge, expertise, and experience in this area. They will explain in greater technical detail how the self-insured marketplace works.

However, it is worth noting just how vitally important this health insurance option has become. Approximately 60 percent of all individuals covered by employer-sponsored health insurance are in a self-insured plan. Even unions are embracing the benefits of this approach. A majority of Taft-Hartley health plans are self-insured.

Support for self-insurance has grown because it can be tailored to the needs of the workforce and offers transparency to ensure the plan is managed in an efficient and effective way. Just as important, self-insurance helps control health care costs, which can lead to higher wages for workers and more resources for employers to invest in job creation.

Across the country we are witnessing what happens when the federal government tries to force millions of individuals into a one-size-fits-all health care plan: costs go up, wages go down, and workers lose the coverage they like and the full-time jobs they need. Self-insurance is a legitimate option for workers and employers who cannot afford this government-run health care plan.

Perhaps that explains why some want to clamp down on the use of self-insured health care plans. In February of 2013, the New York Times reported that Obama administration officials were "considering regulations to discourage small and midsize employers" from using stop-loss insurance, thereby undermining the ability to self-insure. This press report contradicted an earlier statement by Phyllis Borzi, the Assistant Secretary of Employee Benefits Security at the Department of Labor, who vowed that the administration was, "not secretly writing a stop-loss regulation."

For months, the committee has sought clarification, but as usual, the administration has been less than forthcoming. The administration must clarify plans to potentially regulate in this area and explain the legal basis it has to do so.

No more Friday news dumps, midnight regulations, or holiday surprises. The employers, workers, unions, and families who rely on these health care plans deserve to know the truth now. Like every American, they were told if they liked their current health care plan they could keep it, and they have a right to know whether they too will be on the losing end of the president's broken promise.

Let's work together to make health care more affordable instead of raising costs of the more heavy-handed rules and bureaucratic overreach.

Before I conclude, I would like to take a moment to acknowledge the resignation of my friend and our friend and former colleague, Rob Andrews. Over the last few years Rob and I have sat side by side on this subcommittee discussing important issues facing our families—our nation's families and workplaces, such as health care, labor relations, and retirement security. We had our disagreements for sure, but we also shared a desire to advance the best interests of workers, employers, and retirees.

There are a number of challenges that merit our attention and the issue before us today is no exception. We have to ensure federal labor policies are fair and protect the right of workers to join or not join a union. We also have to address the multiemployer pension crisis that grows more severe with each passing day.

Rob and I spent many hours together examining the problems facing the multiemployer pension plans and discussing possible solutions to protect workers, employers, retirees, and taxpayers. For the sake of those whose jobs and retirement security are at stake, I hope this committee can continue that spirit of bipartisan cooperation in the months ahead, and I truly will miss Rob Andrews.

We are pleased today that our colleague, Dr. Dave Loebsack, is serving today as the senior Democratic member of the subcommittee.

And with that, I will now yield to our distinguished colleague for his opening remark?

[The statement of Chairman Roe follows:]

Prepared Statement of Hon. Phil Roe, Chairman, Subcommittee on Health, Employment, Labor, and Pensions

Good morning. I'd like to welcome to our guests and thank our witnesses for joining us.

Rising health care costs remains a significant challenge for workers and job creators nationwide. According to a survey released by the National Small Business Association, 91 percent of employers reported higher costs at their most recent health insurance renewal; one in four experienced cost increases of 20 percent or more. In a report released last Friday, the nonpartisan actuaries at the Centers for Medicare and Medicaid Services estimate roughly two-thirds of small businesses will face higher insurance premiums as a result of the president's health care law.

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We have with us today a panel of witnesses who possess a wealth of knowledge, expertise, and experience in this area. They will explain in greater technical detail how the self-insured marketplace works. However, it is worth noting just how vitally important this health insurance option has become.

Approximately 60 percent of all individuals covered by employer-sponsored health insurance are in a self-insured plan. Even unions are embracing the benefits of this approach; a majority of Taft-Hartley health plans are self-insured. Support for self-insurance has grown because it can be tailored to the needs of the workforce and offers transparency to ensure the plan is managed in an efficient and effective way. Just as important, self-insurance helps control health care costs, which can lead to higher wages for workers and more resources for employers to invest in job creation.

Across the country, we're witnessing what happens when the federal government tries to force millions of individuals into a one-size-fits-all health care plan: costs go up, wages go down, and workers lose the coverage they like and the full-time jobs they need. Self-insurance is a legitimate option for workers and employers who cannot afford this government-run health care scheme. Perhaps that explains why some want to clamp down on the use of self-insured health care plans.

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Before I conclude, I would like to take a moment to acknowledge the resignation of our friend and former colleague Rob Andrews. Over the last few years, Rob and I sat side by side on this subcommittee, discussing important issues facing our nation's families and workplaces, such as health care, labor relations, and retirement security. We had our disagreements, but we always shared a desire to advance the best interests of workers, employers, and retirees.

There are a number of challenges that merit our attention, and the issue before us today is no exception. We have to ensure federal labor policies are fair and protect the rights of workers to join or not join a union. We also have to address the multiemployer pension crisis that grows more severe with each passing day. Rob and I spent many hours together examining the problems facing multiemployer pension plans and discussing possible solutions to protect workers, employers, retirees, and taxpayers. For the sake of those whose jobs and retirement security are at stake, I hope this committee can continue that spirit of bipartisan cooperation in the months ahead.

We are pleased our colleague Representative David Loebsack is serving today as the senior Democratic member of the subcommittee. With that, I will now yield to our distinguished colleague for his opening remarks.

Mr. LOEBSACK. Good morning, all. I want to thank in particular Chairman Roe—Dr. Roe—for calling today's hearing, and thank all the witnesses for testifying today.

Dr. Roe and I have had a personal relationship since I have gotten here, and it has been a very good relationship and I do look forward to working with him today and hopefully into the future, as well. We already discussed our desire to do that on a bipartisan basis going forward, and I know that we feel the same way and it is a mutually respectful and civil relationship, which often is kind of rare in this body now days, so I do look forward to today's hearing and hopefully working together in the future beyond this hearing.

Thank you, Dr. Roe.

The *Affordable Care Act* can pave the way for all Americans to have access to quality, affordable health coverage for the first time. While it is unacceptable that technical problems prevented people from signing up for the state marketplaces at the outset, there is more than a month of open enrollment left and millions of Americans are signing up for coverage.

As of last month, we just heard, approximately 4 million people have enrolled on the marketplace plan and millions more have secured coverage through Medicaid.

The ACA is also helping strengthen employer-sponsored coverage for the more than 150 million workers and their families who get their health insurance through employment. Of the workers who get coverage through their jobs, about three in five work for an employer who self-funds their coverage—three in five—which means that they directly assume responsibility for covering the cost of their employees' medical care.

While the ACA provides employers who self-fund with greater flexibility, it also ensures that workers with this coverage have access to many of the law's important new consumer protections. Because of the *Affordable Care Act's* ban on annual lifetime limits, workers no longer face financial ruin if they confront a chronic or catastrophic illness.

Children can stay on their parents' plan until they are 26, including about 5,400 young people in my district alone. This means that rather than worrying about whether they can afford adequate coverage at the very early stages of their careers, we are giving America's young people a chance to focus on building a strong future right from the start.

Now workers have the right to appeal a benefit denial through an independent third party, and they have the right to a summary of their benefits and coverage to help them compare costs and understand their health care plan.

The *Affordable Care Act* also provides workers with greater freedom, as they are no longer tied to their employer for their health care coverage. This newfound freedom gives workers greater flexibility in the labor market. They are free to make career decisions, such as changing jobs or starting their own business, without worrying about how they will continue to get health insurance.

Employers are also benefitting from the law and saving money through such provisions as the small business tax credit and medical loss ratio. In fact, last year, health care costs grew at the slowest rate in 50 years.

Spending less on health care allows employers to create more jobs. Since the law's enactment, more than 8 million new jobs have been added to the economy and nine out of 10 of those jobs were full-time positions.

Recent reports have indicated that employers may be looking to self-insure. As part of today's hearing I expect we will discuss the issues unique to the self-insurance market. I think this is an important conversation, and while there are many benefits to employers who self-insure, there also can be significant financial risks.

The recent story about AOL exemplifies the risks involved with self-insuring and reinforces why employers must be adequately prepared if they face higher-than-expected health care costs. The CEO of AOL recently blamed the high health care costs incurred by two babies for the company's decision to cut contributions to its retirement plan.

With 5,000 workers, AOL is not what I would consider—and I think most would consider—a small employer, and thus, was ultimately able to absorb the costs. They did not have to shift the costs

onto employees, and after a public outcry they backpedaled their plan to cut retirement benefits.

A small employer, regardless of whether they had stop-loss coverage, may not have as much flexibility to absorb unexpected costs in a self-funded plan.

I hope today's conversation will be a constructive one and I look forward to the testimony.

And again, I want to thank Dr. Roe, the chairman, for putting this hearing together today.

And I yield back. Thank you, Dr. Roe.

[The statement of Mr. Loebsack follows:]

Prepared Statement of Hon. David Loebsack, a Representative in Congress from the State of Iowa

Good morning. I want to thank Chairman Roe for calling today's hearing and thank all of the witnesses for testifying.

The Affordable Care Act paves the way for all Americans to have access to quality, affordable health care coverage for the first time.

While it is unacceptable that technical problems prevented people from signing up for the marketplaces at the outset, there is more than a month of open enrollment left and millions of Americans are signing up for coverage.

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With 5,000 workers, AOL is not what I would consider a small employer and thus was ultimately able to absorb the costs. They did not have to shift the costs onto employees, and, after a public outcry, they backpedaled their plan to cut retirement benefits. A smaller employer—regardless of whether they had stop-loss coverage—may not have as much flexibility to absorb unexpected costs in a self-funded plan.

I hope today's conversation will be a constructive one and look forward to the testimony. Thank you very much, Mr. Chairman. I yield back.

Chairman ROE. I thank you, Dr. Loebsack. And one of the things that you hear in Congress all the time, the more times you hear somebody say they like each other they usually don't. Actually, in this case we do, so I wanted to let you know that to get started.

Pursuant to rule 7—committee rule 7—all members will be permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record will remain open for 14 days to allow such statements and other extraneous material referenced during the hearing to be submitted for the official hearing record.

It is my privilege now to introduce our distinguished panel.

First, Mr. Michael Ferguson is the president and chief executive officer of the Self-Insurance Institute of America in Simpsonville, South Carolina. Mr. Ferguson has significant expertise on self-insurance matters related to group health plans and has been with the Self-Insurance Institute of America for more than 18 years.

And welcome, Mr. Ferguson.

I now would like to yield to my colleague, Dr. DesJarlais, to introduce our next witness?

Mr. DESJARLAIS. Thank you, Mr. Chairman.

And good morning, and thanks to all of you for traveling here in the snow to testify with us today.

I have the privilege of introducing Mr. Wes Kelley, who comes to us from Columbia, Tennessee, which is located in Tennessee's fourth district, and in Maury County. Mr. Kelley is the executive director of Columbia Power and Water Systems and has held that position since May of 2012. Columbia Power provides reliable and reasonably priced utility services to its customers with a personal touch and, under Mr. Kelley's leadership, was able to upgrade many of its services during fiscal year 2013.

Prior to moving to Columbia in 2012, Mr. Kelley was the president and CEO of PES/Energize, a municipal power and fiber-to-home broadband provider in Pulaski, Tennessee. Before this, Mr. Kelley worked for the city of Hillsdale, the Hillsdale Board of Utilities, and the Hillsdale College in Hillsdale, Michigan.

In addition to his professional duties, Mr. Kelley serves on a number of industry and community boards, including the Tennessee Valley Authority's Regional Energy Resource Council, as well as serving as the chair for the Maury County Chamber of Economic Alliance.

Wes Kelley is a graduate of Hillsdale College, where he majored in political economy. He is currently married to Sundown Kelley, with whom he has two daughters, Haven and Cadence.

And I yield back.

Welcome.

Chairman ROE. Thank you, Dr. DesJarlais.

And one of the things that you all that are not from Tennessee don't know is, if you are running for statewide office it goes through Columbia, Tennessee, during Mule Days, so everybody that is running—you know if they show up at Columbia for Mule Days they are running for something statewide.

Am I correct, Mr. Kelley?

I will now continue our introductions. Ms. Maura Calsyn is the director of health policy at the Center for American Progress in Washington, DC. Prior to joining the Center for American Progress, Ms. Calsyn was an attorney with the Department of Health and Human Services Office of General Counsel.

Welcome.

Mr. Robert Melillo is the national vice president of risk financing solutions at USI Insurance Services in Glastonbury, Connecticut. Mr. Melillo has nearly 20 years of experience in group health insurance industry, with more than 15 of these years concentrated on the stop-loss market.

A very distinguished panel, and thank you all for being here.

Before I recognize you to provide your testimony let me briefly explain our lighting system. You have five minutes to present your testimony. When you begin the light in front of you will turn green; with one minute left the light will turn yellow; and when your time is expired the light will turn red.

At that point I will ask you to wrap up your remarks as—I won't cut you off in the middle of your remark, but try to wrap it up at that point. And after everyone has testified, each member will have five minutes to ask questions.

And we will now start with Mr. Ferguson?

STATEMENT OF MR. MICHAEL FERGUSON, PRESIDENT AND CEO, SELF–INSURANCE INSTITUTE OF AMERICA (SIIA), SIMPSONVILLE, SC

Mr. FERGUSON. Good morning, Chairman Roe, members of the subcommittee. Certainly my pleasure to be with you today and talk with you about what I think I would agree is a very timely topic.

I thought probably the logical place to start was to briefly describe or talk about what as self-insured plan is and how it differs from a fully insured plan. So real basically, if you are an employer and you want to provide coverage for your employees you have got two options to do so.

What we call the traditional option is you contact an insurance company and you arrange for a group insurance policy through a traditional insurance carrier, and you pay a premium to that insurance carrier, and in turn, that insurance carrier basically promises to cover the health care risks of your workforce population. So essentially, you are transferring that financial and legal liability risk over to the insurance carrier.

The alternative to that is to decide, "Well, instead of paying an insurance company to do this, what we are going to do as an employer, we are going to self-insure," which essentially means you are going to pay the cost of the claims as they are incurred. So by doing that, you are retaining the financial liability and the legal liability.

