



Self-Insured Health Insurance Coverage

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Summary

Private health insurance can be provided to groups of people that are drawn together by an employer or other organization. Such groups are generally formed for some purpose other than obtaining insurance, like employment. When insurance is provided to a group, it is referred to as “group coverage” or “group insurance.” A common distinction made between private health coverage offered to groups is how such coverage is funded. That is, the plan sponsor may either purchase group health insurance from a state-licensed insurance carrier, or fund the health benefits directly. The former refers to fully insured plans; the latter, self-insured plans.

Self-insurance refers to coverage that is provided by the organization seeking coverage for its members. Such organizations set aside funds and pay for health benefits directly. (Enrollees may still be charged a premium.) Under self-insurance, the organization itself bears the risk for covering medical expenses. Because self-insured plans are not purchased from an insurance carrier licensed by the state, they are exempt from state requirements and subject only to federal regulation. With fully insured plans, the insurance carrier charges the plan sponsor a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. (In turn, the sponsor may decide that each person or family who wishes to enroll must pay part of the premium cost.) Under the fully insured scenario, the private insurer bears the insurance risk; that is, the insurer is responsible for covering the applicable costs associated with covered benefits. Insurance purchased from a state-licensed insurer is subject to both federal and state regulation.

A majority of individuals with private health insurance coverage are enrolled in self-insured plans. In 2008, 55% of private-sector enrollees were in such plans. This proportion differs when comparing small firms and large firms. In 2008, of the private-sector workers who were employed at small firms with health coverage, 12% were enrolled in self-insured health plans. In contrast, of private-sector workers employed at large firms, 65% were enrolled in self-insured plans. Consistent with these findings is the share of private-sector firms that offer at least one self-insured plan. In 2008, while 34% of all private-sector firms that offered insurance had at least one self-insured plan, only 13% of small firms had such a plan, compared with 63% of large firms.

To assist individuals, families, and employers in obtaining health coverage, the 111th Congress passed major health reform legislation. The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010, and later amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). PPACA imposes new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health coverage; and provides financial assistance to certain individuals and, in some cases, small employers. Among the provisions in PPACA are ones that would have a major impact on private health insurance coverage, including self-insured plans.

This report will be updated periodically.

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Introduction

Most Americans with health insurance coverage obtain such coverage through the private sector. Moreover, most private coverage is provided through an employer to workers and dependents of workers. Such employment-based coverage may either be purchased from an insurance carrier (fully insured health plan), or funded directly by the employer (self-insured health benefits). The distinction between self-insured and fully insured plans is significant with respect to applicable law and regulation, which, in turn, affects an enrollee's access to certain health services, applicability of consumer protections, and ability to receive financial compensation in a court of law, among many other issues. To assist individuals, families, and employers in obtaining health coverage, the 111th Congress passed major health reform legislation, which contains provisions that directly affect self-insured plans.¹

This report provides background information on private health insurance coverage, state and federal regulation of private coverage, and self-insured health plans.² It includes data on the prevalence of self-insurance and discusses the employer decision to self-insure. Lastly, it describes selected private health insurance provisions under federal health reform, and application of such provisions on self-insured plans.

Background

People buy insurance to protect themselves against the possibility of financial loss in the future. Such losses may be due to a motor vehicle collision, natural disaster, or other circumstance. For health care consumers, financial losses may result from the use of health care services. Health insurance then provides some protection against the possibility of substantial financial loss due to high health care expenses.

Private health insurance can be provided to groups of people that are drawn together by an employer or other organization, such as a trade union. Such groups are generally formed for some purpose other than obtaining insurance, like employment. When insurance is provided to a group, it is referred to as “group coverage” or “group insurance.” In the group market, the entity that purchases health insurance on behalf of a group is referred to as the plan “sponsor.” Consumers who are not associated with a group may be able to obtain private health coverage by purchasing it directly from an insurer in the individual (or nongroup) insurance market.³

Self-Insured vs. Fully Insured Health Plans

A common distinction made between private health coverage offered to groups is how such coverage is funded. That is, the plan sponsor may either purchase group health insurance from a

¹ For additional information about the private insurance provisions under federal health reform, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind et al. (Hereinafter cited as *Private PPACA*.)

