



Self-Insurance and the Potential Effects of Health Reform on the Small-Group Market

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OVERVIEW — *The Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care Education Reconciliation Act of 2010 makes landmark changes to health insurance markets. Individual and small-group insurance plans and markets will see the biggest changes, but PPACA also affects large employer and self-insured plans by imposing rules for benefit design and health plan practices. Over half of workers—most often those in very large firms—are covered by self-insured health plans in which employers (or employee groups) bear all or some of the risk of providing insurance coverage to a defined population of workers and their dependents. As PPACA provisions become effective, some have argued that smaller firms that offer insurance may opt to self-insure their health benefits because of new small-group market rules. Such a shift could affect risk pooling in the small-group market. This paper examines the definition and prevalence of self-insured health plans, the application of PPACA provisions to these plans, and the possible effects on the broader health insurance market, should many more employers decide to self-insure.*

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More non-elderly Americans obtain health insurance coverage from an employer-sponsored insurance plan than from any other source.¹ Employer-sponsored insurance can be fully insured or self-insured (Table 1).² Employers that choose to fully insure pay premiums to commercial insurers or health maintenance organizations (HMOs) that, in turn, pay providers and assume financial responsibility for the costs of all claims. Employers who self-insure bear all or some of the risk for paying incurred claims. They typically contract with third-party administrators (TPAs) that administer the plan according to a formal document, which sets forth the employer’s specifications for benefits and administrative procedures and is required by federal law.³ Self-insured employers may purchase stop-loss coverage to protect against large payouts (discussed in detail later). In both self-insured and fully insured plans, employers and most workers contribute toward the cost of coverage.

TABLE 1
Characteristics of Fully Insured and Self-Insured Plans

	Fully Insured plan	Self-Insured plan
Bear risk of claims	Commercial insurer or HMO	Employer (or employee group) and stop loss insurer
Perform administrative functions	Commercial insurer or HMO	Third-party administrator (often an insurance company)
Pay for coverage	Employer and/or employee pay premiums to a commercial insurer or HMO	Employees may pay “premium” and employer pays balance of incurred claims
Regulate	Primarily state (Department of Insurance)	Federal (Department of Labor)

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ADVANTAGES AND FEASIBILITY OF SELF-INSURING FOR EMPLOYERS

Self-insuring confers several advantages on employers. Employers self-insure so their benefit plans are not subject to state health insurance regulations and benefit mandates. Because benefit mandates can vary across states and even conflict, self-insurance allows multi-state employers to offer uniform benefits to workers in different locations. Self-insuring firms may also realize greater control over designing plan benefits, provider networks, and employee cost sharing. Further, their costs are based on their own claims experience and are not pooled with others, as they might be for smaller groups purchasing fully insured plans. Therefore, even some smaller firms with a young, healthy workforce may find self-insuring particularly advantageous. Other benefits of self-insuring include maintaining control over reserves; not having to pre-pay for coverage, thus providing for improved cash flow; and not being subject to state health insurance premium taxes. Employers may also save on plan administration.⁴

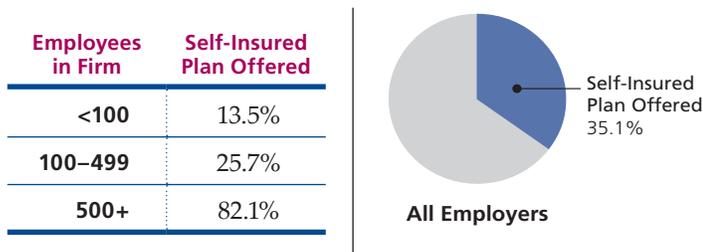
To realize the advantages of self-insuring, employers need to have the ability to assume risk without threatening their solvency. To self-insure, employers must be able to manage variability in costs from year to year. Generally, that requires that they have a sufficiently large workforce over which to spread the risk of insuring their employees and their dependents. As a result, large firms are more likely to have the ability to manage the financial risks of self-insuring and gain from its advantages. But large firms are not the only ones able to self-insure because firms—even small ones—can purchase the ability to manage risk, as discussed in the section “Stop-Loss Insurance.”