Now, most self-insured plans, particularly in the smaller and midsize market range, they will retain what is known as stop-loss insurance to guard against catastrophic risk. So again, as a self-funded plan, you are retaining the risk and you are paying the claims as they are incurred. So it is a financial management tool, if you will, in a way, to help you finance the cost of your health benefits for your workers.

So with that, you know, let's talk about who self-insures.

And, Mr. Chairman, you talked a little bit about this, self-insurance is a pretty major portion of the marketplace today. About 61 percent of workers in private health care plans receive their benefits through a self-insured arrangement.

But it is not limited to the private employer marketplace. There are a lot of union plans that rely on self-insurance. There is estimated about 600 Taft-Hartley union plans that operate on a self-insured basis.

And then finally, there are a lot of public sector entities that utilize self-insurance as the financing tool for the health benefits, and you are going to hear a story today from one such public organization that utilizes self-insurance.

So the self-insurance footprint in the marketplace is fairly large. It is really a mainstream strategy for businesses and organizations these days, and so it is a significant part, so it is good that we are talking about it here in this hearing.

Now, when you are looking at self-insurance it is important to point out that self-insurance is not necessarily the right choice for every organization. Like any major business decision, there are pros and cons.

There are certainly some disadvantages to being self-insured. Clearly you are taking the financial and legal liability risks when you are becoming self-insured, whereas if you transfer that off under a fully insured arrangement.

And the other thing that I would point out that is something that is maybe not said in bullet-point presentations, but when you are self-insured, in order to run a successful self-insured plan you really want to spend the time to sort of roll up your sleeves and take the time to plan out and work through your business advisors and your business partners to make sure the plan runs effectively. So it takes a little extra time to run a successful self-insured plan, so you need—from a corporate culture standpoint, you need to be willing to invest the time.

Now, the upsides are many. There are good cost-saving opportunities, and you can customize the plan to best meet the needs of your particular workforce.

Now, one of the advantages that I particularly did not note is that by self-insuring, this is—companies that self-insure, the main motivation is not to get out of requirements that are put forth by the ACA. In other words, this is not—if you are a self-funded plan, particularly a non-grandfathered plan, which by definition are plans that become self-insured after the ACA, you are subject to almost all of the ACA requirements and you are also included—you are also subject to ERISA, HIPAA, and other consumer protection requirements. So by becoming self-insured it is actually the opposite: You are subjecting yourself to more regulation, not less.

Finally, you know, as members of Congress what can you do to help to make sure that self-insurance continues to be an important and growing segment of the marketplace? Well, there is legislation now pending before Congress, the *Self-Insurance Protection Act,* which basically would set some guardrails around the self-insurance marketplace to protect from new regulatory action that would make it more difficult for employers or—make it more difficult for employers to operate self-insured health plans, and I would ask for your support for that legislation.

Mr. Chairman, those are my remarks. Thank you.

[The statement of Mr. Ferguson follows:]

House Education & Workforce Committee
Subcommittee on Health, Employment, Labor & Pensions
Hearing

February 26, 2014

Providing Access to Affordable, Flexible Health Plans Through Self-Insurance

Testimony Delivered By

Michael W. Ferguson
President & CEO
Self-Insurance Institute of America, Inc.
www.siia.org

INTRODUCTION

Good morning Chairman Roe and members of the subcommittee, thank you for the opportunity to testify on the issue of self-insurance. My name is Mike Ferguson. I serve as President and CEO of the Self-Insurance Insurance Institute of America, Inc. (SIIA).

SIIA is a national trade association that represents companies involved in the self-insurance marketplace, including self-insured organizations and their business partners, mostly in the small and midsized market segments.

My written testimony will address six general areas relating to self-insurance.

- What is Self-Insurance and How Does it Differ from Traditional Health Insurance
- Who Self-Insures
- The Advantages and Disadvantages of Self-Insurance
- Federal Regulation of Self-Insured Group Health Plans
- Stop-Loss Insurance Overview and Marketplace Demographics
- What Congress Can Do to Help Protect the Self-Insurance Marketplace

WHAT IS SELF-INSURANCE AND HOW DOES IT DIFFER FROM TRADITIONAL HEALTH INSURANCE?

Should an organization wish to sponsor a group health plan for its employees or members, it has two basic options. The first option is to purchase a traditional group health insurance policy from a licensed health insurance carrier. Under this arrangement, the organization pays the insurance carrier a fixed premium and the carrier provides health care coverage to the group in accordance with specified policy terms. By choosing the traditional insurance option, the organization transfers the health care-related financial and legal risk to the carrier.

The other option is to retain the financial and legal risk through the use of a self-insured group health plan. This is also known as self-funding. Under this arrangement the organization pays eligible health care claims as they are incurred, either directly like other business expenses or through a separate trust. Self-insured employers typically outsource claims administration functions, and often times retain stop-loss insurance as a financial backstop for catastrophic claims.

WHO SELF-INSURES?

According to the 2013 Kaiser Employer Health Benefits Survey, 61% of covered workers in private employer plans receive coverage through self-insured arrangements. Interestingly, 16% of small employers with 3-199 workers are self-insured. In 2012, this number was 15%.

It is important to note that there are about 1200 Taft-Hartley health plans – sponsored jointly by labor and management – serving a variety of industries. More than half of these plans are self-insured. And, many of these self-insured Taft-Hartley plans are small, with as few as 50 to 100 members.

Given these statistics, it's clear the topic of self-insurance is important to labor and management. And it's also clear that self-insurance is not simply a privilege for large organizations.

DISADVANTAGES OF SELF-INSURANCE

Now that we have established the size and diversity of the self-insurance marketplace, it would be useful to discuss the advantages and disadvantages of self-insurance in order to better understand what must be considered as part of the evaluation process.

It's important to state right up front that self-insurance is not the right option for all organizations. Smaller organizations, in particular, should carefully consider what it means to be self-insured.

Financial Liability

The primary consideration is that once self-insured, the organization is responsible for paying all eligible health care claims incurred by plan participants. While stop-loss insurance provides for a limited reimbursement mechanism for higher cost claimants, the self-insured organization accepts all financial liability for the group health plan. Simply stated, if an organization is not prepared to cut checks to pay providers, the organization should not be self-insured.

Legal Liability

In addition to accepting financial liability, self-insured plan sponsors also subject themselves to significant legal liability. Plan fiduciaries (normally organization executives) are subject to civil and criminal penalties under the Employee Retirement Income Security Act (ERISA) to the extent that plans are not administered in the best interests of the participants. Again, if an organization is not prepared to understand and ensure compliance with applicable federal law, the organization should not be self-insured.

Time and Focus Commitment

While self-insurance allows plan sponsors more flexibility to deliver quality health benefits in a more cost effective way, sponsors must commit to the necessary time and focus to design and manage their plans in order to achieve the desired results. So, the final simple statement is, if an organization is not willing to make this commitment, the organization will likely be better off in a traditional, fully-insured arrangement.

ADVANTAGES OF SELF-INSURANCE

Notwithstanding these disadvantages, there are many reasons why organizations should consider self-insurance as an alternative health plan financing option.

More Cost Effective Than Fully-Insured Plans

A well run self-insured health plan is generally less expensive over time compared to traditional, fully-insured options. The "over time" caveat is important because claims experience often varies from year-to-year.

Traditional insurance premiums must account for the carrier's marketing cost and profit margin, among other cost escalators that are not applicable to self-insured plans, as they are essentially not-for-profit health plans.

Plan Design Flexibility

Federal law provides self-insured plans greater flexibility in designing benefit packages that better meet the specific needs of their plan participants. For example, organizations with a predominately female workforce can structure their plans to incorporate more robust health benefits that would be utilized by female plan participants. Self-insurance plans can also structure more innovative reimbursement arrangements with health care providers.

Improved Cash Flow

Self-insuring allows claims to be funded as they are paid. Fully-insured premiums constitute a form of pre-payment. With self-insuring, a plan pays health plan costs only after the services have been rendered. Insurers set health insurance premiums at levels that anticipate projected increases in healthcare costs – usually well in excess of the actual rise in costs.

Ownership of Health Claims Data

Health claims data is extremely valuable for plan design purposes. But, under traditional insurance arrangements, carriers maintain that they own this data and employers cannot get access to it. By contrast, self-insured organizations have control over this data and can use it to help deliver benefits more efficiently and control costs.

ERISA Preemption of State Regulation

ERISA provides uniform regulatory stability to employers that operate in several states, so those companies do not have to adopt a patchwork of design variations to comply with various states' requirements. This is particularly important for multi-state organizations.

Incorporation of Value-Based Benefits and Wellness Programs

As medical costs have skyrocketed, self-insured plan sponsors have been taking steps to reduce medical costs by emphasizing prevention and maintenance care for chronic diagnoses. Employees have the flexibility to design and integrate into overall strategies, health risk assessments, prevention and wellness programs tailored to the employer's specific employee demographics and needs.

FEDERAL REGULATION OF SELF-INSURED PLANS

Some health care market observers contend that policy-makers should be concerned about employers switching to self-insured health plans and purchasing medical stop-loss insurance in order to "dodge" requirements and fees applicable to fully-insured health plans as provided for by the ACA.

They further argue that if an increased number of small employers self-insure, such actions will contribute to adverse selection, and therefore, compromise the viability of the ACA Exchanges (in particular, the SHOP Exchanges). SIIA believes these contentions are inaccurate based on a review of those ACA requirements applicable to self-insured plans, along with the recent findings of the RAND Corporation on this subject.

For purposes of our discussion, we will focus on non-grandfathered self-insured plans, which by definition include organizations that have switched to self-insurance since the passage of the ACA or have changed their plans since the enactment of the law. Importantly, non-grandfathered self-insured group health plans are subject to almost all ACA's health care market reforms, which means self-insured plans must:

- Eliminate all pre-existing condition exclusions for all participants.
- Eliminate waiting periods that exceed 90 days.
- Stop imposing annual and lifetime limits on the dollar value of "essential health benefit."
- Stop rescissions of coverage.
- Cover "adult children" up to age 26.
- Cover the cost of clinical trial participation.
- Provide coverage for certain preventive health services with no cost-sharing.
- Provide participants with a summary of benefits and coverage.
- Provide annual reports describing the plan's quality-of-care provisions.
- Include new internal and external appeals processes.
- Allow participants a choice of primary care physician/pediatrician/OB/GYN.
- Provide direct access to emergency services.
- Refrain from establishing rules for eligibility based on, among other things, health status, medical condition, claims experience, medical history, or genetic information.
- Limit the plan's cost-sharing to the maximum out-of-pocket limits for a high-deductible health plan defined under the health savings account ("HSA") rules for 2014.

Of the few ACA health care market reforms that do no not apply to non-grandfathered self-insured health plans, there are specific reasons why:

Medical Loss Ratio – As self-insured plans are essentially non-profit entities with the fiduciary requirement to use plan assets for the exclusive benefit of the plan participants, there is no "profit margin" to regulate.

Rating Rules – As non-profit entities, plans have no financial incentives to rate participants unfairly. For fully-insured plans, there is both the profit margin incentive as well as a history of abuse in rating practices.

Review of Rate Increases – Again, as self-insured plans are non-profit entities and prohibited from using plan funds for any other purpose, sponsors have no incentive to increase rates any more than the rate of increase of medical claims and expenses.

Essential Health Benefits – Congress considered whether self-insured plans should be subject to the "essential health benefits" (EHB) requirement. But, because Congress understood that most, if not all, self-insured plans already provided coverage for the enumerated EHB medical services, Congress made the affirmative decision to only impose the EHB requirement on fully-insured individual and small group market health plans. It is important to note that self-insured plans sponsored by employers with 50 or more "full-time equivalent employees" must offer coverage that provides "minimum value" or face a potential penalty tax. Most observers agree that the "minimum value" test is a proxy for the EHB requirement, so in essence self-insured plans are indirectly subject to a requirement to provide comprehensive coverage.

Finally, although not considered when Congress drafted the law, the fact that HHS directed the states to develop their own "essential health benefits-benchmark plan" lends to the argument that the EHB requirement would be preempted under ERISA, and therefore, not applicable to self-insured plans.

Related Consideration – Other Federal Laws Regulate Self-Insured Plans
Self-insured group health plans (grandfathered and non-grandfathered) are highly regulated by other federal laws such as ERISA, HIPAA and COBRA that existed prior to the ACA. Consumer protection requirements/mandates under these laws include:

- Prohibited from denying coverage based on preexisting conditions
- Prohibited from discriminating on cover based on health status
- Mandated internal review procedures
- Privacy protections
- Plan fiduciary standards
- Prohibited from rescinding coverage for non-fraudulent purposes
- Continued access to coverage post job termination

STOP-LOSS INSURANCE OVERVIEW AND MARKETPLACE DEMOGRAPHICS

Stop-Loss Insurance Overview
As referenced earlier in this testimony, smaller and mid-sized self-insured organizations typically retain stop-loss insurance to provide a financial backstop to guard against catastrophic claims. In this regard, I believe it would be useful to clearly explain what stop-loss insurance is and how it differs from traditional health insurance, as it is more closely related to liability insurance products than health insurance products.

Quite simply, stop-loss insurance provides financial reimbursements to self-insured organizations for health care payments that exceed pre-determined levels, known in the industry as "attachment points." Stop-loss policy attachment points can either be for specific plan participants and/or for total claims incurred by the plan, known as "aggregate."

Unlike health insurance, stop-loss insurance does not cover individuals nor pay health care providers regardless of attachment point levels. Stop-loss insurance can only reimburse the sponsor or the plan for health payments in excess of the attachment point.

Stop-Loss Insurance Marketplace Demographics

Milliman released a report last year commissioned by the Self-Insurance Educational Foundation (SIEF), highlighting key policy characteristics found in the U.S. employer medical stop-loss (ESL) market. The underlying policy data was provided by eight of the largest stop-loss carriers which collectively represent approximately 50% of the market. Milliman therefore assumed that the data is a reasonable approximation of the entire ESL market. A summary of this data revealed the following:

- Employers with 100 or fewer covered employees represent approximately one-quarter of the ESL market if the market is measured by count of employers. If measured by covered employees, however, that same segment represents only 2% of the ESL market.
- Most ESL purchasers obtain both specific and aggregate stop-loss. However, employers with over 1,000 employees are more likely to purchase specific stop-loss without aggregate. Very few employers found in the underlying data purchased aggregate coverage without specific stop-loss.
- The data included employers that purchased specific deductibles ranging from $5,000 to $2,000,000. However, 81% of employers purchased deductibles of $50,000 or greater.
- The median specific deductible found in the calendar year (CY) 2012 data across all plans was $80,000. For groups with 50 or fewer covered employees, the median deductible was $35,000. For groups of 51-100 employees, the median was $45,000.
- Less than 0.2% of specific stop-loss policies had specific deductibles of $10,000 or less. About 0.3% of specific stop-loss policies were written with specific deductibles of less than $20,000.
- The data included employers that purchased aggregate corridors ranging from 110% to 200% of expected claims. By far, the most common corridor (found on 90% of policies with aggregate coverage) was 125% of expected claims.