² For additional background information about health insurance in general, see CRS Report RL32237, *Health Insurance: A Primer*, by Bernadette Fernandez.

³ For additional information about the private health insurance market, see CRS Report R40834, *The Market Structure of the Health Insurance Industry*, by D. Andrew Austin and Thomas L. Hungerford.

state-licensed insurance carrier, or fund the health benefits directly. The former refers to fully insured plans; the latter, self-insured plans.

Organizations that self-insure (or self-fund) do *not* purchase health insurance from an insurance carrier. Self-insurance refers to coverage that is provided by the organization seeking coverage for its members (e.g., an employer offering health benefits to his employees). Such organizations set aside funds and pay for health benefits directly. (Enrollees may still be charged a premium.) Under self-insurance, the organization itself bears the risk for covering medical expenses. Firms that self-fund health benefits typically contract with third-party administrators (TPAs) to handle administrative duties such as enrollment, premium collection, customer service, and utilization review. Because self-insured plans are not purchased from a carrier licensed by the state, they are exempt from state requirements and subject only to federal statutes and regulation. This exemption from state law allows employers who self-fund health benefits to offer the same health plans in multiple states.

With fully insured plans, the insurance carrier charges the plan sponsor a fee for providing coverage for the benefits specified in the insurance contract. The fee typically is in the form of a monthly premium. (In turn, the sponsor may decide that each person or family who wishes to enroll must pay part of the premium cost.) Under the fully insured scenario, the private insurer bears the insurance risk; that is, the insurer is responsible for covering the applicable costs associated with covered benefits. From a commercial insurer's perspective, the total amount of premiums collected ideally will cover the costs of any insurance claims generated by the enrollees plus administrative and other plan costs, and still leave funds leftover for profit. Insurance purchased from a state-licensed insurer is subject to both federal and state rules.

Regulation of Health Plans

The regulation of insurance traditionally has been a state responsibility, and tremendous variety exists in health insurance regulation among the states.⁴ Individual states have established standards applicable to the business of insurance; requirements imposed on insurance carriers range from rating rules and consumer protections to licensing requirements, solvency standards, and premium taxation. For example, all states require state-licensed carriers to offer coverage for specified health care services; these requirements are known as benefit mandates. Some states have many benefit mandates; other states have relatively few. Even if multiple states have mandates concerning the same type of benefit (e.g., mental health services), such mandates may still vary in scope or specificity. Because fully insured plans are subject to state law, those plans must offer benefits that are mandated. On the other hand, self-insured plans are not subject to state insurance rules so they are exempt from such mandates.

⁴ Insurance matters are primarily regulated at the state, rather than the federal, level. Congress explicitly recognized the role of the states in the regulation of insurance with the passage of the McCarran-Ferguson Act of 1945. This law was passed in response to the Supreme Court's ruling in *United States v. South-Eastern Underwriters*, 322 U.S. 533 (1944), in which the Court affirmed the federal government's right to regulate the competitive practices of insurers under the Commerce Clause of the United States Constitution. The intent of the McCarran-Ferguson Act was to grant states the explicit authority to regulate insurance in light of the *South-Eastern Underwriters* decision. Section 2(a) of the act states: The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business. 15 U.S.C. §1012(a). However, under the act, Congress also reserved to itself the right to enact federal statutes that "specifically" relate to "the business of insurance." 15 U.S.C. §1012(b).

Regardless of whether health plans are fully insured or self-funded, they are subject to a number of federal standards, albeit fewer than state health insurance requirements. Two federal laws, the Employee Retirement Income Security Act of 1974 (ERISA, P.L. 93-406) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), have significant impact on how health insurance is provided. ERISA outlines minimum federal standards for private-sector employer-sponsored benefits, including health benefits. (Governmental plans and plans sponsored by churches are exempt from ERISA.) In general, ERISA requires plan fiduciaries to act prudently and in the best interest of beneficiaries, participants be informed of their rights, and there be disclosure of a plan's financial activities. It preempts state laws that "relate to" employee benefit plans, but provides an exception for state laws that "regulate insurance."⁵ The delineation of issues attributable to the phrases "relate to" and "regulates insurance" is not clear, and have led to longstanding debates and active litigation over the scope of ERISA preemption.⁶