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Prevalence of Self-Insurance

Self-insured plans are the most common source of health insurance for American workers. In 2009, 57 percent of covered workers were enrolled in a partially or fully self-insured health plan.⁵ The share of workers in self-insured plans has increased markedly since the passage of the Employer Retirement Income Security Act (ERISA) of 1974 (discussed in the next section).⁶ As shown in Figure 1 (next page), self-insured plans are much more common among the largest firms (500 or more employees) than among firms with fewer employees.⁷ The Employer Health Benefits 2010 Annual Survey by the Kaiser Family Foundation and Health Research & Educational Trust similarly

FIGURE 1
Percentage of Private-Sector Firms Offering Health Insurance That Offer Self-Insured Plans



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends, 2009 Medical Expenditures Panel Survey-Insurance Component, table I.A.2.a, “Percent of private-sector establishments that offer health insurance that self-insure at least one plan by firm size and selected characteristics: United States, 2009,” 2009.

showed that the share of covered workers in self-funded plans increases with the number of workers in the firm.⁸

Statutory and Regulatory Framework for Self-Insured Plans

Legal authority over employer-sponsored plans depends on whether a plan is fully insured or self-insured. According to the McCarran-Ferguson Act of 1945, the “business of insurance” is to be regulated by the states. However, ERISA, which applies to private,⁹ employer-sponsored plans, pre-empts state regulation of employee benefits, including employer-sponsored health plans.¹⁰ As a

result, states are permitted to regulate insurers, including insured ERISA plans, but they may not regulate self-insured plans. ERISA pre-emption of state regulation of self-insured employer plans¹¹ in effect means that such plans are not subject to laws or regulations that states impose, such as benefit mandates, assessments on health insurers, and other requirements for insurers such as reserve requirements. As the Government Accountability Office (GAO, then called the General Accounting Office) pointed out in 1995, ERISA pre-emption of state regulation of self-insured plans results in different applicable regulatory frameworks “depending on whether the employer purchases its health care coverage from an insurer, which the state regulates, or self-funds its health plan, avoiding many state regulations.”¹²

Precisely when state law is pre-empted has proven to be less than clear for state regulators who must determine which insurance entities and products are under their regulatory authority. In a paper from 2008, Phyllis Borzi (currently assistant secretary of labor of the Employee Benefits Security Administration) pointed out that, in enacting ERISA, “Congress did not establish the type of comprehensive and detailed regulatory scheme for health benefit plans (the largest group of ‘employee welfare benefit programs’ covered by ERISA) that exists for employee pension benefits.”¹³ In the absence of any comprehensive regulatory scheme for health benefit plans, it has largely fallen to the courts to determine the scope of ERISA pre-emption, and thus the boundary between state and federal jurisdiction. Despite the number and variety

of court cases, the regulation of self-insured health plans, including defining them, continues to vex policymakers and regulators.

STOP-LOSS INSURANCE

Many self-insured employers purchase stop-loss insurance that transfers some share of a firm's risk of insuring their worker and dependent population to an insurer. Stop-loss coverage protects the self-insuring entity (and those covered by the self-insured plan) from unexpectedly high expenses that could otherwise threaten the firm's ability to pay claims and its financial stability. Stop-loss coverage can be structured in two main ways. It can kick in when an insured individual incurs claims above a specified dollar threshold; this is known as specific or individual stop-loss. It can also be designed to kick in when aggregate claims for the covered population exceed a specified dollar threshold in a given period of time; this is called aggregate stop-loss. The dollar amount above which the self-insured employer is covered by the stop-loss, and therefore not at risk, is called the attachment point. Stop-loss coverage typically pays 100 percent of the cost of the claim above the attachment point. The cost of a stop-loss policy is a function of the attachment points, the extent of a firm's health benefits, the characteristics of a firm's workers and dependents in the plan, and the claims experience of the firm.