WHAT CONGRESS CAN DO TO PROTECT THE SELF-INSURANCE MARKETPLACE

Despite the many positive advantages of self-insurance described in this testimony, SIIA is concerned that the Administration may make this option more difficult by restricting the availability of stop-loss insurance. Specifically, it is believed that the Federal agencies may "interpret" the definition of health insurance coverage to include stop-loss insurance based on attachment point levels.

The Administration first signaled its interest in regulating stop-loss insurance in May of 2012 through a tri-agency request for information (RFI) about stop-loss policies. Then, a letter to Congress dated August 22, 2013 by HHS Secretary Kathleen Sebelius confirmed that the Department is "interested in the possible effects of self-funded arrangements with stop-loss insurance on the risk pool and premiums in the fully-insured small group market."

Most recently, the final Health Insurance Tax Rule, published on November 26, 2013, included a section on stop-loss insurance that does not rule out the possibility that future guidance may specify, "Under what circumstances stop-loss coverage constitutes health insurance."

Based on these observations, SIIA strongly supports H.R. 3462, known as the Self-Insurance Protection Act (SIPA). This simple, three-page bill amends the definition of "health insurance coverage" under the Public Health Services Act (PHSA) and parallel sections of ERISA and the Tax Code to clarify that stop-loss insurance is not health insurance in order to prevent overly creative interpretation of the federal statute by regulators.

It is important to note that the legislation does not amend the ACA. As a result, SIIA does not view SIPA as a partisan bill. Rather, the bill essentially establishes guardrails around a segment of the employer-based health care system that is working well. We therefore ask members on both sides of the aisle to support this sensible public policy objective.

CONCLUSION

In conclusion, I would like to thank the committee again for this opportunity to provide input on the increasingly important topic of self-insurance, and I look forward to addressing any questions you may have. Additional information about self-insurance can be accessed on-line at www.siia.org

Chairman ROE. Thank you very much, Mr. Ferguson.

Mr. Kelley, you are recognized for five minutes?

STATEMENT OF MR. WES KELLEY, EXECUTIVE DIRECTOR, COLUMBIA POWER AND WATER SYSTEMS, COLUMBIA, TN

Mr. KELLEY. Thank you very much, Chairman Roe, Ranking Member, members of the subcommittee. I appreciate this opportunity to provide testimony today on the importance of self-insurance to small and midsized organizations. I represent one such organization that utilizes self-insurance to provide health care benefits to our employees while maximizing our cost control opportunities.

My name is Wes Kelley, and I am proud to serve as executive director of Columbia Power and Water System in Columbia, Tennessee. We are the electric and water and broadband provider for much of Maury County. Columbia, for those of you that don't know, haven't had the good fortune to visit Mule Day, is located about 40 miles south of Nashville, Tennessee.

We are a small organization. We have an annual budget of about $85 million, but our 115 employees, 55 retirees, and 204 family dependents are all proud of the work we do serving our local community.

In 1993 our Board of Public Utilities decided to move our employee health insurance program from the fully insured marketplace and create a self-funded health plan to better manage costs and the benefits provided to our employees and eligible retirees. Enough money was saved in the first year of self-funding to establish a solid financial reserve that has continued to build to this day.

Initially established with a $20,000 specific stop-loss retention level, this was increased to $30,000 in 2004, where it remains. Last year total funded costs were reduced by 1.8 percent and this downward trend has been in place for several years. For example, claims were $1.7 million in 2006, but have been reducing gradually to $1.2 million last year even though coverage was provided to essentially the same number of employees and eligible retirees.

While occasionally costs may rise in response to unusual conditions, we have worked closely with our employees to control the cost of our health care and keep the plan affordable. We regularly solicit bids from qualified providers for stop-loss coverage along with our health care network and third-party administration.

Since the plan was established we have taken much of our savings and placed those dollars in a reserve account. Today we have more than $1 million in reserves. Indeed, in previous years our board intentionally stopped funding the plan to keep the reserve from growing too large.

Over the past 22 years our self-funded arrangement has allowed the utility to maintain above-average benefits to our employees, dependents, and retirees. In an era of ever rising deductibles we have been able to keep our participants' deductibles at $200 for an individual, $400 for a family, with a $10 drug copay.

Also, we provide a full range of dental benefits, including orthodontia. These benefits are provided without the employees contrib-

uting to the cost of health insurance through their paycheck or otherwise.

Furthermore, eligible early retirees and their dependents enjoy the same benefits as active employees. Retirees age 65 and older, along with their surviving spouses, maintain Medicare supplemental coverage with CPWS, along with access to drug discounts.

These health benefits have allowed us to retain the best possible workforce, increase productivity, and maintain a high level of satisfaction with the plan. Some of the dollars saved since implementing our self-funded plan have been used to fund wellness and disease control measures, the cost of which would have otherwise been on top of the premiums we pay in a fully insured environment.

Some of the wellness benefits include annual blood tests, PSA screening for men, and mammograms for female employees. Also, biannual physicals are provided to the employees at no cost.

Controlling the cost of health care is critical to our organization because we realize that any increase in that cost will ultimately impact the ratepayers that use our utility services. In spite of our small size, we believe our self-funded health insurance has been successful thanks to the good advice we receive from knowledgeable consultants; strong, business-minded board of directors; an appreciative workforce; and perhaps most importantly, affordable stop-loss insurance that protects the financial solvency of the plan.

Thank you again for this opportunity to share our experience.

[The statement of Mr. Kelley follows:]

Written Testimony of Wes Kelley
Executive Director
Columbia Power & Water Systems
Columbia, Tennessee

Before the House Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor and Pensions

February 26, 2014

Chairman Roe and Members of the Subcommittee, thank you for the opportunity to provide testimony today on the importance of self-insurance to small and mid-sized organizations. I represent one such organization that utilizes self-insurance to provide quality health benefits to our employee while maximizing cost control opportunities.

My name is Wes Kelley, and I serve as the Executive Director of Columbia Power and Water Systems (CPWS), the municipal utility for the City of Columbia and much of Maury County, Tennessee. Columbia is located about 40 miles south of Nashville. Our utility provides electricity, water, and broadband services to more than 25,000 homes and businesses. CPWS is a small organization, with a combined annual operating budget of just over $85 million. Our staff of 115 employees, 55 retires, and 204 family dependents are proud of the work we do serving our local community.

In 1993, our local Board of Public Utilities decided to move our employee health insurance program from the fully-insured marketplace and create a self-funded group health plan to better manage costs and the benefits provided to our employees and eligible retirees. Enough money was saved in the first year of self-funding to establish a solid financial reserve that has continued to build to this day.

Initially established with a $20,000 specific stop loss risk retention level, this was increased to $30,000 in 2004, where it remains. Last year, total funded costs were reduced by 1.8%, and this downward trend has been in place for several years. For example, claims were $1.7 million in 2006, but have reduced gradually to $1.2 million last year, even though coverage was provided to essentially the same number of individuals. While occasionally, costs may rise in response to unusual conditions, we have worked closely with our employees to control the cost of our health care and keep the plan affordable. We regularly solicit bids from qualified providers for stop loss coverage, along with our health care network, and third-party administration.

Since the plan was established, we have taken much of our savings and placed those dollars in a reserve account. Today, we have more than $1 million in reserves. Indeed, in previous years, our Board intentionally reduced funding for the plan to keep the reserves from growing too large.

Over the past 22 years, our self-funded arrangement has allowed the utility to maintain above average benefits for our employees, dependents, and eligible retirees. In an era of ever rising deductibles, we have been able to keep our participants' deductibles at $200 for an individual, $400 for a family, and a $10 drug copay. Also, we provide a full-range of dental benefits, including orthodontia. These benefits are provided without the employees contributing to the cost of health insurance through their paycheck or otherwise. Furthermore, eligible early retirees and their dependents enjoy the same benefits as active employees. Retirees aged 65 and older, along with their surviving spouses, maintain Medicare supplement coverage through CPWS with access to drug card discounts.

These health benefits have allowed us to retain the best possible workforce, increase productivity, and maintain a high-level of satisfaction with the plan. Some of the dollars saved since implementing the self-funded plan have been used to fund wellness and disease control measures, the cost of which would have otherwise been on top of the premiums paid to a fully-insured health insurance company. Some of these wellness benefits include annual blood tests, PSA screening for men, and mammograms for female employees. Also, bi-annual physicals are provided at no cost to the employees.

Controlling the cost of health insurance is critical to our organization because we realize that any cost increase will ultimately impact the utility rates we charge our customers. In spite of our small size, we believe our self-funded health insurance has been successful thanks to the good advice we receive from knowledgeable consultants, a strong business-minded board of directors, an appreciative workforce, and perhaps most importantly—affordable stop loss insurance that protects the financial solvency of our plan.

Thank you again for the opportunity to share our experience, and I will be glad to answer any questions you may have.

Chairman ROE. Thank you, Mr. Kelley.

Ms. Calsyn, you are recognized for five minutes?

STATEMENT OF MS. MAURA CALSYN, DIRECTOR OF HEALTH POLICY, CENTER FOR AMERICAN PROGRESS, WASHINGTON, DC

Ms. CALSYN. Thank you, Mr. Chairman, Ranking Member, and members of the Subcommittee. Thank you for the opportunity to testify today.

My testimony is going to focus on the following three topics: first, how the *Affordable Care Act* preserves flexibility for self-insured employers, while also giving workers greater flexibility and security; second, the risks of self-funding to employers and employees; and third, why an increase in smaller businesses' self-funding creates problems for employers and employees who remain in the fully insured market.

First, the ACA reformed much of the private insurance market but had a much smaller impact on self-insured employers because the law exempts these plans from many of its key reforms. This approach accounted for the differences between the fully insured and self-insured markets.

For example, the majority of self-funded large employers offer fairly comprehensive benefits, in stark contrast to plans in the individual market. The essential health benefits and actuarial value requirements fixed this problem in the individual and small-group fully insured markets, but do not apply to self-insured plans.

This is an example of how the ACA's treatment of self-insured plans is a compromise that largely preserved the flexibility in this market while making targeted changes to protect consumers, like banning lifetime limits.

When discussing flexibility, affordability, and health care, we should also consider how the ACA helps workers. The law provides security for those with job-based insurance in case they lose that coverage in the future, and employees are no longer tied to a particular job because that is their sole source of coverage.

Second, self-funding is not a panacea. My two co-witnesses have detailed the benefits of self-insurance as well as the use of stop-loss policies and other arrangements to mitigate its risks. But, self-funding still requires significant resources and expertise to understand and manage the legal and financial complexities of these arrangements.

And when discussing affordability of group health plans we must also consider employees' costs, not just employers'. If businesses do, in fact, self-insure to avoid complying with the ACA reforms they may offer fewer categories of benefits or pass along those costs to their employees.

Sicker employees in these plans may also face higher costs down the road and even employment discrimination because of lasering. A laser is a higher attachment point for an enrollee with costly preexisting conditions or other health risks, which shifts liability for those costs back to the employer and potentially the employee.

Third, the trend of smaller businesses self-insuring creates problems for the businesses and employees who remain in the fully insured market. Millions of small business employees have histori-

cally been uninsured, and those with coverage have often paid more.

One reason why is because small businesses may not have enough employees to adequately spread risk. To solve this problem the ACA not only prohibits practices that priced older and sicker groups out of the health care market, but it spreads risks among all small employers.

But if businesses with healthier employees leave the fully insured market en masse these changes are meaningless, and without a stronger regulatory framework for the self-insured market and stop-loss insurance this is a significant risk. That is because there are few incentives for employers with healthier-than-average workforces to join the fully insured risk pool that may include older, less healthy individuals.

But once the group's health status declines, self-funding becomes much riskier. Stop-loss insurers, for example, can raise premiums or refuse to renew coverage. Small employers may drop coverage or return to the fully insured market, adding their less healthy employees to that risk pool, and for small businesses a single injury or unexpected illness can trigger this response.

One study found that without further regulation of stop-loss policies, up to 60 percent of small businesses could self-fund, leaving more costly employees in the fully funded market. This could increase premiums by up to 25 percent, which could, in turn, deter other businesses from offering insurance coverage or cause others to drop coverage, further increasing costs and disrupting coverage.

Anecdotal evidence suggests that this shift is beginning. The increase in stop-loss policies marketed to extremely small companies is also telling.

In conclusion, self-funding will likely lower costs for some employers, but it will dramatically increase costs for others that remain in the fully insured market because self-funding is simply not a viable alternative. Millions of workers will also see higher costs.

We must acknowledge these tradeoffs during this discussion. Greater oversight and regulation of stop-loss insurance will help stabilize the small-group market and protect employers and employees.

Mr. Chairman, this concludes my testimony. I am happy to answer any questions.

[The statement of Ms. Calsyn follows:]

U.S. House of Representatives
Committee on Education and the Workforce
Subcommittee on Health, Employment, Labor, and Pensions

"Providing Access to Affordable, Flexible Health Plans Through Self-Insurance"

February 26, 2014

Statement of
Maura D. Calsyn
Director of Health Policy
Center for American Progress

Mr. Chairman, Ranking Member, and members of the Committee—thank you for the opportunity to testify today about the impact of the Affordable Care Act on self-insurance options, particularly for smaller businesses, and how the decision to self-insure can affect employees enrolled in those plans, as well as the broader health care market.

My testimony will focus on the following issues:

1. How the Affordable Care Act not only preserves flexibility for businesses that offer their employees health insurance through self-insured, or self-funded, arrangements, but also how the law gives American workers greater flexibility and autonomy over their health care decisions
2. The reasons why self-insurance is not a panacea—there are real risks for both employers who choose to self-insure and their employees
3. How a shift toward self-insurance in the small-group market can create problems for the employers and employees who remain in the fully insured market

Increased flexibility under the Affordable Care Act

The Affordable Care Act reformed much of the private insurance market to guarantee that all Americans have access to high-quality health insurance. But the law has a much smaller impact on employers that choose to self-insure—meaning the employer functions as an insurer and bears the risk of employees' health care costs—as an alternative to purchasing health insurance coverage for their employees. The law exempts these plans from many of its key reforms.