Under §514(b)(2)(A) of ERISA, a state law that relates to an ERISA plan may avoid preemption if it regulates insurance within the meaning of ERISA's "saving clause." This section "saves" from preemption "any law of any State which regulates insurance, banking, or securities." Thus, the savings clause permits states to regulate health insurance without running afoul of ERISA's preemptive scheme, and states may therefore impose requirements on health insurers that are more comprehensive than the requirements set forth under ERISA. However, under §514(b)(2)(B) of ERISA, commonly referred to as the "deemer clause," a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company for purposes of regulation. In interpreting this provision, the Supreme Court has found that a self-insured health plan cannot be "deemed" an insured plan for the purpose of state regulation. Accordingly, a plan that provides health benefits through an insurance company can, in effect, be regulated by state insurance law, as well as by ERISA. On the other hand, a plan that is self-insured is only subject to ERISA's requirements, and is immune from state law.⁷

While ERISA provides for general regulation of employee benefit plans, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically regulates health benefits. The core motivation behind HIPAA is to address the concern that insured persons have about losing their coverage if they switch jobs or change health plans ("portability" of health coverage). HIPAA contains health insurance provisions which amended ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) in an effort to apply broadly to different types of health plans. HIPAA established federal requirements on private coverage and issuers of such coverage, including the availability and renewability of coverage for certain individuals under specified circumstances, limitations on the amount of time that coverage for pre-existing medical conditions may be excluded, and prohibition of discrimination on the basis of health factors. It also includes tax provisions designed to encourage the expansion of health coverage through several mechanisms. Another set of HIPAA provisions addresses the electronic transmission of health information and the privacy of personally identifiable medical information (administrative simplification and privacy provisions, respectively).⁸

⁵ 29 U.S.C. §1144(a)-(b).

⁶ For more information about ERISA preemption, see CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*, by Patrick Purcell and Jennifer Staman.

⁷ For more information about ERISA and health insurance, see CRS Report RS22643, *Regulation of Health Benefits Under ERISA: An Outline*, by Jennifer Staman.

⁸ For more information about HIPAA, see CRS Report RL31634, *The Health Insurance Portability and Accountability Act* (continued...)

Data Related to Self-Insured Plans

A majority of individuals with private health insurance coverage are enrolled in self-insured plans. In 2008, 55% of private-sector enrollees were in such plans. This proportion differs when comparing small firms (less than 50 workers) and large firms (50 or more workers). In 2008, of the private-sector workers who were employed at small firms with health coverage, 12% were enrolled in self-insured health plans. In contrast, of private-sector workers employed at large firms, 65% were enrolled in self-insured plans. Consistent with these findings is the share of private-sector firms that offer at least one self-insured plan. In 2008, while 34% of all private-sector firms that offered insurance had at least one self-insured plan, only 13% of small firms had such a plan, compared with 63% of large firms.⁹

As reflected in the preceding data, the value of self-insurance to a firm generally is related to firm size. A large firm typically is able to spread risk across a large pool of enrollees, which means it is better able to deal with large health care expenses should they occur, compared to a small firm. Also a large firm is more likely than its small counterpart to have a human resources department that has the expertise and resources to self-fund health benefits.

While the ability to avoid state health insurance regulations may appear to be the primary reason for self-insuring, economic analyses do not support this assumption, at least not uniformly. For example, one study from 1993 found that benefit mandates and premium taxation were not associated with the decision to self-insure, but small group health reforms were.¹⁰ Another study concluded that while avoidance of state regulation motivated employers' decision to self-insure in the early 1980s, by the mid 1980s "regulatory considerations played only a minor role."¹¹ Such conclusions are borne out, for example, in more recent comparisons of benefits provided in self-insured plans to those in fully insured plans. Researchers have observed that self-insured plans typically include benefits offered in fully insured plans, despite the exemption from state benefit mandates for self-insured plans.¹²

Health Reform

The 111th Congress passed the Patient Protection and Affordable Care Act (P.L. 111-148, PPACA); President Obama signed it into law on March 23, 2010. On March 30, 2010, PPACA was amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152).

(...continued)

Act (HIPAA) of 1996: Overview and Guidance on Frequently Asked Questions, by Hinda Chaikind et al.