Information on the amount of risk that self-insured plans bear or the terms of their stop-loss policies is not widely available. According to the Society of Actuaries, the "typical aggregate stop-loss coverage provides reimbursement to the employer when actual claims (excluding those reimbursed by specific stop-loss coverage) exceed 125 percent of the group's expected claims."¹⁴ Such a policy provides for coverage for an unexpected event. However, one researcher observed, small groups can achieve the advantages of self-insuring, but with less financial uncertainty, by buying individual stop-loss coverage with a low attachment point; this arrangement is like insurance with a catastrophic deductible for the employer.¹⁵ The expectation in such an arrangement is that the stop-loss policy will likely pay for some claims because of the low attachment point.

Whether a self-insured plan with a low attachment point stop-loss policy qualifies as a self-insured ERISA plan, and thus cannot be regulated by the state, is not explicitly resolved in ERISA or federal regulation. Such arrangements have become matters for litigation in the past. On the one hand, "[m]ost courts hold that the existence of

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stop-loss insurance does not turn the underlying employee plan into an insured plan.”¹⁶ On the other hand, “the Department of Labor and the courts...have recognized that stop-loss coverage with very low attachment points can make self-insured status a sham, although the limits are far from clear.”¹⁷ In an attempt to clarify regulatory authority, low attachment point stop-loss plans have prompted some states to define minimum attachment points for stop-loss policies, with varying results in the courts.

State Attempts to Regulate Stop-Loss Insurance

Several states and the National Association of Insurance Commissioners (NAIC) have attempted to define whether a stop-loss policy with a low attachment point is, in fact, stop-loss coverage or health insurance coverage. The NAIC developed a model stop-loss law in 1995 that “defined an attachment point below which a health plan’s alleged use of stop-loss coverage would be considered health insurance subject to state regulation, and above which would be considered reinsurance of a self-insured plan.”¹⁸ State laws in Maryland and Missouri, which were similar to the NAIC model law, were challenged in court and found to be in violation of ERISA, meaning that the state could not enforce their laws. For example, in *American Medical Security, Incorporated v. Bartlett* (4th Cir. 1997) the Fourth Circuit Court held that ERISA pre-empted a Maryland law that regulated the terms of the stop-loss policy that self-funded employee benefit plans purchased. In the opinion of the Fourth Circuit Court, the state law amounted to regulation of self-funded plans even though it applied to state-licensed stop-loss carriers because the effect of the law was to mandate that self-funded plans provide specific benefits unless they forego stop-loss coverage.¹⁹ A state court in Missouri also invalidated that state’s stop-loss rule on similar grounds.²⁰ Yet another case demonstrates variability in courts’ rulings: a court in Kansas disagreed with the federal Court of Appeals in the Maryland case, finding instead that ERISA did not pre-empt the Kansas stop-loss rule because regulating stop-loss policies does not “relate to” ERISA health plan benefit design or structure.²¹

Maryland subsequently revised its law in 1999 “to make it more clear that the statute regulates stop-loss carriers and the policies they issue” as opposed to applying to the underlying employer plan.²² The revised Maryland law “deletes references to employee health plans, defines stop-loss insurance as insuring individual people (not the

plan), does not indicate an intention to consider stop-loss policies as health insurance or to deem employee plans to be insurance, and prohibits insurers from selling stop-loss policies with attachment points lower than those set out in the statute.”²³ NAIC similarly amended its model state law in December 1999 “to clarify that the law only applied to insurers and imposed requirements only on stop-loss carriers; it did not impose obligations on the plan.”²⁴

The current version of the NAIC model stop-loss law says that an insurer shall not issue a stop-loss insurance policy that has an attachment point that is less than \$20,000 per person per year or that provides direct coverage of an individual’s health expenses. Aggregate stop-loss for groups of more than 50 may not be lower than 110 percent of expected claims.²⁵ For groups of 50 or fewer people, aggregate stop-loss may not be less than the greater of (i) \$4,000 times the number of group members, (ii) 120 percent of expected claims, or (iii) \$20,000.²⁶ According to the NAIC, three states—Minnesota, New Hampshire, and Vermont—have adopted the model law. Sixteen other states have undertaken related activity but not in a “uniform and substantially similar manner” to the NAIC model stop-loss law.²⁷