This approach to the self-insured market took into account differences between the fully insured and self-insured markets prior to the Affordable Care Act. For example, the majority of currently self-funded large employers offer fairly comprehensive benefits, while benefits offered in the fully insured market prior to the Affordable Care Act were far less uniform and some were so minimal that they provided virtually no financial protection to enrollees. The essential health benefits and actuarial-value requirements fixed this problem in the individual and fully insured small-group markets but do not apply to self-insured plans.

This is just one example of how the Affordable Care Act's treatment of self-insured plans reflects a compromise that largely preserved the self-insured market while making targeted

changes to protect employees, such as banning lifetime and annual limits and requiring dependent coverage and preventive care. As a result, employers wishing to self-fund still have significant flexibility to design their health benefits to fit the needs of their business and employees.

In any discussion of flexibility, affordability, and health care, we should also acknowledge how the Affordable Care Act offers American workers greater flexibility and autonomy over their health care decisions. The Affordable Care Act also provides security even to those people with employer-based insurance who might lose that coverage in the future.

Employees no longer need to be tied to a particular job because it is the only possible source of health insurance. For example, an individual with a pre-existing condition can now find affordable, comprehensive health care options beyond employer-sponsored insurance, which might allow that person to start a new business or return to school.

Self-insurance is not a panacea

Employers that self-insure gain a number of benefits. This approach gives them flexibility to tailor health care benefits to meet their employees' needs. There are also significant financial benefits: These plans can cost less than commercial insurance and give employers more control over health care expenditures. Employers pay for the cost of their employees' care instead of paying a set amount to an insurer, and if health care costs are low in a particular month, the employer—not the insurer—keeps the savings.[1]

But in this model, employers assume the risk for employee health care costs that exceed employee contributions. For that reason, self-insured plans are far more common among large employers, especially those with at least 1,000 employees.[2] Their size gives these employers bargaining power in the health care market and allows them to adequately pool risk across their employees. These businesses also have sufficient financial resources to pay unpredictable, potentially costly claims.

Businesses have several ways to mitigate these risks, making self-insuring even more attractive. Most employers purchase private secondary insurance called stop-loss insurance. Stop-loss insurance protects employers from unpredictable or catastrophic claims by shifting responsibility for those costs from the employer to the stop-loss insurer.

Specific, or individual, stop-loss insurance protects an employer from a single, unusually high claim from any one employee, and aggregate stop-loss insurance limits the total amount the employer must pay each year for all employee health care claims. In both types, the point at which stop-loss coverage begins is called the attachment point. Lower attachment points minimize the employer's financial risk, and if they are particularly low, they start to blur the line between self-insured plans and self-funded plans entirely.[3] Stop-loss issuers may also structure stop-loss policies to protect businesses' cash flow in the case of unpredictable claims.

Other common practices further ease the financial and administrative burdens on employers wishing to self-insure. Employers frequently contract with insurers that serve as third-party administrators, processing claims and handling other administrative services on behalf of self-insured employers. And self-funding arrangements between employers and third-party administrators also commonly include access to the insurer's provider network.[4]

Even with these mitigation strategies, self-funding can still be a risky option for smaller businesses that choose this approach.[5] Because self-funding requires a number of complex components—often including complicated contracts, provider networks, benefit administrators, and management of financial reserves—even firms with stop-loss insurance must have significant resources and expertise to understand and manage the financial and legal complexities of the plan.

And when discussing the affordability of group health plans, we must consider not just the employers' costs but also the cost to employees.

If smaller businesses choose to self-insure to avoid complying with changes made by the Affordable Care Act, employees in these plans may find their coverage to be limited. Some employers—especially those with healthier employees—may choose to cut costs by offering fewer categories of benefits or structuring their benefits to pass along certain costs to their employees.

Sicker employees in self-funded plans may also face higher out-of-pocket costs and possibly employment discrimination because of a process known as lasering. Lasering allows stop-loss insurers to set higher attachment points for employees with costly pre-existing conditions or other health risks, which shifts liability for these employees' costs back to the employer and potentially to the employee.[6] The Affordable Care Act explicitly prohibits such targeted discriminatory behavior, but that protection does not apply to this practice.

Problems for businesses and their employees that remain in the fully insured market

For many small businesses, the Affordable Care Act helps make coverage affordable. Millions of small-business employees have historically been uninsured, and those with coverage have often paid more out-of-pocket for their coverage.[7] Unlike their larger counterparts, small businesses may not have enough employees to spread risk if the group includes sicker or older individuals. Small businesses that have a disproportionately older and less healthy workforce face even higher costs.[8]

The Affordable Care Act tackles these problems in different ways. First, the law prohibits many formerly common practices that priced older and sicker groups out of the health care market. Second, the law spreads risk among all small employers. Third, the law created small-business marketplaces.[9]

But if businesses with healthier employees decide to leave the fully ensured market en masse, these changes will not help businesses that remain in that market. And without a stronger regulatory framework for the self-insured market or limits on stop-loss insurance, this is a significant risk.

As long as a group of employees remains young and healthy, there are few incentives for employers to join the fully insured risk pool that includes older, less healthy individuals who increase the price of insurance premiums.

Once the group's health status declines, self-funding becomes far more risky and expensive. Stop-loss plans, for example, can raise premiums or refuse to renew coverage once a group

becomes less healthy or more expensive to cover. In this case, small employers could either drop coverage or return to the fully insured small-group market, adding its less healthy employees to that risk pool.

For small businesses, a single unexpected injury or illness can raise costs sharply for the employer and trigger the above response. But if that employee leaves or resolves the health issue, the firm may opt to self-fund again. Churning between the self- and fully funded markets would allow small businesses to capitalize on the fully funded and regulated market only when employer risk is high without otherwise participating in the risk pool. This adverse selection could, in turn, raise premiums in the fully funded small-group market.

One study has found that without further regulation of stop-loss policies, up to 60 percent of small businesses could self-fund, leaving mainly older, more costly employees in the fully funded small-group market. This could increase premiums in the small group market by up to 25 percent.[10] These substantial premium increases could, in turn, deter other small businesses from offering health insurance or encourage them to drop the coverage they now offer, further driving up costs in the fully insured market. Anecdotal evidence from various news articles suggests that this shift toward self-insurance is already occurring.[11] A brief review of stop-loss policies that are marketed to small firms also indicated this shift.[12]

Ultimately, self-funding will likely lower costs for some employers who choose this path. But this trend will dramatically increase costs for other employers and their employees who remain in the insured market because self-funding is not a viable alternative. We must acknowledge this and other trade-offs as part of the discussion about self-funding and affordability. Oversight and regulation of stop-loss insurance, which is extremely limited today, will help stabilize the small-group market and protect both employers and employees.

Mr. Chairman, this concludes my testimony, and I am happy to answer any questions that members of the committee may have.

Endnotes

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Chairman ROE. Thank you very much for your testimony.

Mr. Melillo, you are recognized for five minutes?

STATEMENT OF MR. ROBERT MELILLO, NATIONAL VICE PRESIDENT OF RISK FINANCING SOLUTIONS, USI INSURANCE, GLASTONBURY, CT

Mr. MELILLO. Thank you.

Chairman Roe and members of the subcommittee, thank you for the opportunity to testify on the issue of self-insurance. Again, my name is Robert Melillo, and I am the national vice president of risk financing solutions for USI Insurance Services, who happens to be one of the largest insurance brokers in the country, specializing in employee benefits, representing more than 10,000 employee benefit clients.

My testimony today will include an overview of what is involved with migrating a group that is currently fully insured into a self-funded arrangement, and I will also share with you two case studies of groups under our advisement right now that are in a self-funded arrangement.

So, the role of the insurance broker or consultant is to educate their client and inform their client of the options available to them in the marketplace to allow them to deliver a competitive and comprehensive health benefits package to their employees and their dependents. Traditionally, the fully insured programs have been the easiest option, yet they have been some of the least flexible and creative options.

Self-funding offers plan sponsors a platform that allows them to effectively and efficiently manage their health care spending while allowing the stakeholders the ability to analyze the data and modify the plan design and swap out the service vendors to improve the outcomes and eliminate waste. Before a plan sponsor converts from a fully insured program to a self-funded program they first must go through an evaluation process, a preparedness process, if you will, focusing on five key elements: risk and financial stability, risk tolerance in management, innovation, engagement, and ultimately education.

And that is the role of the employee benefits producer or a consultant. Now, by assessing the plan's preparedness to convert from a fully insured plan to a self-funded arrangement the plan sponsor themselves and the consultant become better acquainted with their risk tolerance level and their preparedness to make that transition.

Now, two case studies that I have to share today—one is Sheffield Pharmaceuticals, a family-owned, midsized manufacturing firm in Connecticut. They have 162 employees of which 75 are under the employee benefits plan.

Prior to converting to a fully insured arrangement they received consistent renewal increases of approximately 10 to 15 percent year over year. In 2008 they received an increase of 25 percent because of a few catastrophic claims within that pool. The following year, with no bad claims experienced, they received a 39 percent rate increase from their fully insured carrier.

Therefore they began to look, you know, more aggressively with their consultant at self-funding as an option. They ended up making the switch to a self-funded program using basically the same

plan design they had in their fully insured plan, and over a 4-year span they saved over $400,000, a 19 percent savings, of which their success allowed the company to realize savings that, number one, allowed them to maintain a gold standard plan, and they did not increase their employee contributions for the entire term.

The second case study is a firm in Mason, Ohio—SpearUSA. In 2011, they converted to a self-funded program, and by converting to a self-funded program they used the stop-loss insurance to help them reduce their spend by $4.4 million over a 3-year span.

By doing so, they were able to also maintain their same benefit plan while adding a wellness program, so they increased their benefits. In addition, they did not increase their employee contributions for the entire term, as well.

In conclusion, I would like to thank the committee for the opportunity to speak about the true benefits of self-insurance and what it can do for the employer. And I believe that plan sponsors' choice to self-insure with the use of quality and customizable stop-loss insurance programs is essential if they are to have a chance to manage their future and current spend instead of getting this set-it-and-forget-it mindset that tends to lend itself to a fully insured program.

Thank you.

[The statement of Mr. Melillo follows:]

USI Insurance Services

House Education & Workforce Committee

Subcommittee on Health, Employment, Labor & Pension

February 26, 2014

Providing Access to Affordable, Flexible Health Plans Through Self-Insurance

Testimony Delivered By

Robert J. Melillo

National Vice President, Risk Financing Solutions

USI Insurance Services

www.usi.biz

INTRODUCTION

Chairman Roe, and members of the committee, thank you for the opportunity to testify on the issue of self-insurance. My name is Robert Melillo and I serve as the National Vice President of Risk Financing Solutions for USI's Employee Benefits Division.

USI is a leader in the insurance brokerage and consulting market with more than 4,000 experienced and innovative professionals working with more than 10,000 employee benefits clients.

Founded in 1994, USI is a leading distributor of property and casualty insurance, employee benefits and specialty products throughout the United States. Headquartered in Valhalla, NY, the Company operates out of 100 offices in 28 states. USI combines its client-centric culture at the local level with leading edge technical resources on the national level.

USI is the 10th largest insurance broker in the U.S.[1], the 3rd largest privately held[2], and the 14th largest insurance broker in the world[3]. We are a leader in property & casualty and employee benefits. We are the #1 employee benefit communication and enrollment services provider in the U.S.[4]

My written testimony will include an overview of the process involved with migrating a fully insured plan to a self-insured arrangement. It will also include two case studies of plans that have converted from fully insured to self-insured arrangements, along with the results of their financing change.

1 Business Insurance Top Broker Ranking 2013
2 Insurance Journal Top 100 Privately-Held Independent Agencies Ranking 2013
3 AM Best Top Global Insurance Brokers Ranking 2013
4 Internal estimates based on competitive analysis

SELF-INSURED PROCESS

The role of the Insurance Broker or Consultant is to educate and inform their client of the options available to them in the marketplace for delivering a competitive and comprehensive employee benefits package to their employees and dependants. For many clients, a fully insured program is the easiest option for a group to implement, but successfully managing a

groups healthcare spend requires engagement from the plan sponsor, innovation and access to utilization data. Self-insurance offers our employee benefits clients a platform to effectively and efficiently manage their healthcare spend by allowing our team to analyze the data and modifying the plan to improve outcomes and eliminate waste.

Regardless of the funding arrangement (i.e. Fully Insured or Self-Insured), the plan sponsor first hires a licensed insurance broker or consultant to represent and advise them through the purchase of their group health insurance purchase.

A fully insured arrangement bears little risk to the plan sponsor. The plan sponsor purchases an insurance policy from a licensed insurance company. The benefits within the policy are predefined and filed with the state insurance department. They pay the insurance company premium each month and the insurance company pays all eligible claims incurred during the policy period.

A self-insured arrangement can include the same services and the same benefits, but the financing of the benefits is different. Instead of paying a monthly premium to an insurance company, they fund a claim account that pays for claims incurred under their plan and they purchase stop loss insurance to manage the catastrophic risk. Self-insured plans can be customized to meet the unique goals and objectives of each plan sponsor and their employee population needs.

Before a plan sponsor converts from a fully insured program to a self-insured arrangement they must first review preparedness as it relates to five key areas:

1. Financial & Population Stability
2. Risk Management
3. Innovation
4. Engagement
5. Education & Support

By assessing a plan sponsors preparedness to convert to a self-insured arrangement relating to each of these five key areas, the plan sponsor and the broker or consultant can better determine if self-insurance is appropriate for the group. Below is an overview of the discussions a plan sponsor will have with their Insurance Broker of Consultant.

Financial & Population Stability

A self-funded program is responsible for the funding of all eligible claims incurred and paid by the plan administrator (ASO), or third party administrator (TPA). Therefore, a plan sponsor must have access to the necessary capital to fund all claims. How financially stable, and solvent, are you today and in the future? Are you prepared to fund all claims under a self-funded arrangement?

Risk Management

A self-funded arrangement exposes the plan sponsor to greater financial exposure than that of a fully insured arrangement. However, that additional risk comes with greater reward potential as well. This additional exposure is typically fluid, but can be managed with risk transfer vehicles (such as Specific Stop Loss, Aggregate Stop Loss, etc.). Are you prepared to manage the financial exposure associated with a self-funded arrangement and based on a three-year healthcare strategy? How comfortable are you with managing this exposure with your Insurance Broker or Consultant?

