

SELF-INSURANCE FOR SMALL EMPLOYERS UNDER THE AFFORDABLE CARE ACT: FEDERAL AND STATE REGULATORY OPTIONS

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Introduction	539	R
I. Why Does the Small-Group Market Struggle?	541	R
A. The Affordable Care Act and the Small-Group Market	542	R
II. The Self-Insurance Exception.....	545	R
A. The Growing Prevalence of Self-Insurance in Small Groups.....	546	R
B. Self-Insured Plans Under the ACA.....	550	R
C. Self-Insured Plans and ERISA.....	552	R
D. Defining “Self-Insured” Under ERISA and the ACA.....	554	R
III. State Regulation of Stop-Loss Insurance	556	R
A. ERISA Preemption	558	R
B. Federal Responses	562	R
Conclusion	565	R

INTRODUCTION

The small employer group insurance market is a core concern of the Patient Protection and Affordable Care Act’s insurance reforms. There are good reasons for this. Millions of the 40 million Americans who work for small businesses¹ are uninsured. Whereas 99% of employers with 200 or more employees offer their employees health insurance, only 48% of employers with fewer than ten employees and 71% of employers with ten to twenty-four employees do so.² Because many workers at small firms who are offered insur-

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1. *Statistics About Business Size*, U.S. CENSUS BUREAU, Table 2a, <http://www.census.gov/econ/smallbus.html> (last updated Aug. 22, 2012) (deriving the 40 million figure from the sum of table entries for businesses smaller than 100 in 2008).

2. KAISER FAMILY FOUNDATION & HEALTH RESEARCH & EDUCATIONAL TRUST, *EMPLOYER HEALTH BENEFITS* 5 (2011) [hereinafter KFF/HRET].

ance decline the offer—often because they cannot afford their share of the premiums—only 31% of employees of the smallest firms are covered by their employer’s group health insurance.³ Finally, Americans insured through small businesses tend to face much higher cost-sharing obligations, in particular higher deductibles, when they actually use health care.⁴ If the United States ever hopes to provide access to health care for all Americans, the nation must determine how to extend adequate coverage for employees of America’s small businesses.

Congress attempted to address these problems in the Affordable Care Act (“ACA”). The ACA contains numerous provisions intended to make health insurance more affordable to small businesses and to offer better coverage to their employees.⁵ However, the ACA contains a major loophole. Many of the ACA’s protections do not extend to “self-insured” employment-related groups.⁶ Self-insured plans are employee health benefit plans where the risk is borne by the employer. Typically they are found among large employers, but insurers increasingly are marketing self-insured plans to small groups that are less capable of bearing the risks associated with such plans.⁷

Enrollees in self-insured plans are deprived of important protections guaranteed by the ACA. Moreover, small employers can game the provisions of the ACA by self-insuring at a low cost as long as their employees are healthy, and then switching into the regulated insurance markets as soon as the health of their group deteriorates. Within the ACA’s regulated insurance markets, all groups are charged the same rate regardless of health status and insurers cannot exclude individuals with preexisting conditions. Thus self-insurance threatens to undermine the ACA’s small-group reforms, presenting “a clear and present danger to the viability of the small-employer market.”⁸

This Article examines the threat that self-insurance poses to the ACA’s small-group reforms. First, it considers the dysfunctions of the small-group health insurance market and how the reforms of

3. *Id.* However, many of those not covered may be covered by their spouse’s policy or by Medicaid or another public program.

4. *Id.* at 101–02.

5. *See infra* pp. 3–5.

6. *See infra* pp. 9–10.

7. *See infra* pp. 6–8.

8. RICK CURTIS & ED NEUSCHLER, INST. FOR HEALTH POLICY SOLUTIONS, SMALL-EMPLOYER (“SHOP”) EXCHANGE ISSUES 10 (2011), *available at* [http://www.healthexchange.ca.gov/Documents/Small%20Employer%20\(SHOP\)%20Exchange%20Issues.pdf](http://www.healthexchange.ca.gov/Documents/Small%20Employer%20(SHOP)%20Exchange%20Issues.pdf).

the ACA address these problems. It next explains how self-insurance works and how it came to be common. It then analyzes the dangers self-insurance poses for the small-group market, focusing in particular on the role that “stop-loss” coverage—which is reinsurance for self-insured firms—plays in threatening the ACA’s small-group reforms. Finally the Article analyzes how the state and federal governments can protect the ACA’s small-group market reforms by limiting the ability of small groups to self-insure.

I. WHY DOES THE SMALL-GROUP MARKET STRUGGLE?

Unlike the individual health insurance market, the small-group market does not suffer from inadequate availability of insurance. Rather, the problem is affordability. Since the enactment of the Health Insurance Portability and Accountability Act in 1996, all insurers that participate in the small-group market have been required to guarantee coverage and renewability to small employers that desire it.⁹ However, this existing federal law neither regulates the pricing of small-group insurance nor, in particular, prohibits insurers from charging higher premiums depending on the health status of the group.