PPACA AND SELF-INSURED PLANS

The Patient Protection and Affordable Care Act (P.L. 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111–152) (hereafter referred to as PPACA) was signed by President Obama on March 23, 2010. Over the next few years, PPACA provisions will make changes that affect health insurance policies and insurance markets for individuals and small groups. The law creates State Health Benefits Exchanges, which will serve as state-level marketplaces for insurance starting in 2014. Several provisions are designed to mitigate the risk of adverse selection in the new exchanges for individual and small-group plans. These include:

- Individuals will be required to have health insurance or face a financial penalty, provided this provision withstands recent legal changes.
- Health insurance products sold on the exchanges will be standardized and required to meet one of four actuarial values²⁸ to make policies comparable.²⁹
- Federal premium subsidies will be available to people with incomes up to 400 percent of the federal poverty level for individual plans purchased through the exchanges.

- Risk adjustment methods, which will be developed by the Secretary in consultation with the states, will be applied to premiums. Health plans or health insurance issuers that provide coverage in the individual or small-group market within the state and experience less favorable selection (relative to the average) will receive payments, and those that experience more favorable selection will be assessed a fee.³⁰

Having a pool of enrollees who do and do not expect to use health care services helps to keep premiums lower than they would be if only predictably heavy users of health care services purchased insurance. However, because premiums can only vary by limited amounts on the basis of age, smoking, status, geography, and individual or family coverage, those who are low users of services, typically younger and healthier individuals, will pay more than they would have paid if their premiums were based on their own utilization.

Title I of PPACA adds new requirements that apply to all insurance plans, including self-insured plans and group or individual health plans offered by insurance companies.³¹ The applicability of many PPACA provisions to health insurance plans depends on several factors. For plans sold by health insurers, key factors to determining applicability of PPACA provisions are whether the insurance plan is sold to individuals or to small or large groups, and whether the plan is grandfathered by the law.³² Self-insured employer plans are explicitly exempted from some requirements, though “self-insured” is a term not defined in PPACA (or elsewhere).³³ The exemptions are described below.

- Self-insured plans are not required to provide coverage with minimum essential benefits.³⁴
- Individual and small-group plans are required to participate in a risk-adjustment system, but self-insured plans are exempt.³⁵
- Self-insured plans are not subject to provisions (specifically, medical loss ratio requirements³⁶ and review of premium increases³⁷) that are intended to limit insurer earnings.
- Starting in 2014, health insurers are required to pay an annual fee to be calculated by the Secretary,³⁸ but self-insured plans do not have to pay this fee.³⁹

PPACA's new insurance market rules and requirements for insurers are significant changes for insurers, employers, and consumers. Self-insured exemptions provide opportunity to preserve the source of coverage for millions of workers. Some observers have noted that

as PPACA is implemented, self-insuring may become a better value than the fully insured plans for small firms with an adequate size and risk profile.

EFFECT ON SMALL-GROUP MARKET

In 2014 and beyond, smaller employers with relatively healthy workers that have low medical costs may find it financially advantageous to pay for their own firm's risk (with a third-party administrator vendor and stop-loss coverage) than to purchase a plan through the exchange (or outside of the exchange), where, because of small-group market reforms, their workers' premiums will be a function of the broader risk pool and subject to risk adjustment. If enough small firms with healthier enrollees opt out of a state's small-group market in 2014, that state exchange could experience adverse selection. Adverse selection in the exchange could raise the premiums for those purchasing through the exchanges. In a September 2010 paper, Timothy Stoltzfus Jost described the "threat" of self-insuring to exchanges:

If small businesses with healthy employees can remain "self-insured" until the health of their pool deteriorates and then join the exchange, premiums within the exchange will increase and the exchange will become less viable. If a state opens its exchange to groups above 100, the threat is even greater, as legitimate self-insured plans will seek to insure their employees through the exchange when their experience deteriorates. Moreover, the self-insured plans that have proven most adept at providing high-quality benefits to their employees at low cost (which exist at many large firms) are likely to remain independent of the exchange, while less successful self-insured plans turn to the exchange for coverage.⁴⁰

Some have observed that the cost of self-insuring and purchasing stop-loss coverage could be becoming competitive with fully insured plans for some small firms, even before 2014. One provider of stop-loss coverage interviewed for this issue brief observed that, in response to the environment of continuing rate increases for fully insured products, the stop-loss insurance market is developing different types of products to meet the needs of smaller firms that are considering switching to self-insurance. These products are reportedly priced to compete with fully insured products, and vendors are actively marketing such products to small employers. Data are not available to assess the availability of stop-loss for smaller firms or the premiums or terms for the products being sold.