Engagement

A self-funded program allows a plan sponsor to customize, measure, evaluate and manage each and every aspect of their benefit plan, compared to a fully insured program that typically has a pre-determined offering through a single source company. As a result, managing a self-funded program requires an elevated level of engagement from the plan sponsor if a multi-year health care strategy is expected to be successfully executed. Are you prepared to engage in the development and implementation of a multi-year health care strategy and the management of your health care spend?

Innovation

Why are you offering the benefit plan you have today? Most fully insured programs offer a "canned" plan design, loaded with state mandated benefits packaged by the insurance carrier and often do not address your financial goals and unique needs. Many of today's health care benefit innovations have originated from the self-funded marketplace. Are you comfortable stepping outside of the box with the design and structure of your benefits program? Are you interested in designing a benefit plan with best in class vendors, in essence creating your all-star team or health care service provider?

Education & Support

The foundation of the self-funded model was developed from the desire to leverage cash-flow, customize benefits plans, and the belief that if you manage the pennies, the dollars will take care of themselves. Managing this process takes a seasoned and committed team of internal and external professionals committed to monitoring and managing all aspects of your health care spend and the risk. Do you have the internal and external (i.e. Benefits Advisor) team in place to develop and execute a successful self-funded strategy?

Fully insured health programs not only limit a plan sponsors ability to manage their health care spend by limiting their access to claims and utilization data, they also lack flexibility and innovation. Today, more than ever, plan sponsors need to address several areas if they plan on managing future health care expenses. This worksheet is designed to help your organization determine if your plan is a viable candidate for self-funding your benefits program. Self-funding is a time tested and proven model for financing health care -- with ongoing innovative approaches leading the health care industry.

CASE STUDY #1 (Sheffield Pharmaceuticals)

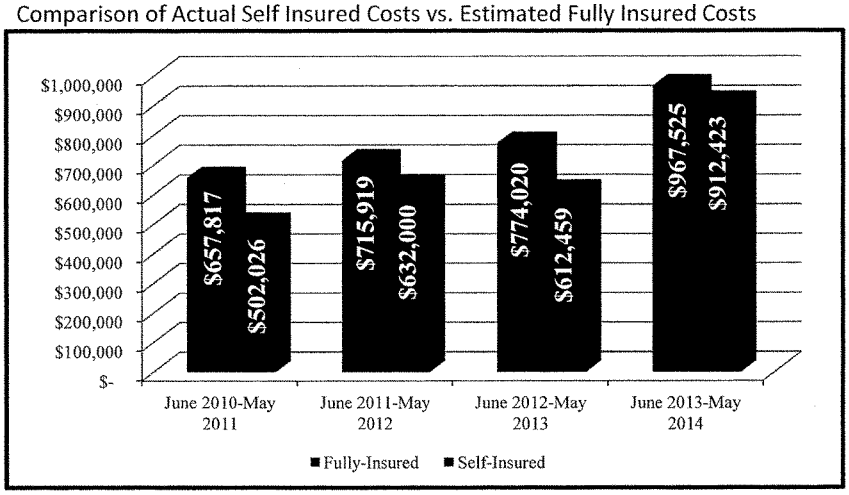
Sheffield Pharmaceuticals is a family owned, mid-sized manufacturer of over the counter toothpastes, creams and ointments located in New London, Connecticut. Over the past decade Sheffield has grown to a company with roughly $30 Million in revenue and an employer of 162 workers. Sheffield provides health insurance to 75 of these employees and their families.

Like all big and small businesses, every year Sheffield would meet with their insurance consultant, evaluate their health care costs and send its health insurance plan out to bid to try to gather competitive quotes. While every year a modest increase was expected, starting in 2005 the increases began to average over 10% per year. At times they would look to lessen the blow of this increase by either increasing the employees' share of premiums or by cutting back on some of the benefits. This worked somewhat effectively until 2008. In that year, a small amount of employees in the company experienced significant health issues which drove our utilization up. In response, their existing health insurance provider increased their rates 25%. This was followed up in 2009 when their provider told them told that due to their high utilization, their rates would increase 39% while other providers quoted higher. They began looking closely at self-insurance as a viable option with their insurance consultant. They evaluated and weighed the potential positive benefits of being able to gain greater awareness and mastery of our total

health care costs versus the potential negatives of not having a fixed cost to budget, along with the potential for a catastrophic occurrence to severely impact our costs. It was believed that due to the relatively good health of the employees, the odds of having another high utilization year were low. When we asked our insurance consultant if he expected the insurance provider to reduce premiums following a better utilization year and he answered no, the decision to move to self insurance became an easy one for the company.

Based on estimates of the yearly average increases that the traditional health care plans charged in Connecticut for plans of our size, we believe that self insuring saved the company over $400,000 over the span of four years.

Comparison of Actual Self Insured Costs vs. Estimated Fully Insured Costs



This dollar figure amounts to roughly a 19% savings over the expected costs of insuring traditionally during this period. Our success with self insurance has allowed the company to realize savings which have allowed it to still provide "Gold" caliber insurance coverage to its employees that covers 75% of the total health care costs, all while holding the overall costs to the employees in check.

BENEFITS OF SELF INSURANCE TO SMALL BUSINESSES

There are a number of benefits that self insurance affords to plan sponsors. Below is a brief listing of some of the benefits:

- Improved cash flow
- Reduced claims
- Access to claim and utilization data
- Ability to analyze and compare expenses and utilization patterns and trends
- Transparency helps to support employee incentives and more effective employee communication
- Creative and customizable benefit plans suited specifically for a plan sponsors employee population and their dependants.

One example of the power of transparency that comes with a self-insured plan surfaced when we met with Sheffield Pharmaceuticals to review their claims and utilization data after their first year of self-insuring. The data showed that their employees had a higher utilization of the Emergency Room visits than what should have been expected. Further analysis showed that some employees were utilizing the ER for non emergency care items that normally should be handled by a physician, who typically charges a quarter of what hospitals do. By doing this, not only were these employees unknowingly increasing the costs to themselves and the plan but also they were negatively impacting their future health by not creating a regular relationship with a primary physician. By adjusting our plan to incentivize employees to find and utilize physicians instead of the emergency room, Sheffield was able to use its health data in a way that reduced overall employee and plan costs while also benefiting the current and future health of its employees.

Many plan sponsors that self-insure begin investing in the health of its employees, by implementing programs that educate and incentivize healthy habits amongst their employees. Program may include paying for yearly physicals, reducing the cost for prescriptions for chronic conditions, or offering rewards to employees who received yearly physicals. This allows employees and their physicians an opportunity to develop a health relationship and address potential major health issues before they occur. In addition to physicals, there are reward programs for employees that work towards maintaining healthy biometric levels, including cholesterol, blood pressure, body mass index and smoking activity is a popular approach used

today. By addressing these important health factors now, it's believed that an employees' future health can be dramatically improved, and cost stabilized.

CASE STUDY #2 (SpearUSA)

SpearUSA is a 300 employee company headquartered in Mason, OH. In 2011, they converted to a self-insured arrangement from a fully insured plan. By converting to a self-insured arrangement with the use of stop loss insurance, SpearUSA was able to reduce their three year healthcare spend by greater than $4.4Million.

Year	Average Emp's	Fully Insured Premium (FIP)	FIP Per Emp/Per Month	FI Increase	Self-Insured Expenses (SIE)	SIE Per Employee /Per Month	Self-Insured Increase	Actual Savings
2010	328	$3,461,320	$879.40	N/A	$3,461,320	$879.40	N/A	N/A
2011	328	$3,700,151	$940.08	6.90%	$2,326,814	$591.16	-32.78%	$1,373,337
2012	307	$3,758,346	$1,020.18	8.52%	$2,125,290	$576.90	-2.41%	$1,633,056
2013	302	$3,945,049	$1,088.59	6.71%	$2,510,857	$692.84	20.10%	$1,434,192
Total/Average		***$14,864,866***		***7.38%***	***$10,424,281***		***-5.03***	***$4,440,585***

SpearUSA was risk adverse and did not want to assume much of the liability and exposure. So, we assisted them in securing specific stop loss coverage with a conservative risk threshold, (e.g. $60,000 per individual) reducing their risk exposure under their self-insured plan and protecting them from catastrophic claims per individual greater than $60,000. By converting to a self-insured arrangement and using stop loss insurance to manage their risk, SpearUSA was able to reduce their healthcare spend by more than 36% after three years by capturing and analyzing their claims and utilization data, and modifying their plan design to a more focused offering taking into account the specific needs of the SpearUSA employees, and improving employee communications that both empowered and educated their covered members to be smarter consumers.

Since converting to a self-insured arrangement, SpearUSA has not increased employee contributions or reduced benefits.

CONCLUSION

In conclusion, I would like to thank the committee for the opportunity to speak with you about the true benefits and success that self-insurance has offered for nearly forty years. I believe a plan sponsors choice to self-insure with the use of quality and customizable stop loss insurance programs is essential if they're to have any chance of managing their future healthcare spend.

Robert J. Melillo

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Chairman ROE. Thank you very much.

And I am going to start the questioning, and I usually wait till the last but I have to go at 11 o'clock to another committee and testify, like you all are doing now, so someone is going to have to take my seat.

I really appreciate your being here today and I think we have seen the advantages and basically some of the complexities of health coverage. As you know, I spent over three decades as a physician practicing medicine dealing with all of this.

And I also spent a number of years as a city mayor dealing with exactly the same issues Mr. Kelley brought along with the self-insured, where we insured our employees, we insured our city workers and our teachers. And it was about 2,500, as best I recall, the total number, and we were able to take this flexibility.

And the thing that no one brought up, but I did read in your testimony that you had that is so valuable in self-insured plans is the transparency and the data that you get. You are able to control that data and see what is actually going on and where the claims are and what you need to do, what moves you need to make in your business to address that.

And so what we did was we set up a—first with diabetes. We screened everyone for diabetes. We found occult diabetes in our population, were able to start a cholesterol, hypertension, a smoking cessation program.

And I have gone through a number of these across the country and seen, Mr. Kelley, exactly the same thing. And I think that is why rising costs—and the premise of the *Affordable Care Act* was—we are going to increase access for people and lower costs.

One of the things that I was noticing in Ms. Calsyn's testimony—and she is correct, she says ultimately self-funding will lower costs for some employees who choose the self-funding path but raise it dramatically for others. What the *Affordable Care Act* has done is done exactly that: It has raised costs for 11 million people and lowered it for 6 million. It is already doing that now.

And that is why I think businesses are scrambling to look at self-insurance. And I can assure you that the practice I was in with 450 employees, Mr. Melillo, is going to be looking at that very model, because we have the traditional insurance plan that most people have now.

I think a question—I want to ask a couple of questions—how has—any of you who do these self-insurance plans—Mr. Kelley, you may want to mention this—how has the ACA affected you all with the $63 fee? Because I held a hearing in Concord, North Carolina, several months ago—eight or nine months ago—and it was a gold standard plan like you have. And, I mean, you have a plan that your employees pay nothing into, as I understood it. Am I correct?

Mr. KELLEY. That is correct. Yes, sir.

Chairman ROE. And basically they have wellness benefits, all the benefits, essentially, of the ACA, and yet you have the flexibility to design those plan benefits that best suit you. And I think that is the biggest knock I have on the ACA is that the essential health benefits telling me exactly what I need to buy—as a consumer and you as an employer figure out for your employees what is best for them to buy.

So if you could—I know there is a $63 fee. I know in Johnson City, Tennessee, the city manager told me it costs us $177,000. I know in Washington speak that is not a lot of money, but in Tennessee that is still a lot of money. So—

Mr. KELLEY. Thank you, sir. Yes, we do absorb those fees and we comply with the requirements of ACA, both in terms of coverage—we are a grandfathered plan, being established 22 years ago, but there are certainly some requirements that impact us. And indeed, if our plan shifts dramatically then that grandfathered status goes away and we comply with all the requirements stipulated in the ACA.

I want to speak more broadly to the point that you raised about how we determine our benefits. We determine our benefits by listening to our employees. You know, we are a small organization—115 active employees. We have a pool of 55 retirees who are just as vocal as the active employees.

And when they step forward and say, "Hey, you know, this doesn't seem right. Can we work on this?" we sit down with our consultants and we say, alright, what do we need to do to make this right? And we have been blessed by the fact that overall, claims have been reducing as employees realize that we are all in this together, and there has been a lot of ownership on the part of our employees.

And I have been very pleased. Our overall costs have been decreasing, and that is what has allowed us not to pass these costs onto our employees.

Chairman ROE. See I think one of the things you could do that the ACA didn't do that it should have done, and a lot of parts of it—26-year-olds, lifetime limits, preexisting conditions, I agree with all of that. The problem with it is that it prescripts what you must buy instead of you sitting down with your employees and finding exactly what they need as an employee and what—and how you can react to what their needs are.

I think instead of having us up here tell you what to do, you are deciding in Columbia, Tennessee what to do.

Mr. Melillo, very quickly, who should have a self-funded plan and who should not?

Mr. MELILLO. So, who should have the self-funded plan and who shouldn't actually comes down to the assessment process, and basically it determines a mindset. So if the employer or the plan sponsor is comfortable and understands all the facets that are involved with a self-funded program, has the financial capital to sustain itself on a program, those are the elements that they have to take into consideration.

Those five bullets I mentioned—you know, stability, population, you know, risk tolerance and management capability, et cetera—those elements are the things that you really have to sit down with a qualified, licensed broker or consultant to help you make that assessment. There are a number of things they need to take into account.

Chairman ROE. I thank you.

My time is expired.

Dr. Loebsack?

Mr. LOEBSACK. Thank you, Dr. Roe. Thanks again for having this hearing. It has been very informative. Looking forward to hearing some more Q&A.

First thing I want to ask, actually, is of Mr. Melillo, and then I am going to go to Ms. Calsyn.

Even before I ask my question, you know, it seems to me what we are talking about here are a number of issues. You know, when we talk about self-funding, a lot of it is from the employer perspective and I want to make sure we don't lose sight of the employees, as well, and the benefit structure and making sure that those folks have what they need. I understand all these things have to be taken into account when someone is being consulted—an employer is being consulted as whether they ought to self-fund or not.

But, Mr. Melillo, you mentioned that in those two cases over the course of a 3- or 4- or 5-year period that the premiums didn't increase—

Mr. MELILLO. Right.

Mr. LOEBSACK.—over those years. What was the comparison of the premium at the outset compared to when they were fully insured when they made that transition? How did the premium—how do the premiums compare to one another?