Comparable health insurance coverage costs more for small groups than large groups.¹⁰ This is because administrative costs are higher for covering small groups, smaller groups have less bargaining power, and insurers charge a risk premium to account for the increased actuarial uncertainty of insuring smaller groups.¹¹ Small groups that disproportionately employ older workers or that cover employees or family members with serious medical needs face even higher costs.¹² Indeed, such employers may find coverage simply unaffordable. For example, many small groups that disproportionately employ low-wage workers, such as restaurants or landscaping services, may find that providing health insurance nearly doubles

9. 42 U.S.C. §§ 300gg–11(a), 300gg–12(a) (2006).

10. STACEY McMORROW ET AL., *THE URBAN INST., THE EFFECTS OF HEALTH REFORM ON SMALL BUSINESSES AND THEIR WORKERS 2* (2011), available at <http://www.urban.org/UploadedPDF/412349-Effects-of-Health-Reform-on-Small-Businesses.pdf>. In fact, small businesses pay lower premiums than large groups, but this is a function of the fact that small-group plans have much higher cost sharing, and thus provide much less in benefits. KFF/HRET, *supra* note 2, at 22.

11. McMORROW ET AL., *supra* note 10, at 2.

12. MARK A. HALL, *REFORMING PRIVATE HEALTH INSURANCE 18–19* (1994).

their labor costs.¹³ As a result, in low-wage sectors of the economy health insurance may be unaffordable even for healthy groups.

Even if small employers offer health insurance coverage to their employees, coverage is usually less generous than that offered by large employers. While services covered by small groups are usually comparable to those covered by large groups,¹⁴ small-group plans generally have much higher cost-sharing requirements in the form of deductibles, coinsurance, and copayments. Over 25% have deductibles of over \$2000, compared to only 5% of large employer plans.¹⁵ This is directly related to the problem of affordability, because high cost-sharing plans are often all that small employers can afford. These plans can leave small-firm employees exposed to considerable expense, even beyond their insurance premiums.

A. *The Affordable Care Act and the Small-Group Market*

Congress attempted to address the problems facing the small-group market through the ACA by building on previously enacted legislation. Despite widespread belief to the contrary, the ACA is fundamentally a conservative piece of legislation because it builds on the current health care finance system rather than creating a new system from scratch.¹⁶ Therefore the ACA relies on the existing private insurance market, rather than establishing a new public system, and it builds on the employment-based system, rather than replacing it with coverage purchased only by individuals. While keeping these elements in place, the ACA attempts to reform our private health insurance system to give American employers, employees, and families access to private insurance that they can afford and that will meet their needs.

The ACA does this in four ways. First, the ACA incorporates a number of important consumer protections, some of which are al-

13. A worker employed at minimum wage of \$7.25 per hour for forty hours per week, fifty-two weeks per year, earns \$15,080 over the course of a year. *See Wages*, U.S. DEP'T OF LABOR, http://www.dol.gov/dol/topic/wages/minimum_wage.htm (last updated July 24, 2009). In contrast, the average cost to the employer of a small-group health insurance policy in 2011 was \$5,328 for individual and \$14,098 for family coverage. KFF/HRET, *supra* note 2, at 22.

14. *See* DEP'T OF HEALTH & HUMAN SERV., CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 4–5 (2011), http://ccio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

15. KFF/HRET, *supra* note 2, at 101–02.

16. The ACA amends sections of the Public Health Service Act, which was enacted by Congress in 1944. Public Health Service Act of 1944, Pub. L. No. 78-410 (codified as amended in 42 U.S.C. ch. 6A (2006 & Supp. V 2012)) [hereinafter PHSA].

ready in effect and some of which will go into effect in 2014. Among those already in effect are provisions forbidding insurers from capping the dollar amount they will pay for an enrollee's claims each year or over a lifetime, prohibiting insurers from retroactively rescinding coverage except for fraud or intentional misrepresentation, requiring insurers to cover adult children up to the age of twenty-six, banning cost sharing for preventive services, and providing consumers with an easily comprehensible summary of benefits and coverage.¹⁷ Consumer protections coming into effect in 2014 will require non-group and small-group insurers to cover a package of essential health benefits and limit deductibles.¹⁸

Second, the ACA changes the way in which insurance is sold. Health insurers historically have screened and evaluated individuals and small groups for their particular health risk characteristics. The greater the predicted medical costs presented by an enrollee or small group, the higher the premium.¹⁹ Insurers also routinely exclude coverage of preexisting conditions.²⁰ The ACA will change these practices. Beginning on January 1, 2014, it will require guaranteed access to insurance for all applicants and coverage for all individuals regardless of health status and ban exclusion of preexisting conditions.²¹ Additionally, in the individual and small-group markets, the only rating factors the ACA will allow insurers to consider are age (limited by a three-to-one variance), location, tobacco use, and family size.²² The ACA establishes reinsurance and risk-adjustment programs that will reward insurers who take on higher risks and impose costs on insurers who risk-select.²³ The ACA also ensures that risk is spread over a broader base by preventing insur-

17. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 1001, 10101, Stat. 119 (2010) [hereinafter ACA] (adding §§ 2711, 2712, 2713, 2714, 2715, 2715a, 2717, 2718, 2719, & 2719a to the PHSA).

18. ACA § 1002 (adding § 2707 to PHSA § 1302).

19. HALL, *supra* note 12, at 13. In the small-group market, states have set limits on how much premiums may vary by risk, but those limits are broad enough in most states to still allow rate variations of 50% or more based on health status, on top of unconstrained rate variation based on age and gender.