As discussed above, many states do not have requirements for minimum attachment points, and state attempts to define requirements for stop-loss have met with ERISA challenges, though some states have imposed requirements on stop-loss plans. In light of possible market responses that could affect small-group and individual market risk pools, states and the federal government may need to renew their attention to the effect of self-insured plans, given the potential for adverse selection, on the exchange described above. In fact, this possibility was anticipated in PPACA, which mandates that the Secretary of Health and Human Services, in consultation with the Department of Labor, study fully insured and self-insured group health plan markets. The study is to compare characteristics of employers, benefits, and financial solvency, and to determine whether reforms are likely to cause adverse selection in the large group market or encourage small and midsize employers to self-insure.⁴¹ Findings could vary in each state depending on the relative size of the insured versus self-insured small employer population, the behavior of employers in the state, and the market for new insurance products on the exchange. State regulation of stop-loss coverage could also have an effect. The ease with which an employer can opt to self-insure depends in part on its ability to bear risk and its ability to mitigate that risk with stop-loss coverage. The study is due no later than one year from the enactment of the law: March 23, 2011. Ongoing or subsequent studies may be required given the dynamism of insurance markets and that insurance market reforms will not be fully implemented until 2014.

Because of the potential for adverse selection in the small-group market if small employers with healthier populations opt to self-insure, Jost and others have advocated that the Departments of Labor and Treasury define “self-insured status to clarify that only employers who are capable of bearing, and do in fact, bear, the substantial risk of the cost of health care for their group may qualify as self-insured.”⁴² Given the courts’ mixed findings on state attempts to define stop-loss as a way of ensuring that self-insured plans bear risk, such action at the federal level could be the only way to achieve a consistent national policy. However, employers, workers, and insurers that offer third-party administrator services and stop-loss coverage would likely resist such efforts to define “self-insured,” which provides employers with considerable freedom to control their health benefits as they have for decades. Employers have also argued that self-insuring has helped them to better control costs.

CONCLUSION

As mandated in PPACA, monitoring state insurance markets for potential and actual adverse selection on the exchanges and collecting information about self-insured plans' stop-loss arrangements could help policymakers to understand the effects of employers' decisions to self-insure and the number of people and firms that could be affected by clarifying definitions of self-insured. Monitoring could also provide critical evidence, such as the costs and consumer protections for those in self-insured versus fully insured small-group policies, to understand the potential effects of regulatory changes to the definition of "self-insured" or other policies that could affect coverage for small employers and their employees.

ENDNOTES

1. Stephen Blakely, "Employers, Workers, and the Future of Employment-Based Health Benefits," EBRI Issue Brief, no. 339, February 2010; available at www.ebri.org/pdf/briefspdf/EBRI_IB_02-2010_No339_EB-Bens.pdf.
2. Self-insured and self-funded are terms that are both used to label employer health plans that are not fully insured plans. This report will use the term "self-insured" to refer to these plans.
3. Mark Troutman, "Employer Stop Loss Insurance Considerations," American Society of Actuaries; available at www.soa.org/files/pdf/employer-stop-loss-ins.pdf.
4. Advantages adapted from the Self-Insurance Institute of America.
5. The Kaiser Family Foundation and Health Research & Educational Trust (KFF/HRET), *Employer Health Benefits: 2009 Annual Survey*, 2009; available at <http://ehbs.kff.org/pdf/2009/7936.pdf>.
6. Phyllis C. Borzi, "There's 'Private' and Then There's 'Private': ERISA, Its Impact, and Options for Reform," *Journal of Law, Medicine, and Ethics*, 36, no. 4 (Winter 2008): pp. 660–669.
7. The MEPS-IC (Medical Expenditure Panel Survey-Insurance Component) defines a self-insured plan as a "plan offered by employers where the financial risk for the enrollee's medical claims is assumed partially or entirely by the employer offering the plan. Employers with self-insured plans commonly purchase stop-loss coverage from a reinsurer who agrees to bear the risk (or stop the loss) for those expenses exceeding a predetermined dollar amount. Some self-insured employers contract with an insurance company or third-party administrator for claims processing and other administrative services. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (including Conventional Indemnity, PPO, EPO, HMO, and POS) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees." See "MEPS Insurance Component Glossary of Health Insurance Terms" p. 4, available at www.meps.ahrq.gov/mepsweb/survey_comp/ic_ques_glossary.pdf.