Mr. MELILLO. So the premium equivalent is based on what you would fund the account at, so what you project. You know, in one instance it was significantly lower. In my written testimony there is a chart and a graph for both with detail, okay?

As a matter of fact, the case in number one, which was Sheffield Pharmaceuticals, their number was approximately—in 2014 their premiums were—fully insured premiums would have been $967,000 and their self-funded funding level is projected to be $912,000. The prior year, which are the real numbers as opposed to projected, in 2013 Sheffield funded—their fully insured premiums would have been $774,000, and the self-funded—what they actually funded and paid for fees was $612,000.

Mr. LOEBSACK. Right. That is from the company—that is the total company perspective.

Mr. MELILLO. Right.

Mr. LOEBSACK. That is the aggregate. Right.

What about on an individual basis? When they moved from fully insured to self-funding did the premiums for the individuals go down? Did they change at all?

Mr. MELILLO. So again, it goes back to the employee contribution strategy, so some employers will use a percentage of what the premiums should be and the employee will pay a certain dollar amount. In this case the employee was set with a specific dollar amount—

Mr. LOEBSACK. Right.

Mr. MELILLO.—and what they did—from 2008 to present what the employee funds for their portion of the benefits has not increased.

Mr. LOEBSACK. I understand that, but I think to be fully accurate we need to compare what they are paying at the outset versus what they would have paid with a fully insured plan. That is my point. I don't know if you can get that—

Mr. MELILLO. Okay, so—

Mr. LOEBSACK.—data or not. It would be interesting to see that. Because it is great to talk about over time how their—and it is wonderful that their contribution doesn't increase, but it would be nice to see what it was at the outset because if it had gone up dramatically—and I am not saying it did; I don't know the answer to that and that would make some difference, obviously, too, in making a comparison between these two approaches—

Mr. MELILLO. Right.

Mr. LOEBSACK.—so if we could get that data, I don't know if that is possible, it is—

Mr. MELILLO. Oh, absolutely.

Mr. LOEBSACK. Okay.

Mr. MELILLO. But for what it is worth, the $612,000, what was actually funded, versus $774,000, one could argue that it would be relational. So if they are currently paying $50 per paycheck for their portion of benefits it would go up relational.

Mr. LOEBSACK. And I am not disregarding those numbers. Thank you.

Ms. Calsyn, in your testimony you state that workers could face coverage gaps if they get their coverage from a self-funded health plan because self-funded employers are not required to cover the Affordable Care Act's essential health benefits. Go back to that issue, the essential health benefits.

Am I correct that a worker in a self-funded plan could lack access to mental health and substance use disorder benefits, for example? Mental health is a very important issue, as you know, and mental health parity is a very important issue.

Ms. CALSYN. Well, this could come up in a variety of ways I think. First, because a self-funded plan is not subject to the EHB requirements they might decide not to have that category of benefits. You know, the witnesses here today have described plans that are very robust but there could be examples of smaller employers especially who are being marketed to exit—you know, to exit the fully insured market to move to self-insured markets. One of the ways they could save money by doing so is to structure their benefits in a way that don't include some of those categories.

Because the EHB requirement doesn't apply to these self-funded firms, you also have a kind of interesting, complicated interaction with the mental health parity law, too. So even though in theory the mental health parity law applies to firms of this size, if they decide not to include mental health coverage then they don't have to really worry about that.

The other situation, I think, where this might happen is there is a little bit of a downstream effect that could happen, too. You know, if somebody, said—take another essential health benefit that a lot of people say is going to raise a lot of cost. If you look at maternity care, for example, a plan might decide not to have that or limit that in some way. For very small firms if they decide to do that there also wouldn't be any protections under the Pregnancy Discrimination Act.

So, you know, in many cases you are not going to see this, but there could be places where the different overlapping laws that protect workers just simply—a few people can fall through the cracks.

Mr. LOEBSACK. Thank you.

Thank you, Dr. Roe, and I yield back.

Chairman ROE. Thank you.

Dr. DesJarlais, you are recognized.

Mr. DESJARLAIS. Mr. Ferguson, can you please elaborate on the impact federal regulation of stop-loss insurance may have on self-insured employers, especially smaller self-insured employers?

Mr. FERGUSON. Sure. I would be happy to.

As we talked about earlier, in a self-funded arrangement stop-loss insurance is a critical risk management tool to protect the solvency of the plan. And so most small and midsized employers will retain that coverage for that particular reason.

Now, the terms of those stop-loss policies will vary by the type of organization. It is sort of like any—if you think of any sort of insurance type of product that an employer might buy, they have to determine how much risk they want to take and how much risk that they want to insure, right? And that is the same with stop-loss insurance. And so depending on the particular employer, they may have different risk appetites for stop-loss insurance.

And just as a point of clarification, too, because sometimes this gets lost in the mix, when a self-insured employer retains stop-loss insurance the stop-loss insurance is basically an indemnity type insurance between the insurance carrier and the employer. The stop-loss insurer is not paying claims; it doesn't cover individuals; it doesn't pay providers.

It is a reimbursement mechanism between the employer and the insurer. And the employer has to first pay out those eligible claims and then they can seek reimbursement from the carrier.

So, sometimes there is a misperception that the employer transfers all the risk. Well, it is not exactly true. If you are a self-funded plan, any eligible claim that comes in, you have to pay it, then you have—after the fact you have a reimbursement mechanism with the carrier.

So, with that being said is stop-loss insurance is essential for employers—many employers to self-insure. And what we are hearing, or at least understood to be true, is that the administration has at least an interest—and we can't confirm this, but certainly an interest—in making it more difficult for employers to obtain stop-loss insurance as a way to sort of control a migration towards self-insurance.

So, to the extent that stop-loss insurance is made more difficult through a regulatory process, it will dissuade more employers from being able—or make it difficult for those employers to operate self-insured plans.

Mr. DESJARLAIS. Thank you.

Mr. Kelley, self-insured plans allow them far more flexibility to design a plan that is best for the employer and his or her workforce, as you have talked with Dr. Roe about. Could you share some specific examples of how Columbia Power has designed a plan that works best for its specific workforce?

Mr. KELLEY. Certainly. As I said, my organization got into this in 1992; I think we started covering employees in 1993. And of course, health insurance was a different animal back then, and what we have been able to do is to respond as sort of the requirements of our workforce dictates.

So there are certain coverages—mental health coverages were talked about, dental coverages, we are talking now about vision coverage, we are talking about early retiree coverage. These are all things that we are in discussions about because I think our employees and our workforce understand that there are costs associated with these things. Those costs impact the overall organization and they want to measure the benefits that they would receive versus the overall cost to the organization.

And so, we have had a very positive dialogue on that, and I think that a healthy employer does that. They engage their workforce and allows them in to sort of peer behind the curtain and understand how those costs are impacting the overall organization and making the employees a team member in that process.

Mr. DESJARLAIS. So you would agree that a company your size can better manage its 115 people than the federal government trying to manage 330 million people and try to do a one-size-fits-all?

Mr. KELLEY. You know, I think that there are—if there are minimum acceptable standards—we will certainly need minimal acceptable standards, but I think as you have seen in our organization, we go above and beyond that.

Now, we don't go above and beyond just simply to lavish excessive benefits on our employees, but we do try to be responsive and be a good community member and a good employer.

And it is always a balancing act and I think that is something that every employer has to balance. I think that there is a responsibility to be good to, in our case our ratepayers and private businesses, their shareholders or whatever their financial arrangements are, but you have to make sure that your workforce is protected and that you are being a strong community citizen. And part of that strong community citizen is to make sure that your employees are not disadvantaged when it comes to receiving health care or any other benefit.

Mr. DESJARLAIS. All right. Thank you.

I yield back.

Chairman ROE. Thank you.

Mr. Scott, you are recognized for five minutes.

Mr. SCOTT. Thank you, Mr. Chairman.

Ms. Calsyn, you indicated we have a zero sum game. If we allow healthier people to get out of the insurance pool that leaves those in the insurance pool with higher costs. Did you estimate that cost that it could—did you say it could get up to 25 percent higher for those left behind?

Ms. CALSYN. That was an analysis done by the Urban Institute, I believe in late 2012.

Mr. SCOTT. But the idea that healthier people can join a separate pool leaves those behind with much higher costs.

Ms. CALSYN. Right. I mean, there has been a lot of talk right now—so far in this hearing about the essential health benefits, but one of the key provisions that really helps small businesses in the Affordable Care Act is the risk pooling, and by taking out—if there is a mass shift and too many fully—I am sorry, too many fully funded, fully insured employers leave to go into the self-insured market you are going to create that problem.

When you talk—

Mr. SCOTT. Well, the lower cost for the self-insured doesn't happen by magic. It is arithmetic. I mean, you said it is lower because you have a healthier pool. How much of it is because of the lower benefits?

Ms. CALSYN. I am not really sure.

Mr. SCOTT. Mr. Melillo, do self-insured policies have a lower administrative cost? I know the significant portion of your policy payment goes to administration—it is estimated 10, 15, up to 20 percent or more in regular policies; Medicare can do it at about 2 percent.

Are the administrative costs in self-insured lower than regular insurance?

Mr. MELILLO. The answer is yes more often than not, and the reason being is when you unbundle the fully insured packaging what you are essentially doing is you are building your own all-star team, if you will, of a health insurance plan specific to the needs and desires of both the plan sponsor and the membership they are writing for, right? So now you have the opportunity to identify and administrator that serves specifically your need, can administer the plan that you want to administer. And you can market one carrier or administrator against another to leverage a better price.

Mr. SCOTT. Okay.

The annual reports, Mr. Kelley, indicated there are cost savings. One of the costs in a small—that is not reported on an annual basis for a small plan is the risk of a rare but catastrophic loss. You have got thousands of policies out there; only a couple are going to get hit with this catastrophic loss. Most of them will report nice savings and one or two unlucky ones will get busted.

How do you calculate the catastrophic loss?

Mr. KELLEY. Yes, sir. Well that gets into our stop-loss protection. So—

Mr. SCOTT. Is your stop-loss per individual or for the entire plan?

Mr. KELLEY. In our case, being a small organization, we have both. We have specific stop-loss at $30,000 per individual, so we are going to absorb the first $30,000. And then as Mr. Ferguson pointed out, we will be reimbursed over $30,000 by our stop-loss insurer.

And then we also have an aggregate cap over the whole of the organization that if our total health care claims exceed a certain amount, which is in our case, you know, well over $1 million, then there is insurance that kicks in at that point as well. So we are in a box. We are in a box in terms of an individual's exposure that we absorb and we are in a box in terms of the overall organization.

Mr. SCOTT. When you talk about those savings, how much of the savings are eroded by the fact that you had to get catastrophic insurance?

Mr. KELLEY. Well, it certainly helps because things can happen, right? I mean, people can get hit with a catastrophic incident. And so what we are absorbing in our sort of daily cash flow is the routine medical, and then that stop-loss is there to, as I said, hem us in.

Mr. SCOTT. You indicated you had a $1 million reserve.

Mr. KELLEY. Yes, sir.

Mr. SCOTT. Who helps calculate the reserve necessary to absorb those unusual losses?

Mr. KELLEY. That is a great question. We use a consultant that has helped us over the years manage this plan.

And before recent health care changes the decision was made, you know, we have claims that average between $1 million to $1.5 million a year. Therefore, once the reserve got to $1 million we would just sort of stop funding it once it exceeded $1 million.

With the current changes in the health care industry—and of course, many of the changes brought on—coming from Washington, D.C.—we have decided to remove that cap and we are just going to continue to fund that reserve once we exceed the $1 million mark because we just don't know what the future holds.

Mr. SCOTT.—Another question to Ms. Calsyn: You talked about discrimination. Is there any evidence that people in self-insured plans are being discriminated against in employment?

Ms. CALSYN. No. I think that what—the scenario that I laid out is, in the new concern—

Mr. SCOTT. Well, I mean, if an employer on a self-insured plan knows that a family policy would include a very sick child, is there any evidence that would count against an employee in terms of prospective employment?

Ms. CALSYN. It certainly could, and for—if there is a very sick child that—in most situations it would be a—if there was discrimination you would be able to—there are protections under the ADA for that. There are associational claims under the ADA. But for smaller employers who choose this path, they can be exempt from the ADA requirements so there is that risk.

Mr. MESSER. [Presiding.] Gentleman's time has expired.

Would next like to recognize my good friend and colleague from the great state of Indiana, Dr. Bucshon, for five minutes.

Mr. BUCSHON. Thank you very much.

I was a practicing cardiovascular and thoracic surgeon for 15 years so I have spent my career in health care and, you know, the ACA I think has a few good things in there that we have talked about—preexisting conditions, children are 26, Medicare donut hole, lifetime caps, all of which I have had experience with in my medical career, seeing patients all across those categories, and one employee in meeting their lifetime cap—actually their spouse. But the thing that the ACA does not do is change the trajectory of health care inflation and the cost of health care overall.

Some of the things that Dr. Roe discussed about making sure that we identify people early that have diabetes, people that have obesity problems, hypertension, and other things that affect their lives maybe 30 years down the line are extremely important, and I have always been a believer in preventive health care measures. And in fairness, that is one thing our medical system probably has not done as well as we should have historically.

But if we are going to ever get control of this we have to address the cost of health care. Providing coverage, either through Medicaid or through exchanges or through private policies or through self-insurance, is something that is a noble goal.

I want everybody to have access to quality, affordable health care, but unless we get the cost down we are not going to be able

to sustain it. It doesn't matter what we discuss, how to cover people. We just are not going to fix that.

So with that, Ms. Calsyn, I wanted to ask you, do you think citizens in our country should pay anything for our health care? I mean individually, like should they have to pay anything to get health care?

Ms. CALSYN. I think that it—are you asking me if everybody should receive every single health care service for free?

Mr. BUCSHON. Yes, essentially.

Ms. CALSYN. I don't think that would necessarily be appropriate.

Mr. BUCSHON. Okay. Because you are here arguing today about, you know, discussing about an avenue that employers are taking on self-insurance and how that is something essentially, from what your testimony says, I think it seems like you don't believe that should be an option. So do you believe that employers should be able to self-insure?

Ms. CALSYN. I believe employers should be able to self-insure. I do believe that there should be appropriate oversight of the self-insured market. I think that marketing stop-loss policies that have extraordinarily low attachment points, for example, probably puts the employer in the exact same position as they would be if they were purchasing fully insured products.