20. Under the Health Insurance Portability and Accountability Act, the ability of insurers to exclude individuals based on pre-existing conditions was limited, in particular when employees continued insurance but changed insurers. *See* 42 U.S.C. § 300gg(a).

21. ACA § 1201 (creating or amending PHSA §§ 2701, 2702, 2703, & 2705).

22. ACA § 1201 (creating PHSA § 2701).

23. ACA §§ 1341, 1343.

ers from splitting their individual or small-group business in each state into smaller risk pools.²⁴

Third, the ACA creates health insurance exchanges that will make a range of health plans available to individuals, small employers, and their employees in an environment where plans will compete based on price and quality rather than through risk selection.²⁵ It is hoped that the exchanges will increase the market power of individuals and small employers and reduce insurers' administrative and sales expenses, so that market dynamics more closely resemble those currently in play for larger employers. If so, these changes, coupled with increased competition, may bring down the cost of health insurance for small businesses.²⁶

Finally, the ACA expands coverage. The exchanges subsidize insurance costs through premium tax credits and cost-sharing reduction payments for lower-income individual purchasers as well as through tax credits for very small businesses with lower-income employees, thus making health insurance affordable to millions of Americans who currently lack coverage.²⁷ The ACA's minimum coverage requirement, often called the individual mandate, adds a stick to these carrots, imposing tax penalties on households that can afford health insurance but fail to obtain it.²⁸ The Employer Responsibilities Provision taxes large employers that do not offer adequate and affordable coverage to their employees.²⁹ Coupled with expansions in the Medicaid program, it is expected that these

24. ACA § 1312(c). Grandfathered plans, that is plans that were in existence as of the enactment of the ACA on March 23, 2010, are excepted from this requirement.

25. ACA § 1311(d)(4).

26. CHRISTINE EIBNER ET AL., RAND HEALTH, ESTABLISHING STATE HEALTH INSURANCE EXCHANGES: IMPLICATIONS FOR HEALTH INSURANCE ENROLLMENT, SPENDING, AND SMALL BUSINESSES (2010), available at http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR825.pdf; MCMORROW ET AL., *supra* note 10, at 3.

27. ACA §§ 1311, 1401, 1402, & 1412.

28. ACA § 1501.

29. ACA § 1513. Large employer is defined in this instance to include employers with fifty or more employees. I.R.C. § 4980H(c)(2) (2006). Thus some employers that are considered to be small employers elsewhere in the legislation, but those that nevertheless have more than fifty employees will be subject to the mandate. ACA § 1304(b)(1) (identifying employers with 100 or fewer employees as "small employers").

programs will reduce the number of uninsured Americans by 33 million.³⁰

II. THE SELF-INSURANCE EXCEPTION

But, there is a fly in the ointment. Although many of the ACA's reforms apply to all major insurance markets—individual, small group, and large group—as well as both fully-insured and self-insured plans, some reforms only apply to individual and small-group plans and others only apply to fully-insured plans.

It makes some sense that the ACA would treat large groups differently than small groups and individual enrollees. The large-group market functions pretty well. As already noted, most larger employers offer insurance.³¹ Large employers have the bargaining clout to obtain favorable rates from insurers.³² They present insurers with large risk pools and enough healthy employees to balance out any unhealthy employees. As a result, they offer insurers a measurable and manageable risk.³³

Large groups usually work well for their enrollees as well. Federal law already prohibits discrimination within groups on the basis of health status, both in terms of availability of coverage and premiums.³⁴ Additionally, large employer plans usually offer reasonably generous coverage and often a choice of plans.³⁵

Although there is logic behind treating large-group and small-group plans differently, it is not so clear that self-insured plans should be treated differently than insured plans. Before proceeding further, it is necessary to define more precisely the term “self-insured.” In theory the distinction between insured and self-insured plans is clear. It is based on who pays claims and bears risk—the employer or the insurer. In an insured plan, the employer pays the insurer a premium and the insurer pays all covered claims, bearing the risk that the cost of claims will exceed premium income. In a

30. CONG. BUDGET OFFICE, UPDATED ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT 3 (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf>.

31. Ninety-nine percent of firms with more than 200 employees, and ninety three percent of firms with between 50 and 199 employees, offer insurance. KFF/HRET, *supra* note 2, at 36.

32. David A. Hyman and Mark Hall, *Two Cheers for Employment-Based Insurance*, 2 YALE J. HEALTH POL'Y, L. & ETHICS 23, 30–35 (2001).

33. *Id.*

34. See 29 U.S.C. § 1182 (2006).

35. KFF/HRET, *supra* note 2, at 55.

self-insured plan, the employer (or other plan sponsor such as a union trust fund) pays claims out of its own funds and bears the risk that claims may exceed estimates.³⁶

In reality, the distinction between insured and self-insured plans is not so clear. Self-insured employers generally purchase “stop-loss” insurance, which transfers to a “reinsurer” a specified portion of the risk of self-insuring.³⁷ If an employer purchases a stop-loss policy with a very low specific or individual “attachment point” (the amount above which the stop-loss insurer bears the risk), a stop-loss policy can look very much like a regular high-deductible insured plan. There is little practical difference between a self-insured plan with an individual stop-loss attachment point of \$10,000 and a normal insurance plan with a high \$10,000 deductible.