8. KFF/HRET, *Employer Health Benefits: 2010 Annual Survey*, 2010, p. 173; available at <http://ehbs.kff.org/pdf/2010/8085.pdf>. The survey defines a self-funded plan as “an insurance arrangement in which the employer assumes direct financial responsibility for the costs of enrollees’ medical claims. Employers sponsoring self-funded plans typically contract with a third-party administrator or insurer to provide administrative services for the self-funded plan. In some cases, the employer may buy stop-loss coverage from an insurer to protect the employer against very large claims.”
9. ERISA does not apply to church-based or governmental plans. See United States Code Title 29, Chapter 18, Subchapter I, Subtitle A, § 1003(b).
10. Mark Merlis, “Fundamentals of Underwriting in the Nongroup Health Insurance Market: Access to Coverage and Options for Reform,” National Health Policy Forum, Background Paper, April 13, 2005; available at www.nhpf.org/library/details.cfm/2480.
11. There are three legal tests that are used to determine whether ERISA pre-empts state insurance law. State laws that “relate to” employee benefit plans are pre-empted. State laws that regulate insurance are not pre-empted. States cannot deem employee benefit plans to be insurance companies or insurers in order to regulate them. From M. Patricia Smith, “ERISA Preemption and State Insurance Regulation of Healthcare Arrangements,” New York State Attorney General’s Office, available at www.bna.com/bnabooks/ababna/annual/99/annual37.pdf.
12. General Accounting Office (GAO), “Employer-Based Health Plans: Issues, Trends, and Challenges Posed by ERISA,” GAO/HEHS-95-167, July 1995, p. 4; available at www.gao.gov/archive/1995/he95167.pdf.
13. Borzi, “There’s ‘Private’ and Then There’s ‘Private,’” p. 660.
14. Troutman, “Employer Stop Loss Insurance Considerations,” p. 2.
15. Mark A. Hall, “The Geography of Health Insurance Regulation,” *Health Affairs*, 19, no. 2 (March/April 2000): pp. 173–184; available at <http://content.healthaffairs.org/content/19/2/173>.
16. Patricia Butler, *ERISA Preemption Manual for State Health Policy Makers*, National Academy for State Health Policy, State Coverage Initiatives, January 2000, p. 74; available at www.nashp.org/sites/default/files/ERISA_Manual.pdf.
17. Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, Commonwealth Fund, September 2010, p.19; available at www.commonwealthfund.org/Content/Publications/Fund-Reports/2010/Sep/Health-Insurance-Exchanges-and-the-Affordable-Care-Act.aspx.
18. Butler, *ERISA Preemption Manual for State Health Policy Makers*, p. 64.
19. Specifically, the Fourth Circuit Court found that “the purpose and effect of Maryland’s regulation is to force state-mandated health benefits on self-funded ERISA plans when they purchase certain types of stop-loss insurance.” It affirmed the district court ruling “declaring that ERISA preempts the state regulation and that the regulation is, therefore, ‘void to the extent that it mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA.’” “The Court also enjoined Maryland from enforcing the regulation or taking any other step ‘to regulate or

affect the attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans.” U.S. Court of Appeals, *American Medical Security, Inc. v. Bartlett*, No. 96-1376 (4th Cir. 1997).