Mr. BUCSHON. I know you are an attorney. Do you have a background in health insurance in the industry?

Ms. CALSYN. Before I went to the Department of Health and Human Services I was in private practice. I represented managed care organizations, other health insurers, fully insured employers—

Mr. BUCSHON. So you must understand, then, that people that are less healthy, so to speak, from an actuarial standpoint will affect the health insurance market. Because one of the things that the ACA is trying to do to control costs is to cap health care premiums for people that are unhealthy compared to people that are totally healthy, and, you know, it is basically disrupting the actuarial balance in trying to cover people.

I have always agreed that we should have—you know, we should have variance in price for what you have to pay as an individual for health insurance based on whether you smoke or whether you have diabetes that you haven't treated for 30 years. I was a heart surgeon and I can tell you if you have ever been in health care that personal responsibility is a big part of this.

I don't believe the government can legislate whether or not people will take care of themselves or not, and that is what we are trying to do here. So do you believe in the single-payer system? Yes or no? Like the federal government paying for having a single-payer health care system. Do you believe that would be the best way to go?

Ms. CALSYN. I believe that the best approach for this country right now is to implement the Affordable Care Act and work constructively across the aisle—

Mr. BUCSHON. So can you—

Ms. CALSYN.—between Democrats and Republicans, more progressive people such as myself, and conservatives to make the law better.

Mr. BUCSHON. Have you voiced that opinion to the administration, since they have delayed it over 22—I don't know, 29 times the law has been delayed? Have you voiced that opinion to supporters of the law in the administration or on the other side of the aisle? Because I agree with you.

I mean, President Lincoln said years ago the best way to repeal a bad law is to implement it strictly. And so, if this is a good law why do supporters like yourself continue to support delaying different aspects of the law when you think it is the best thing to do?

I mean, and with that, I yield back my time.

Mr. MESSER. The gentleman yields back.

Would next like to recognize the congresswoman from Oregon, Ms. Bonamici, for five minutes?

Ms. BONAMICI. Thank you very much, Mr. Chairman.

I want to thank all of you for testifying before the subcommittee today and sharing your expertise.

As you know, close to 4 million Americans have now signed up for health care since the insurance marketplaces opened. Additionally, many Americans are for the first time able to receive coverage and others are able to consider opening businesses or pursuing new careers without the fear of losing their insurance.

Even in my home state of Oregon, where the technology has been problematic, a couple hundred thousand Oregonians have now received coverage. We have reduced the number of uninsured by up to 20 percent.

So I am glad we are having this hearing today because it is important to make sure that we are building on the progress that we have made. It is important that we work to make sure that the goal is fulfilled, which is having access to high-quality health coverage.

Certainly self-insurance is important to discuss as part of that conversation and I am glad we are having this hearing today.

I wanted to ask you, Ms. Calsyn, you coauthored a report last year that warns of the consequences of businesses with young, healthy employees choosing to self-insure while businesses with comparatively fewer healthy employees join the fully insured market. This may concentrate risk in fully insured marketplaces and drive up costs.

But aside from that, I am really interested in how—your assessment of how self-funded plans affect the people receiving coverage. We have heard some success stories today, but what would be the concerns for employees receiving coverage through self-funded plans? Would there be a reason why an employee of a small business might prefer self-funded or fully insured?

Ms. CALSYN. I think that for many employees self-funded arrangements are fantastic. I think that those are usually larger employers.

I think that there are two groups of employees we need to worry about here. The first are employees who are in self-funded arrangements where their employers may not have as fully assessed the risk, may not be sophisticated enough to deal with it, and may have not, you know, dotted all the i's, crossed the t's in their contracts with stop-loss carriers and other third parties.

In those cases, the employer could potentially be at risk for unforeseen costs. They might not be protected, and obviously when a small business is in economic distress its employees are, too.

You also have a situation in which a self-funded—a very small business might decide to—that they—because they have very young, very healthy employees they want to leave the fully insured market and self-fund. In that case the benefit structure might be a little different. It might not cover certain categories of benefits that the employee would like to see.

I think where we are losing a lot—where some of the focus needs to turn back to is the balancing act—you know, these arrangements might be great for a lot of people in these plans, but there are also the people who—and the small business owners who are stuck in the fully insured market. And if too many of the healthy employees—I am sorry, employers with healthy employees moved into the self-funding route you can leave a lot of people in the fully insured market who are older and sicker and they could see their premiums go up, and it is obviously not just bad for them but it is also bad for the employers who are there.

Ms. BONAMICI. Thank you.

I have a couple more questions. And as I said, we have heard some success stories today.

Mr. Kelley, yours was a positive example, and congratulations to your company for your success. Clearly it has worked for your organization.

Are there circumstances that would keep a company away from that kind of success? What I want to ask is, is there a business that is too small to self-insure? I would like to hear from each of you briefly.

Mr.—is it Melio?

Mr. MELILLO. It is Melillo.

Ms. BONAMICI. Melillo.

Mr. MELILLO. So the, you know, the question is, is a group too small? I think that is like seven or eight on the list of things you need to assess when considering self-funding.

You know, for example, if you are a small or a large company that is chasing a balance sheet, right, that is chasing receivables and your revenue stream isn't as strong and your capital situation doesn't preclude you—doesn't set you up for success—you don't have anything to fall back on, that is a group that a wise consultant would not, you know, suggest self-funding to.

Ms. BONAMICI. Thank you. And I do want to hear real briefly from the others.

Is there a group that—business that would be too small to self-insure?

Mr. KELLEY. I would say, speaking as a public employer, you need to make sure that the policymakers are going to adequately continue to fund the plan. You may have years of savings and you may take your hands off and lower your budget expectations and the next year there is a swing. You have to be consistent in your application of funding and not let it jump around and not let local politics sort of absorb those savings and then be surprised when there is an increase.

Ms. BONAMICI. Right.

What do you think, Mr. Ferguson?

Mr. FERGUSON. I would quickly echo Rob's comment. It is largely a balance sheet decision, and secondarily it is a corporate culture decision in the sense that I mentioned earlier, is if you are not willing—you meaning the management of the company—to take the time to properly structure the plan then you are probably not a good candidate for self-insurance.

Ms. BONAMICI. Thank you.

And I see my time is expired. Thank you, Mr. Chairman. I yield back.

Mr. MESSER. The gentlelady yields back.

Would next like to recognize the gentleman from Texas, Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Mr. Chairman.

Before I ask some questions I want to thank the panelists for coming before us and sharing your thoughts and recommendations.

I wish to identify myself with—or my remarks with Congresswoman Bonamici because I heard my colleague on the other side of the aisle talk about why he doesn't like ACA, and he reminds me of the 30 percent who didn't like Social Security, reminds me of the 30 percent who didn't like Medicare and Medicaid. And it took years to make them work as they do today, to where most Americans fight to make sure that those programs stay in place.

So I, too, support ACA and am pleased to hear about what the options are for small businesses.

Ms. Calsyn, one of the aspects of your testimony I found most troubling was the practice of lasering. This is the process where a stop-loss insurance plan can set its attachment point, which is the specified limit when they will start to pay for an individual or a claim, at a relatively low amount for most employees but target a specific employee who has cancer or some other serious medical condition and set their attachment point at an exorbitantly high amount, placing the small business into much more financial risk. This, to me, is—or rather, this, to me, undermines the very notion of insurance, which is why some states have moved to ban the practice outright.

How do you believe this practice would impact truly small businesses that decide to go the route of self-funded insurance?

Ms. CALSYN. I just want to clarify one point with the lasering. A laser is a modification in the agreement between the employer and the stop-loss carrier. So an employee probably will not know that they are—that they have a laser on them. You know, they go ahead and keep paying and on the surface it will look the same way.

However, it does set up a source of concern for especially a much smaller employer. It sets up another reason why a small employer may not, say, for example, wish to hire somebody, or may set up a way that there could be a motivation for some sort of employment discrimination.

If you, say, have, you know, a very small pool you are—if you have a small number of employees you are going to know exactly who the costliest employees are. You know, there can be some other downstream effects, I think, of the laser, but I just wanted

to make it clear that it is not that person is going to pay more, but there could be adverse downstream effects.

Mr. HINOJOSA. Thank you for your explanation.

Mr. Melillo, I want to thank you for your testimony today. In that statement that I read about your statement you stated that "most fully insured programs offer a canned plan design, loaded with state mandated benefits packaged by the insurance carrier and often do not address your financial goals and unique needs." Isn't that just another way of saying that businesses can switch to this self-funded plan as a way of avoiding covering the categories of benefits that workers deserve?

Mr. MELILLO. I tend to be an optimist, and I actually take that as to say you can enrich your benefits, for example, you know, even richer than what is offered in the state. So for example, Sheffield Pharmaceuticals offers a gold standard plan at the premium equivalent rates of a silver. So, you know, it is not a matter of dodging or avoiding benefits; it is a matter of addressing the specific needs of the population and then financing those needs.

Mr. HINOJOSA. Thank you.

Ms. Calsyn, in recent years the administration expressed concerns that some of the smaller employers may start to self-insure while also including stop-loss insurance with extremely low attachment points in order to avoid some of the new requirements of ACA. In your testimony you said tactics "start to blur the line between self-insured plans and self-funded plants." What are the remedies that you think we should put in place to discourage that kind of activity?

Ms. CALSYN. There are different approaches you could take. There are some states who have been a little bit more active in this area, so one way for—if an individual state saw a problem they could raise minimum attachment levels. Or, for example, in some states they limit the group size who can take this approach.

In the federal level there is probably two different ways. There is language in the Affordable Care Act that could probably be defined to take a closer look at, you know, if somebody is self-insured are they really, in fact, self-insured? Are they actually taking on any financial risk in exchange for this flexibility and these benefits?

Mr. HINOJOSA. Thank you.

Mr. MESSER. The gentleman's time is expired.

Would next recognize congressman from Connecticut, Mr. Courtney, for five minutes?

Mr. COURTNEY. Thank you, Mr. Chairman, and thank you for holding this hearing today, and particularly, having the wisdom of inviting Mr. Melillo, who is my neighbor in Glastonbury, Connecticut.

And we are a state where, you know, actually it was in the New York Times yesterday that when the exchange was set up last summer HHS set a target of 100,000 enrollment through the exchange; we are now over 130,000 with another 6 weeks to go before the end of the March deadline. We had a governor who embraced the ACA and actually had some good people set up a Web site who—you know, they built a Ford Focus, they didn't try to build a Maserati,

and as a result they had a website which actually functions and works.

And what is really exciting is that we are at 238 percent of the target for qualified health plans—in other words, the private side of the exchange—and we know we are going to have at least another three or four insurers who are knocking on the door for next year's enrollment, so, you know, but I would say this, I mean, self-insurance is also, in my opinion, not incompatible with the ACA.

I was at Town Fair Tire on Monday, which I know Mr. Melillo is familiar with down in East Haven, Connecticut. They have 1,800 employees. You know, the employer is actually a pro-ACA guy but, you know, he said, "We are just going to continue with our self-insured plan, which provides good, solid benefits."

By the way, I have been to Sheffield Pharmaceutical. New London is in my district, and it is a great company and they care about their employees and they are doing a great job, as your testimony points out, in terms of, you know, using the self-insured mechanism as a way of, you know, making their business work and keeping, you know, retention high with their workforce.

I guess the question I would just want to sort of explore for a second here—and, Mr. Kelley, you might be the right person to ask—is that we actually had a community in my district which a number of years ago, pre-ACA, self-insured, you know, its education and townside employees. Apparently the finance office forgot to pay for the reinsurance premium for a given year and, I mean, it was a—just, you know, the worst timing ever because they had some catastrophic claims that came in that just completely capsized, you know, what they had in their reserve account.

And frankly, the town's retirees are paying through the nose in the wake of that. They are hopefully at a point where they are going to be able to kind of, you know, restabilize. But I will tell you, it was a real hit on retirees who, as, again, Rob—you know, the state of Connecticut teacher pension plan is actually pretty meager for some folks of a different generation, so this was—you know, and again, they were helpless in terms of, you know, where they could turn in terms of what was clearly, you know, a misadministration of the plan.

And I guess I would just sort of wonder whether you sort of have thoughts of this. I mean, again, obviously you have got to have some kind of reinsurance mechanism, whether it is small or large or private sector or public sector, to make sure that you are not going to have, you know, really disruptive increase in out-of-pocket for employees or retirees.

So should there be a mandate? I mean, you know, really, because it was a pretty big problem, you know, because—again, it wasn't malicious. It was just, you know, somebody messed up.

Mr. KELLEY. There is no doubt that being self-insured places additional administrative burdens on an organization, but there are benefits and savings to be had—

Mr. COURTNEY. No question. That is not the debate. The question is how do you ensure that you are not going to have those kinds of horror shows?

Mr. KELLEY. When I think about the horror story you just talked about, it is not dissimilar to what can happen to a pension plan

that is not properly funded, and then that pension plan ends up getting upside down and then the retirees are bearing the burden of that, or future ratepayers or other public entities are paying for that support.

So, I think that it calls for effective management across the board, but I would want to look at that from a regulatory standpoint in the same overall umbrella of all employee benefits. You know, there are a lot of benefits that employers provide employees, and that is good, standard business practices, and when something falls apart there needs to be an account—people need to be held accountable and then you move on.

But I don't necessarily know that it is appropriate to single out health care with a particular focus when we are not providing that same level of scrutiny and belt and suspenders approach to all employee benefits.

Mr. COURTNEY. Okay.

Mr. Melillo?

Mr. MELILLO. You know, I would like to add that if it was a fully insured plan and premiums had lapsed coverage would have lapsed, but in this case, because the burden fell back on the employer and they are the ones who actually made the mistake, the employee still received their benefits, they just didn't get a reimbursement from their reinsurance or their stop-loss carrier because of their administrative mistake. So in this case it turned out to be a positive for the employee because they still had their coverage.

Mr. COURTNEY. Well, you know, again, I would love to have those teachers come in and sit down with you because it was—you know, it was again, they wanted me to call the Secretary Sebelius to try and intervene with the town, which obviously, you know, wasn't going anywhere. And it was a—you know, it was not pretty.

So with that, anyway, I yield back, Mr. Chairman.

Chairman ROE. [Presiding.] I thank the gentleman for yielding.

Mr. Messer, you are recognized for five minutes?

Mr. MESSER. Thank you, Mr. Chairman. Thank you for this important hearing. Obviously the challenges with the ACA are many and well documented, my opposition well documented as well, so I would rather focus today on the subject matter before us.