But the similarity between insured and self-insured plans does not end there. Often employers do not manage the claims filed under their self-insured plan themselves; instead they enter into “administrative services only” contracts with insurers or other claims managers to process claims, resolve disputes, negotiate payment rates, and contract with provider networks.³⁸ Enrollees in these types of self-insured plans file their claims with an insurer that pays or denies their claims, sends them an explanation of benefits, and handles any appeals from claim denials. To the employee, the distinction between an insured plan and a self-insured plan administered by an insurer is invisible.

A. *The Growing Prevalence of Self-Insurance in Small Groups*

Traditionally self-insurance has flourished only in the realm of larger employer groups—those with 200 or more workers.³⁹ Smaller employers cannot bear the significant risk of incurring crippling expenses if serious medical problems arise, even for only one or two employees or their family members. Although stop-loss insurance can protect smaller self-funded employers from economic ruin, stop-loss insurance comes at a substantial cost, particularly for

36. Russell Korobkin, *The Battle over Self-Insured Health Plans, or “One Good Loop-hole Deserves Another,”* 5 YALE J. HEALTH POL’Y, L. & ETHICS 89, 105–06 (2005).

37. Mark Hall, *Regulating Stop-Loss Coverage May be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms,* 31 HEALTH AFF. 316, 317 (2012).

38. MICHAEL J. BRIEN & CONSTANTIJN W.A. PANIS, DELOITTE & ADVANCED ANALYTICAL CONSULTING GROUP, SELF-INSURED HEALTH BENEFIT PLANS 4 (2011), available at <http://www.dol.gov/ebsa/pdf/ACASelfFundedHealthPlansReport032811.pdf>.

39. *Id.* at 5; KFF/HRET, *supra* note 2, at 152.

older or unhealthy groups, which reduces the net economic benefit of self-insuring. Thus only 10% of employers with fewer than 200 workers were self-insured in 2004, according to the leading national survey.⁴⁰

Currently, however, market observers note that “[v]arious market and regulatory forces are driving a wave of small employers to shift to self-funded insurance coverage.”⁴¹ Principal among these forces are the regulatory changes enacted by the ACA, discussed more below. Anticipating these changes, employee benefits advisors openly tout self-insurance for small employers⁴² and multiple companies market stop-loss and administrative services to this market segment. The following is a sampling of recent revealing statements from websites marketing stop-loss insurance viewed in May 2012:

- AMF can provide stop loss on groups with as few as 10 eligible employees. . . . Stop loss limits of \$10,000+ are available, depending on state law.⁴³
- We underwrite coverage for employers with as few as 11 participating employees, and with specific retention levels from as low as \$5,000.⁴⁴
- Assurant Self-Funded Health Plans could be for you if you have 10 to 50 employees.⁴⁵

40. KFF/HRET, *supra* note 2, at 170.

41. *The Major Trend to Self-Funding: New Opportunities and Pitfalls for Insurers and Employers*, AIS HEALTH, http://aishealth.com/marketplace/c1m38_100511 (last visited Mar. 13, 2013); *see also* Dmah Wisenberg Brin, *Self Insurance May Be Winning Small Businesses*, DOW JONES NEWSWIRES (Mar 22 2011), <http://www.markfarrah.com/press.asp?article=91>.

42. *See, e.g.*, SELF-INSURANCE INSTITUTE OF AMERICA, COMPANIES OF ALL SIZES CAN OPERATE VIABLE SELF-INSURED GROUP HEALTH PLANS (2011), *available at* http://www.avalonbenefits.com/news_story.php?file=2011-02-14_150657.txt; UNITED BENEFIT ADVISORS, LLC, SMALL BUSINESSES BLAZE A NEW TRAIL WITH SELF-FUNDING (2011), *available at* <http://wn.ubabenefits.com/Download.aspx?ResourceID=7630>; George J. Pantos, *PPACA: Small Business And Self-Insurance: Dispelling Some Myths*, THE SELF-INSURANCE SOURCE (May 9, 2011, 1:17 PM), <http://georgegjp.wordpress.com/2011/05/09/ppaca-small-business-and-self-insurance/>; Michael Turpin, *A Case for Self Insuring Small Business*, HEALTH CARE BLOG (Apr. 8, 2011), <http://thehealthcareblog.com/blog/2011/04/08/a-case-for-self-insuring-small-business/>.

43. *Small Group Medical/Dental Stop Loss: 10-100 Lives*, AMF RISK MGMT. SOLUTIONS, <http://www.amfrms.com/smallgroup.htm> (last modified 2008).

44. *The IMG-Stop Loss Advantage*, INTERNATIONAL MEDICAL GROUP, <http://www.img-stoploss.com/about-img-stop-loss/IMG-sl-advantage.aspx> (last visited Sept. 18, 2012).

45. *Small Business Health Plan*, ASSURANT HEALTH, <http://www.assuranthealth.com/corp/ah/HealthPlans/self-funded-health-insurance.htm> (last visited Sept. 18, 2012).