⁹ Tables I.B.2.b and I.A.2.a, Medical Expenditure Panel Survey-Insurance Component, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, 2008, available online at http://www.meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1.

¹⁰ C. Park, "Prevalence of Employer Self-Insured Health Benefits: National and State Variation," *Medical Care Research and Review*, Vol. 57, No. 3, 2000.

¹¹ G. Jensen et al., "State Insurance Regulation and Employers' Decisions to Self-Insure," *Journal of Risk and Insurance*, June 1995, p. 210.

¹² For example, see J Gabel, et al., "Self-Insurance in Times of Growing and Retreating Managed Care," *Health Affairs*, Vol. 22, No. 2, 2003; M. Matthews, "Lessons from Tennessee's Failed Health Care Reform," *Heritage Foundation Backgrounder #1357*, 2000, available online at <http://www.heritage.org/research/healthcare/bg1357.cfm>; and G. Acs et al., "Self-Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums," *Health Affairs*, Vol. 15, No. 2, 1996.

PPACA imposes new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health coverage; and provides financial assistance to certain individuals and, in some cases, small employers. Among the provisions in PPACA are ones that would have a major impact on private health insurance coverage, including self-insured plans.

Health Reform Definitions Relevant to Self-Insured Plans

Under federal law, self-insured plans are considered to be a type of “group health plan.”¹³ PPACA refers to this definition of group health plan and applies certain insurance reforms to such a plan. Because PPACA employs a patchwork approach in specifying which type of private plan would be subject to which reform, the impact on self-insured plans depends on the provision being considered. For example, group health plans will be subject to the prohibition on coverage exclusions for preexisting health conditions, but not subject to community rating rules under PPACA.¹⁴

In addition, PPACA includes grandfathering provisions for existing health insurance plans. A group health plan or health insurance coverage (either nongroup or group), in which a person was enrolled on the date of enactment, is grandfathered and exempt from most insurance reforms. Therefore, self-insured plans that existed on date of enactment are grandfathered plans and subject only to a handful of the private insurance reforms.¹⁵

Private Health Insurance Reforms

PPACA establishes new federal standards and requirements applicable to the private market, with the aim of increasing consumer access to health insurance, especially for persons with pre-existing health conditions and for other higher-risk groups. These requirements relate to the offer, issuance, and renewal of insurance, applicable consumer protections, and costs borne by consumers, employers, and health plans.

As mentioned above, PPACA requires group health plans (and, by extension, self-insured plans) to comply with some but not all private reforms.¹⁶ Depending on the insurance reform, it may apply to all self-insured plans (i.e., both new and grandfathered¹⁷), or only one type of self-insured plan (see **Table 1**).

¹³ The PPACA definition for “group health plan” refers to the existing PHSA definition of that term, which, in turn, refers to the ERISA definition (29 U.S.C. §1191b). The term “group health plan” under PPACA includes self-insured plans.

¹⁴ Note that to the extent that PPACA regulates “health plans,” self-insured plans are exempt from those requirements. See §1301(b)(1) for the definition of “health plan.” The inclusion of definitions for both “group health plan” and “health plan” in PPACA seems to indicate the intention of using both terms, and underscores the importance of noting which term is applied to which health insurance standard. For example, group health plans would be subject to the prohibition on discrimination based on health factors (§1201, adding new PHSA §2705), but health plans that provide the essential health benefits package would be subject to specified cost-sharing limits (§1302(c)).

¹⁵ For additional information about grandfathered plans, see CRS Report, CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (PPACA)*, by Bernadette Fernandez.

¹⁶ For additional information on the applicability of private health insurance reforms to “group health plans” (among other types of plans), see *Private PPACA*.

¹⁷ Application of insurance reforms to grandfathered, self-insured plans is based on analysis of specific provisions (continued...)