20. Butler, *ERISA Preemption Manual for State Health Policy Makers*.

21. Butler, *ERISA Preemption Manual for State Health Policy Makers*. Ms. Butler also points out that in both the Maryland and Kansas cases, the court affirmed that states can impose regulation (such as taxes and reporting requirements) on stop-loss insurance policies that do not “directly affect the structure or administration of the underlying ERISA plan.” (p. 65)

22. Butler, *ERISA Preemption Manual for State Health Policy Makers*, p. 64.

23. Butler, *ERISA Preemption Manual for State Health Policy Makers*, p. 64.

24. NAIC Model #92: Stop Loss Insurance Model Act, available for purchase from the National Association of Insurance Commissioners, p. 7.

25. The NAIC model law provides for indexing of dollar amounts.

26. NAIC Model #92: Stop Loss Insurance Model Act.

27. NAIC Model #92: Stop Loss Insurance Model Act. The remaining 31 states and the District of Columbia have taken no action, p. 3.

28. According to the American Academy of Actuaries, actuarial value “is commonly either the dollar value of average expected benefits paid out by the plan or the average share of total health spending that is paid for by the plan.” See “Critical Issues in Health reform: Actuarial Equivalence,” May 2009, available at www.actuary.org/pdf/health/equivalence_may09.pdf.

29. The Small Business Health Options Program is created in PPACA and referred to as the “SHOP Exchange.” The SHOP exchange in each state is intended to assist qualified small employers with facilitating the enrollment of their employees in qualified health plans offered in the small-group market in the state (PPACA § 1311.) For purposes of eligibility for purchasing coverage through the SHOP exchange, the term “small employer” means an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. For plan years beginning before January 2016, a state has the option of defining small employers as not more than 50 employees (PPACA § 1304).

30. PPACA § 1343.

31. Provisions of Title I of PPACA are included as amendments to Title XXVII of the Public Health Service (PHS) Act. A conforming amendment (§ 1562(e)), applies the PHS Act provisions to ERISA and the Internal Revenue Code. Specifically the provisions apply to group health plans, which are employee welfare benefit plans (as defined in ERISA) to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. Provisions also apply to health insurance issuers, which are an insurance companies, insurance services, or insurance organizations including health maintenance organizations licensed to engage in the business of insurance in a state and subject to state law which regulates insurance.

32. According to the Congressional Research Service, “A grandfathered health plan is an existing group health plan or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of enactment. Therefore, as long as a person was enrolled in a health insurance plan on March 23, 2010, that plan has been grandfathered.” See Bernadette Fernandez, *Grandfathered Health Plans Under PPACA (P.L. 111-148)*, Congressional Research Service, Report Number R41166, April 7, 2010, p. 1.

33. The exemptions described are independent of whether the self-insured plan is grandfathered. Other exemptions apply to grandfathered plans, regardless of plan type, as long as they maintain grandfathered status. For a summary of provisions from which grandfathered group health plans and health insurance issuers are exempt, see Congressional Research Service, *Grandfathered Health Plans Under PPACA*.

34. Public Health Service Act § 2707 as amended by the PPACA. See “Compilation of Patient Protection and Affordable Care Act,” prepared by the Office of the Legislative Counsel for the use of the U.S. House of Representatives, May 2010; available at <http://docs.house.gov/energycommerce/ppacacon.pdf>.

35. PPACA § 1343. Self-insured plans are required to contribute to the transitional reinsurance program in each state from 2014 through 2016 per § 1341 of PPACA.

36. PHS Act § 2718 as amended by PPACA.

37. PHS Act § 2794 as amended by PPACA.

38. PPACA § 9010.

39. Self-insured plans are subject the excise tax on high-cost employer-sponsored health coverage (§ 9001) and the assessment to fund the Patient-Centered Outcomes Research Trust Fund for each plan year beginning after September 30, 2012, through plan years ending September 30, 2019 (Internal Revenue Code § 4376 as amended by PPACA).

40. Jost, *Health Insurance Exchanges and the Affordable Care Act*, p. 22.

41. PPACA § 1254.

42. Jost, *Health Insurance Exchanges and the Affordable Care Act*.