- Spectrum is a leading provider of a comprehensive line of stop loss products and services for small employers with 25 to 199 employee lives.⁴⁶
- IAC specializes in small group plans . . . with “stop loss numbers” ranging from as low as \$10,000 to as high as \$25,000.⁴⁷
- CIGNA offers . . . administrative services for self-funded health plans . . . for employers with as few as 25 employees.⁴⁸
- Our expertise is in underwriting, selling and managing large claim risk for medical stop-loss for groups starting at 25 lives.⁴⁹
- Our goal is to bring a self insured product that best fits the below components of a self insured program to meet your needs. . . . Who is eligible? 10 - 50 Employee Businesses.⁵⁰
- Bardon Insurance Group is more than pleased to offer excess loss coverage to the small-group market (minimum of 35 participating employee lives).⁵¹
- . . . providing Medical Stop Loss Insurance to employer groups who self fund their medical benefits, . . . ECU specializes on employer groups with 25-250 covered employee lives.⁵²

46. *Spectrum’s Medical Stop Loss Products*, SPECTRUM UNDERWRITING MANAGERS, <http://www.spectrumhq.com/> (last visited Sept. 18, 2012).

47. *JAC Group Advantage*, SMALL BUSINESS INSURANCE SERVICES, http://www.sbisvcs.com/iac_group_advantage.htm (last visited Sept. 18, 2012).

48. *Group Health Insurance Designed for Companies with 51 to 250 Employees*, CIGNA (2012) <http://www.cigna.com/grouphealthplans/index.html> (last visited February 18, 2013). Cigna has been one of the most aggressive marketers of stop-loss insurance among the major insurers. Their stop-loss business grew by 17% between the first quarter of 2011 and 2012 and accounted for over \$400 million in revenue in the first quarter of 2012. CIGNA CORP., QUARTERLY FINANCIAL SUPPLEMENT 6 (2012), available at http://www.cigna.com/assets/docs/about-cigna/Investor%20Relations/CignaCorp_1Q12QFS.pdf. During the same period, their traditional “guaranteed cost” revenue fell by 3%.

49. IHC RISK SOLUTIONS, <http://www.ihcrisksolutions.com/> (last visited Sept. 18, 2012).

50. *About Self Insurance*, THE EXCHANGE FOR SELF INSURERS, http://healthexchangeforselfinsurers.com/About_Self_Insurance.html (last visited Sept. 18, 2012).

51. *Small Group Excess Loss*, BARDON INSURANCE GROUP, INC., http://www.bardon.net/prod_pdf_new/Excess_loss_for_35_to_10_%20Employee_Life_Groups.pdf (last visited Sept. 18, 2012).

52. E. COAST UNDERWRITERS, LLC, www.ecumgu.com/ (last visited Sept. 18, 2012).

- In today's stop-loss market, employers can find coverage with attachment points as low as \$10,000.⁵³
- I have recently heard about one of our competitors doing [self-funding] for small groups sized 5 and up.⁵⁴

The composition of the 474 self-insured groups to which the Department of Health and Human Services ("DHHS") granted annual insurance cap waivers further demonstrates the prevalence of self-insurance in the small employer market.⁵⁵ Almost 25% (109) of these self-insured employers had fewer than 50 enrollees, and 10% (47) had fewer than 25 enrollees.⁵⁶

A sophisticated simulation analysis by The Urban Institute concluded that if small employer stop-loss insurance was largely unregulated, a significant proportion of the small-group market would shift to self-insured status under the ACA.⁵⁷ The only contrary indication comes from an econometric projection by the RAND Corporation, which predicts no substantial increase in small employers that self-insure under a scenario with attachment points no lower than \$75,000.⁵⁸ However, changing that assumption to allow for stop-loss as low as \$20,000 produced an estimate that as many as one-third of small employers with up to 100 employees might self-insure, and the authors noted that small-firm self-insurance might become even more widespread if the ACA "induce[s] stop-loss insurers to offer more attractive policies geared specifically toward

53. Joanne Wojcik, *Smaller Firms Try Self-Funding Benefits*, BUSINESS INSURANCE (May, 29 2011), <http://www.businessinsurance.com/article/99999999/NEWS050101/399999918#>.

54. 100in1998, *Response to ASO for Small Groups of 5 and Up?*, ACTUARIAL OUTPOST (Feb. 14, 2011, 12:23 PM), http://www.actuarialoutpost.com/actuarial_discussion_forum/showthread.php?t=211409.

55. ACA § 1001 (adding PHSA § 2711). DHHS can grant waivers to this provision.

56. See THE CTRS. FOR MEDICARE AND MEDICAID SERVS.' CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, *SELF-INSURED EMPLOYERS: APPROVED APPLICATIONS FOR WAIVER OF THE ANNUAL LIMIT REQUIREMENTS*, available at http://cciio.cms.gov/resources/files/employer_07152011.pdf (last updated July 15, 2011).

57. MATTHEW BUETTGENS & LINDA J. BLUMBERG, THE COMMONWEALTH FUND, *SMALL FIRM SELF-INSURANCE UNDER THE AFFORDABLE CARE ACT 12* (Nov. 2012), available at http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2012/Nov/1647_Buettgens_small_firm_self_insurance_under_ACA_ib.pdf.