Table I. Private Health Insurance Reforms Applicable to Self-Insured Plans

Insurance Reforms	Self-Insured Plans	
	Grandfathered	New
Near-Term Insurance Reforms (prior to 2014)		
Prohibits lifetime benefit limits ^a	X	X
Restricts annual benefit limits ^{a, b}	X	X
Restricts rescissions	X	X
Requires coverage for preventive services with no cost-sharing	NR	X
Extends dependent coverage to age 26	X	X
Requires uniform explanation of plan benefits	X	X
Prohibits discrimination based on employee compensation	NR	NR
Requires quality of care reporting	NR	NR
Requires reporting of medical loss ratio and provision of rebates	X	NR
Requires internal and external appeals processes	NR	X
Long-Term Insurance Reforms (Beginning 2014)		
Prohibits coverage exclusions for preexisting conditions	X	X
Imposes adjusted community rating rules	NR	NR
Imposes guaranteed issue requirements	NR	NR
Imposes guaranteed renewability requirements	NR	NR
Prohibits discrimination based on health factors	NR	X
Prohibits discrimination against medical providers	NR	X
Requires coverage for essential health benefits	NR	NR
Limits out-of-pocket spending	NR	X
Prohibits excessive waiting periods	X	X
Requires coverage for clinical trials for qualified individuals	NR	X

Source: CRS analysis of PPACA.

Note: NR = not required.

- a. Benefit limits based on essential health benefits.
- b. Beginning in 2014, this provision will prohibit annual limits of any kind.

(...continued)

discussed earlier: (1) the applicability of grandfathering provisions to “group health plans,” and (2) the distinction between the terms “group health plan” and “health plan,” with the former including self-insured plans and the latter not including self-insured plans. As noted in footnote #14, inclusion of both terms in PPACA indicates the intention to apply them to insurance reforms, depending on the provision. Moreover, interim final rules issued by HHS, Labor, and Treasury (regarding dependent coverage for children under age 26) states the Administration’s intention to distinguish between “group health plan” and “health plan” for the purpose of adding PPACA provisions to existing federal requirements. The rules are available at http://www.hhs.gov/ocio/regulations/pra_omnibus_final.pdf.

Health Insurance Exchange

PPACA will establish health insurance exchanges, similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance, to facilitate the purchase of health insurance by certain individuals and small businesses. An exchange will not be an insurer; it will provide eligible individuals and small businesses (and large businesses at the state's discretion) with access to insurers' plans in a comparable way (in the same way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). Exchanges will have additional responsibilities as well, such as negotiating with plans and determining eligibility for and administering premium and cost-sharing subsidies.¹⁸

Because the plans offered through an exchange are offered by insurance carriers for purchase by individuals and groups, by definition exchange plans will not be considered self-insured.

Employer Requirements

PPACA does not mandate an employer to provide employees with coverage; however, beginning in 2014, it does impose requirements on certain employers. A large employer (as defined in the law) with at least one full-time employee (based on a 30-hour work week) who receives a premium credit through an exchange may be subject to a penalty.¹⁹

The employer requirements under PPACA do not depend on the funding for an employer plan. In other words, the potential imposition of an employer penalty will not be contingent on whether the plan is self-insured or fully insured.

Taxes on Health Insurance Plans

PPACA will impose three different fees on health insurers: The first is a 40% excise tax on issuers of high-cost health plans (defined as those with premiums exceeding \$10,200 for single coverage and \$27,500 for family coverage in 2018).²⁰ In addition, there is an annual fee on health insurers based on their market share. Finally, PPACA will impose an annual fee on health insurance plans to fund comparative effectiveness research. This additional fee will be calculated by multiplying \$2 per insurance product by the average number of covered lives.

Under PPACA if an employee has "applicable employer sponsored coverage" and the cost of such coverage exceeds the premium limits described above, then issuers of such coverage will pay a tax. This term is defined to include "group health plans," which includes self-insured plans. In

¹⁸ For additional information about exchanges and premium credits, see CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (PPACA)*, by Chris L. Peterson and Thomas Gabe.

¹⁹ Such employers will be exempt from paying a penalty if they have 30 or fewer full-time employees. Actual penalty amounts are calculated using formulas specified in the law. For additional information about employer requirements, see CRS Report R41159, *Summary of Potential Employer Penalties Under the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind and Chris L. Peterson.

²⁰ These thresholds will be adjusted for certain high-risk groups. For additional information about this and other revenue provisions under PPACA, see CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Janemarie Mulvey.

contrast, the annual fee on insurers will not apply to sponsors of self-insured plans, among other plan entities. The tax to fund comparative effectiveness research will apply to self-insured plans in the same manner as the tax will apply to fully insured plans.

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