The employer-sponsored health insurance is the predominant source of coverage for individuals and families. In a near-term world that will remain true under the ACA, self-insurance is an important option and tool for employers, and stop-loss insurance an important tool in those self-insurance efforts.

I would like to focus first on Mr. Melillo, and your testimony discusses the financial stability of self-insured plans, and I want to ask a couple questions together that maybe you can respond to.

Is the financial stability of these self-insured plans due solely to a reliance on stop-loss insurance? Maybe said a different way, how—could you talk a little bit more detail about how stop-loss insurance is used by a self-employed insurer? And for example, do employers ever change their stop-loss insurance coverage levels?

Mr. MELILLO. The answer is all of the above. The stop-loss is used as a financial risk lever to help the plan manage what they believe their exposure to be. The lower the stop-loss deductible that they choose to buy, the greater the premiums.

And so by ceding the risk back to an insurance company, their favorable experience below that deductible starts to erode. It goes back to the reinsurance or the stop-loss carrier.

That being said, one of the benefits to self-funding is to benefit from the increased cash flow and positive results. It is common to see a group or a plan move their stop-loss deductible based on their balance sheet, based on their risk tolerance level, and a number of other key factors.

But the stop-loss, it is important to note that more often than not, the percentage of stop-loss premiums that make up the entire annual spend is typically between 5 and 15 percent of the total spend, so it tends to be a small piece.

Mr. MESSER. Okay. And your testimony provides great examples of how self-insurance—self-insured plans allow the employer more flexibility, as you just described, to design a plan that is best for the employer and his or her workforce. Could you please share additional examples of a unique workforce and how an employer might design a plan that was best suited for that workforce?

Mr. MELILLO. So I could go through—I have an example of a group that used the data that came from their utilization experience where they identified that there was a great deal of emergency room visits occurring—greater than the national average, greater than the regional average, greater than their SIC code. That being said, they realized that it was a communication issue and they realized that they weren't being steered, informed, or incentivized to use clinics or walk-in centers for things like a runny nose or minor issues. We identified that data, made modifications to the plan design, and the E.R. costs went down dramatically.

Mr. MESSER. Great.

For Mr. Ferguson, in a recent final rule issued by the Department of Treasury, the administration reiterated its concern regarding stop-loss insurance, stating stop-loss plans with low attachment points are a, quote—"functionally equivalent alternative," end quote, to a fully insured group health plan. Mr. Ferguson, are stop-loss plans the functional equivalent of a fully insured health plan? And what data exists to—what, if any, data exists to support the administration's concern that self-insured plans are utilizing stop-loss insurance with low attachment points?

Mr. FERGUSON. Thanks for the question. First, a bit of terminology correction: There is no really such thing as a stop-loss plan. There is the plan—the employer-sponsored plan—and then there is stop-loss insurance or a stop-loss product. So it is important to sort of separate the plan from the actual—the insurance arrangement that is—serves as the backstop for that plan.

And again, as I mentioned earlier, the stop-loss is really the financial tool, which I think should be distinguished from the delivery of health benefits that is done through the plan.

Mr. MESSER. So comment on the Department of Treasury's—

Mr. FERGUSON. Well, the comment there is they are—you know, for some time we have been hearing concerns that the stop-loss insurance has facilitated, you know, a growth in the self-insurance marketplace and that is—potentially would have negative consequences, as one of the fellow witnesses has articulated. We don't agree with that.

We believe that the self—this is one of the tenets of the ACA, right, was to build on the employment-based health care system, and we agree. Size and organization, we have no comments to offer as to the overall merits of the ACA. We will leave that to other parties.

What we see our role here is to try to protect this segment of the marketplace that is working well. And to the extent that you have a regulatory process that has a result of making it more difficult for smaller and midsized employers to self-insure, well, not only do we not think that is good for our members and folks that are in the marketplace but again, going back to the origins of the ACA, if that compromises the employment-based health care system from a larger standpoint, we don't think that is positive.

Mr. MESSER. Thank you.

Chairman ROE. Thank you, Mr. Messer, and thank you for sitting in the chair.

Dr. Holt, you are recognized for five minutes?

Mr. HOLT. I thank the chair and thank the witnesses.

Ms. Calsyn, there has been reference to the CMS actuarial report that says 11 million workers in small-group plans will see premiums rise. That has been used as an argument that the Affordable Care Act is a failure. Wasn't that report responding really to a fairly narrow inquiry? Can you put it in perspective, please?

Ms. CALSYN. The report was analyzing the effect of three discrete provisions in the law. It was looking at guaranteed issue, renewability, and community rating, I believe—

Mr. HOLT. Yes, you are right—

Ms. CALSYN.—So there are plenty of other provisions of the law that are going to have an effect throughout the economy. And CMS stated that in the report and they are—I believe that they are looking into that and planning on issuing another report that is a little bit more comprehensive.

The thing that I think that is also important to remember about the—you know, the 11 million, six million is it is really a snapshot in time. It is the 11 million small businesses that right now are healthier than average, have lower cost than average.

But especially for a lot of smaller businesses, you know, that can change overnight. You know, there was reference to the AOL situation with the high-cost babies, and if that happens to a smaller employer, you know, that person is automatically going to—that group is going to go from the 11 million losers to the six million winners. And I think that what is really important about the ACA is this risk—

Mr. HOLT. By six million winners you mean the premiums go down.

Ms. CALSYN. Premiums go down, yes.

Mr. HOLT. Okay.

Ms. CALSYN. And like any health care reform, any changes to our health care system, there are going to be people who benefit and people who, at a particular time, might see themselves as worse off. And I think that stepping back and looking at the benefits for people even who might be healthier now is always an important thing to keep in mind.

Mr. HOLT. Okay. Again, to make sure that the details and the complications here aren't misused as an indictment of the entire attempt to reform health care in America and go back to something that a lot of people thought was working fine but anybody who knew about it realized was unsustainable, unfair, inequitable, and provided worse health care coverage than we would want for our people.

Let me ask you about job lock. How has the *Affordable Care Act* reduced job lock and how important is that?

Ms. CALSYN. Well, I think that has always been a concern, I think, for members on both sides of the aisle, and the Affordable Care Act, by making the individual market an actual viable alternative for people they are able to not just see their current job as their only option for health care. As a result there are going to be productivity gains, there—lower health care costs, increased wages. So there are a large number of economic benefits to the law that CBO has pointed out.

Mr. HOLT. You spoke a little bit about churn, people moving in and out of self-funded, fully insured markets. What has been the—could you describe that a little bit better in terms that an ordinary person would understand? And how would one guard against any negative effects of that churn?

Ms. CALSYN. Well, the churn would result if there—if we start with the assumption—and this is completely oversimplifying it—if you start with the assumption that there are X number of fully insured plans right now and they do an assessment and they decide that they have lower risk than average and that group decides to go into a self-funded arrangement, and then say three to five years down the line they realize: Oh, wow. My group that was, say, all in their 20s and 30s, now they are getting a little bit older, you know, as we all age—a little more risk of health issues, you know, and they might then do another assessment and then put their group back into the fully insured market.

Now, this isn't something that they can do overnight. There is obviously a large—you know, there are a lot of business decisions that need to be made into this, but it is so much easier for—I should say it is so much financially more feasible for younger or healthier-than-average groups to self-fund, and by drawing out those people, the people who remain in your fully funded market are probably going to see increased premiums.

Mr. HOLT. And so, that could be a nasty surprise for people who are unaware that they are involved in this churn.

Ms. CALSYN. Right. Exactly. And again, I just—I think that it is so important to remember that, you know, even if you are healthy today, you are not going to be healthy—you might not be healthy tomorrow. And looking back at what the issues were and the horror stories we heard before the ACA is always kind of—is always very important to keep in the back of your mind when discussing these issues.

Mr. HOLT. Thank you.

Thank you, Mr. Chairman.

Chairman ROE. I thank you very much.

And I thank the panel. Terrific job.

And I am sorry I had to step out, but I am going to ask my colleagues here to support the bill I was over testifying, which is a bill of mine to build a memorial for Desert Storm/Desert Shield veterans, so that is why I stepped out for just a minute.

And I appreciate this. This was a very, very good panel and everyone did a good job of staying in time.

I will now yield to Dr. Loebsack for his closing comments?

Mr. LOEBSACK. Thank you, Dr. Roe. I do want to thank you again for convening this hearing.

And I do want to thank all the witnesses today. It has been very informative, I think, for all of us here. It has been a great discussion about the self-insurance market and about the risks and the benefits, really, of self-funding health care.

Do look forward to a couple of answers in terms of sort of what those premiums would have been had they stayed in the fully insured market, if that is possible. I don't know that it is possible, but it would be great to get those numbers so we can compare apples and apples on that. I appreciate that, Mr. Melillo.

And as work continues going forward I think it is really critical that we think very carefully about how to balance the needs of both small and large businesses, but also what the Affordable Care Act's goal of increasing access to affordable, quality health care for all employees. This is a balancing act, there is no question about it.

We have to take into account, clearly, what businesses' calculations are and all the rest, but we have to be thinking about the health care benefits that are there and available to folks, because the idea is to do what we can to make sure that everyone is covered and has access to quality, affordable health care.

So, I look forward to working with my colleagues on both sides of the aisle as we go forward, hopefully fixing the ACA and doing everything we can to ensure that folks have that access. Thank you very much.

And thank you, Dr. Roe.

Chairman ROE. I thank the gentleman for yielding.

And I will once again thank the panel for being here.

And I am going to just think out loud for a minute as we close. When businesses are out there, as I was in for 30-something years, and we grew our medical practice from four doctors and 12 employees, we now have 100 providers and 450 employees, all primary care, all still independently operating in Johnson City, Tennessee.

And when I became more aware of the self-insurance market—we just use traditional insurance and, Mr. Kelley, I think you pointed it out extremely well—what I do every year is look at our budget and see how much money we are going to spend on health insurance coverage for our employees. And every year it changed a little bit. There would be some changes in the plan.

But as you begin to look at whether you self-insure or not, I guess it is like—Mr. Melillo, you maybe brought this up about how much stop-loss insurance you will buy. It isn't cheap, by the way. I know when you buy it isn't inexpensive. It is a significant cost—5 percent or 10 percent of $900,000 is still a lot of money.

And so the way I looked at it is, how much loss can I stand? The way I do it is like going into a casino and you write a check, and

how much can I stand and walk out of here if I throw it in the garbage can, which if you walk into a casino you are going to do.

So you just say, how much risk can I take in this business? And you look at it and then you calculate, can I work that into my business plan?

And it is a very simple decision that you make and you are absolutely right, you have to have the right consultant. That consultant has to advise you to have deep enough pockets to sustain—I wish I could have heard Mr. Courtney—all of his testimony because, Mr. Kelley, you pointed out it is not just health insurance that can be mismanaged. We are dealing right now with multiemployer pension plans on this subcommittee—this very thing that we have to get right this year, so it is mainly employee benefits we are talking about.

So you look at that, and this is a plan right now that is working very well in many places. And sure, there are places where it has been mismanaged. I am sure any plan can say that.

But if you look at our community, the money we have saved, you are able to go in and initiate wellness programs that we did in diabetes, hypertension, smoking, weight loss, and so on that have really affected the lives and made the employees' lives better and made your insurance cheaper. And that is certainly what the scenario that you point out and Mr. Ferguson and all of you pointed out.

And I think, Ms. Calsyn, that is the same thing you would want, too.

As far as job loss is concerned—and I will have to respectfully disagree. I was at a—and hopefully when this works out five or 10 years from now if the ACA is still in effect it will do what you say, but I am in a hospital system that had a referral center with a medical school, of which I was on the clinical faculty for over 25 years. We have lost 1,000 employees. There are registered nurses now that are worried to death that they are going to lose their jobs.

There is a major medical center in my state that has laid off 1,000 people. These are great jobs. And you take a town my size of 65,000 people and we have lost 1,000 jobs. And it has caused great disruption.

And I think right now what the federal government needs to do is stay out of the part—there is so much uncertainty out there about how businesses deal with the ACA—is before we do anything else to any part of the insurance market, let's just leave it alone. Let's do what I used to say in medicine and provide skillful neglect. That is also a thing you can do that is a good thing to do is just don't do anything right now and let this sort of settle out so we can see where the dust falls.

And I would also like to ask, Ms. Calsyn, if you could supply any data that—on the last statement you made to Dr. Holt about job creation and so forth, and also about the churning of people getting in and healthy populations. I know in 30 years we never did that. We simply looked at how much our budget was, what we could afford, and we wanted to provide, as Mr. Kelley did, the absolute best benefits we could to our employees because we think—and I still think so today—you get a better employee by doing that. And I think that is what most employers want to do if they can afford it.

So we had a very, very good hearing today and I certainly learned a lot. And I appreciate my colleagues on both sides of the aisle.

Mr. Holt—

Mr. HOLT. Would the gentleman yield?

Chairman ROE. I will.

Mr. HOLT. I will just in 15 seconds say that if the chairman is looking for a jobs program I think you can do better than setting up a health care system that neglects tens of millions of people and excludes them.

Chairman ROE. Reclaiming my time, I totally agree with you. I think we should—I think we absolutely should look at a program, and I agree with the idea of increasing access, increasing quality, lowering costs, and trying to cover all Americans. I could not agree more with you on that.

I want to thank, again, our witnesses.

With no further comments, the hearing is adjourned.

[Questions submitted for the record:]

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March 20, 2014

Mr. Robert Melillo
National Vice President of Risk Financing Solutions
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Dear Mr. Melillo:

Thank you for testifying at the February 26, 2014 Subcommittee on Health, Employment, Labor and Pensions hearing entitled, "Providing Access to Affordable, Flexible Health Plans through Self-Insurance." I appreciate your participation.

Enclosed are additional questions submitted by committee members following the hearing. Please provide written responses no later than April 3, 2014, for inclusion in the official hearing record. Responses should be sent to Benjamin Hoog of the committee staff, who can be contacted at (202) 225-4527.

Thank you again for your contribution to the work of the committee.

Sincerely,

Phil Roe
Chairman
Subcommittee on Health, Employment,
Labor, and Pensions

Questions Submitted by Representative David Loebsack:

1. You state in your testimony that the employee contribution for your business's coverage did not increase over a 4-year period. What were the premiums for those years, and how do they compare to premiums for the fully-insured plans your business could have chosen?

[Whereupon, at 11:37 a.m., the subcommittee was adjourned.]

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