58. Christine Eibner et al., *Small Firms' Actions in Two Areas, and Exchange Premium and Enrollment Impact*, 31 HEALTH AFF. 324, 326–28 (2012). The study also projects that prohibiting self insurance would cause a net decline in small-firm workers covered by employer-sponsored insurance.

small firms that wish to avoid regulation.”⁵⁹ As shown by the marketing excerpts above, this is already happening.

B. Self-Insured Plans Under the ACA

Despite the fact that there is often little practical—indeed often no visible—difference between an insured and self-insured plan, this distinction has major legal consequences, both under the ACA and under prior law. For example, only insured individual and small-group plans are subject to the ACA’s requirement of covering an essential benefits package; self-insured plans are not.⁶⁰ Self-insured plans are not part of the ACA’s risk-adjustment program and are not part of the market-wide risk pooling to which insured individual and small-group plans are subject.⁶¹ Also, self-insured plans are not subject to the ACA’s limitations on factors that can be considered in setting insurance premiums.⁶² Neither are they governed by the ACA’s provisions that require individual, small-group, and large-group insurers to spend a minimum percentage of their premium revenue on health care claims and quality improvement (the “medical loss ratio” requirement), or those that require insurers to justify unreasonable rate increases.⁶³ None of these provisions apply to self-insured plans simply because they are not insurers, or to use the ACA’s term, “issuers.”⁶⁴

If small groups self-insure, two goals of the ACA will be thwarted. First, many of the ACA’s consumer protections for small-

59. *Id.* at 326.

60. ACA § 1201 (creating PHSA § 2707).

61. ACA §§ 1312(c), 1343.

62. ACA § 1201 (amending PHSA § 2701).

63. ACA § 1001 (creating §§ 2718 and 2794 of the PHSA); *see also* ACA § 1563(e) (adding § 7115 of ERISA); ACA § 1563(f) (adding § 9815 of the Internal Revenue Code and noting that § 2718 and § 2716, requiring insurers to meet minimum medical loss ratios and prohibiting discrimination in insured plans in favor of high-compensated employees, do not pertain to self-insured plans). I.R.C. § 105(h) already prohibited discrimination in favor of highly compensated employees in self-insured plans.

64. For the same reason, self-insured plans may not be subject to the ACA’s premium tax on health insurers. In fact, it is far from clear that the tax imposed by ACA § 9010 does not apply to stop-loss insurers. This fee applies to “covered entities,” defined by ACA § 9010(c) as an entity that “provide[s] health insurance for any United States health risk,” subject to a number of exclusions. Stop-loss insurers insuring self-insured employers cover “health risks,” and thus should be subject to the fee. *See* Timothy Jost, *Does the Fee Imposed by Section 9010 of the Affordable Care Act Apply to Stop-Loss Coverage?*, HEALTH REFORM WATCH (Nov. 2011), <http://www.healthreformwatch.com/2011/11/15/does-the-fee-imposed-by-section-9010-of-the-affordable-care-act-apply-to-stop-loss-coverage>.

group enrollees will be avoided. In particular, self-insured plans are not subject to the ACA's requirement that individual and small-group plans cover "essential health benefits,"⁶⁵ including hospitalization and ambulatory patient services, and also rehabilitative and habilitative services and devices, maternity and newborn care, and pediatric oral and vision care.⁶⁶ Therefore self-insured employers may choose to provide the lowest level of coverage that satisfies the Act's "minimum essential" standard, or perhaps provide standard coverage that does not satisfy the ACA's individual mandate. Moreover, self-insured plans are not subject to state insurance regulation; thus consumers will not be able to benefit from any additional protections provided by state law above and beyond the ACA's protections.⁶⁷ Finally, the stop-loss plans that insure self-insured plans are not subject to the ACA's guaranteed issue or renewal requirements, unreasonable premium increase restrictions, minimum medical loss ratio, or underwriting prohibitions.⁶⁸ Thus stop-loss insurers are able to raise their prices dramatically for self-insured groups, or to refuse to provide stop-loss coverage altogether if the risk experience of a self-insured plan deteriorates.

Second, if small groups self-insure, they escape the ACA's risk-adjustment and risk-pooling requirements and will be able to purchase stop-loss insurance at premiums based on the risk profile and experience of the group ("experience-rated premiums"). As long as self-insured small groups remain healthy, their sponsors will be able to access less expensive stop-loss insurance with premiums that reflect their low-risk status. However, if their experience deteriorates they will be able to purchase insurance in the regulated small-group market—either from the Small Business Health Options Program ("SHOP") exchanges, which will sell insurance to small groups, or in the market for small-group coverage that will continue to exist outside of the exchanges. The ACA makes this insurance available on a guaranteed issue basis, at average community rates, with no waiting periods or exclusion of preexisting condi-

65. ACA § 1201 (adding PHSA § 2707). In fact, labor market conditions may drive most self-insured plans to cover more or less the same benefits covered by insured plans, particularly since the summary of benefits and coverage required under § 2715 of the PHSA, added by ACA § 1001, applies to self-insured as well as insured plans and will make coverage gaps and restrictions transparent to plan applicants and enrollees.

66. ACA § 1302(b).

67. See *infra* text accompanying notes 80–81.

68. These requirements, as they apply to insured plans, are found in PHSA §§ 2701, 2702, 2703, & 2794, as amended by ACA §§ 1001, 1201.

tions.⁶⁹ Literally employers could buy their insurance when their employees are “on the way to the hospital,” almost instantaneously, since the exchange regulations allow small-group plans to enroll on a rolling basis rather than only during designated open enrollment periods.⁷⁰ The possibility of adverse selection against the exchanges and insured markets and serious destabilization of the small-group market is substantial.⁷¹

Presumably Congress did not apply some of the ACA’s requirements to self-insured plans because self-insurance has historically been a large-group phenomenon. Other provisions, such as the medical loss ratio or unreasonable premium review provisions, do not apply because they are directed at traditional state-regulated insurance products. However, as self-insurance becomes more common among small groups, one must ask whether all of the ACA’s exceptions for self-insured groups make sense, particularly if the consequences are so serious. One must also consider how the adverse consequences of these exceptions might be mitigated. Before we address these questions, however, we will look further into the history of the insured/self-insured distinction.

C. *Self-Insured Plans and ERISA*

The legal distinction between insured and self-insured health plans grew out of the Employee Retirement Income Security Act of 1974 (“ERISA”).⁷² ERISA was adopted to address the failure of prominent national pension funds.⁷³ Because pension funds were often sponsored by large national corporations, it made sense for reform to take place at the federal level. However, ERISA covers more than just pension funds. It also governs other employee “welfare benefits,” such as health insurance funds.⁷⁴ This created a conflict. In the early 1970s, employee welfare plans were almost all provided through purchased insurance.⁷⁵ Insurance, however, was regulated by the states, not by the federal government. The Supreme Court had held in 1869 that insurance was not sold in interstate commerce and thus Congress had no power to regulate it.⁷⁶ In

69. See *supra* notes 21–22.

70. 45 C.F.R. § 155.725(b) (2012).

71. BUETTGENS & BLUMBERG, *supra* note 57, at 2–5.

72. 29 U.S.C. § 1001 (2006).

73. See James A. Wooten, *A Legislative and Political History of ERISA Preemption*, Part 1, 14 J. PENSION BENEFITS 31, 33 (2006).

74. See *id.* at 34.

75. See Steve Kalmeyer, *ERISA and State Health Reform*, HEALTH POL’Y MONITOR, Spring 1997, at 1.

76. See *Paul v. Virginia*, 75 U.S. 168, 183–85 (1868).

1944, the Supreme Court reversed course in *United States v. Southeastern Underwriters*, recognizing authority for Congress to regulate insurance under the Commerce Clause.⁷⁷ Congress responded by adopting the McCarran-Ferguson Act, ceding back to the states the primary responsibility to regulate insurance.⁷⁸

In adopting ERISA, Congress reconciled the conflict between federal regulation of employee benefit plans and state regulation of insurance by creating a complex preemption clause that has bedeviled courts and commentators ever since. First, section 514(a) provides that ERISA “supersedes” any state law that “relates to any employee benefit plan,”⁷⁹ leaving these plans exclusively subject to federal regulation. Section 514(b)(1), however, provides that state laws regulating insurance are “saved” from preemption.⁸⁰ State authority over insurance regulation therefore is left firmly in place. However, section 514(b)(2) states that employee benefit plans shall not be “deemed” to be insurers or engaged in the business of insurance for state regulation purposes.⁸¹ That is, employee benefit plans themselves, as opposed to the insurers that insure them, are subject exclusively to federal regulation.

Nowhere in the original ERISA can the term “self-insured” be found, but when the question of the authority of the states to regulate employee benefit plans reached the Supreme Court in 1990, the Court held that ERISA exempts self-insured plans from state regulation.⁸² This is clear enough as far as it goes, but the practical impact requires further explanation. While ERISA exempts all employee benefit plans from direct state regulation, it allows state regulators to influence many of the terms of insured employee benefit plans by regulating the insurers that insure them.⁸³ The Supreme Court has upheld, for example, state laws requiring insurers that insure employee benefit plans to cover mandated benefits or to provide external appeals of plan decisions.⁸⁴ However, states cannot directly assert regulatory authority over employers themselves; thus self-insured plans are beyond the reach of state regulation and are exclusively subject to federal regulation, which was largely nonexistent until the ACA.

77. See *United States v. Se. Underwriters Ass’n*, 323 U.S. 533, 553 (1944).

78. McCarran-Ferguson Act, 15 U.S.C. §§ 1011–12 (2006).

79. 29 U.S.C. § 1144(a) (2006).

80. *Id.* § 1144(b)(1).

81. *Id.* § 1144(b)(2)(B).

82. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

83. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985).

84. See *id.* at 758; see also *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 370–87 (2002).

Self-insured plans were much less common before ERISA,⁸⁵ but the self-insured “loophole” in ERISA led to their rapid growth. Although the percentage of employee benefit plans that are self-insured varies, at least half of the employees in the United States with health plan coverage are covered by self-insured plans in any given year,⁸⁶ although, as noted above, some of these plans are self-insured in name only, with the plan sponsor bearing minimal risk and most of the risk borne by the insurer.

D. Defining “Self-Insured” under ERISA and the ACA

Although ERISA did not define the term “self-insured,” a definition is found in an unrelated provision of the Internal Revenue Code adopted four years later which prohibits self-insured plans from discriminating in favor of highly compensated employees.⁸⁷ That statute defines the term to mean, “[a] plan of an employer to reimburse employees for [medical] expenses . . . for which reimbursement is not provided under a policy of accident and health insurance.”⁸⁸ The word “policy” suggests that an employer is not self-insured if it purchases insurance that provides at least partial reimbursement for medical costs, which might include stop-loss coverage. Stop-loss insurance reimburses only the employer, not the employees, so it is unclear how this definition would apply to typical self-funded employer arrangements.⁸⁹

In contrast to the paucity of references to self-insured employee benefit plans in statutes affecting health benefit plans prior to 2010, the ACA uses the term “self-insured” two dozen times (and the term “self-funded” once). Again, however, it does not define the term.⁹⁰ In some sections, the statute uses the following phrases: “self-insured plan that is not subject to State insurance regula-

85. Kalmeyer, *supra* note 75.

86. KFF/HRET, *supra* note 2, at 151.

87. I.R.C. § 105(h) (2006).

88. *Id.* § 105(h)(6). Section 105 further defines “accident and health insurance” to mean an accident and health plan or state sickness and disability fund. *Id.* § 105(e).

89. Other federal statutes regulating employee benefit plans also refer to self-insured plans, notably the continuation of coverage provisions of the Consolidated Omnibus Reconciliation Act, 29 U.S.C. § 1164-2 (2006), and a 2008 statute providing for continued coverage for students on medically necessary leaves of absence, 29 U.S.C. § 1185c(e)(2) (2006). However, these statutes also do not define “self-insured.”

90. Section 4376(c) of the ACA defines the term “applicable self-insured plan” for purposes of a fee imposed on self-insured plans to help finance the patient-centered outcomes research program, but this definition is found in title VI of the ACA, not in Title I, and does not seem to apply generally.

tion;⁹¹ “self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974);⁹² or, “group health plan . . . to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.”⁹³ This indicates that the term is meant to incorporate ERISA’s preemption schema, but otherwise self-insured is left undefined.

The ACA also indirectly incorporates the concept of self-insurance through its regulatory structure. Most of the regulatory provisions of Title I apply to “a group health plan and a health insurance issuer offering group or individual health insurance coverage.”⁹⁴ A group health plan is defined as an ERISA plan.⁹⁵ An “issuer” is defined as “an insurance company, insurance service, or insurance organization . . . which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance (within the meaning of section 514(b)(2) of the Employee Retirement Income Security Act of 1974). Such term does not include a group health plan.”⁹⁶ Thus the ACA divides the world of health benefits coverage into two continents: state-regulated “issuers” that cover groups and individuals, and other “group health plans” covered by ERISA, which refers to self-funded employers.⁹⁷

91. *See, e.g.*, ACA § 2719(b)(1)(B).

92. *See, e.g.*, ACA § 1343(a)(1).

93. *See, e.g.*, ACA § 1301(b)(1)(B).

94. *See, e.g.*, PHSA §§ 2711, 2713, 2713, 2714, 2715, 2715A, 2717, 2719, & 2719A (codified as amended by ACA § 1001 in scattered subsections of 42 U.S.C. § 300gg); PHSA §§ 2704, 2705, 2706, & 2709 (codified as amended by ACA § 1201 in scattered subsections of 42 U.S.C. § 300gg).

95. *See* 42 U.S.C. § 300gg-91(a)(1) (2006).

96. *Id.* § 300gg-91(b)(2). “Health insurance coverage” “means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.” *Id.* § 300gg-91(b)(1).

97. Almost, but not quite. Excepted benefit plans, for example fixed-dollar indemnity plans, are not covered if offered as independent benefits. *See id.* § 300gg-91(c)(3); *see also* Timothy Stolfus Jost, *Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them*, 5 ST. LOUIS U. J. HEALTH L. & POL’Y 27, 45–51 (2011).

III. STATE REGULATION OF STOP-LOSS INSURANCE

As explained shortly, stop-loss insurance is subject to state regulation, making it a ready vehicle for policy reforms. In exercising their authority, state lawmakers should regulate the sale of stop-loss to small employers in a manner that preserves the integrity of state and federal regulation of regular health insurance. States can do so by taking one of two basic approaches to regulating stop-loss insurance for small employers: banning its sale or declaring that stop-loss coverage is subject to the same laws that apply to regular health insurance. Currently examples of both approaches and various hybrids can be found in the laws of about twenty states.⁹⁸

Under the banning approach, states declare that certain forms of stop-loss may not be sold at all or not sold to certain employers. Banning stop-loss makes self-insuring infeasible for small employers, since the risk of being self-insured would be too great without stop-loss protection. This in turn encourages small employers to become fully insured and thus subject to the ACA's consumer and market protection provisions.

Under the regulatory approach, stop-loss insurance may be sold, but it must meet some or all of the same requirements that apply to normal health insurance that covers employees more directly. Regulating stop-loss allows self-insuring to continue but removes most or all of the regulatory differences that might motivate using self-insurance principally as a legal loophole.

Each approach (banning or regulating) requires that states draw a line between which forms of stop-loss should be banned or regulated and which should be permitted or left unregulated. The majority of state laws that have addressed this issue are based on the National Association of Insurance Commissioners' Stop-Loss Insurance Model Act ("NAIC Model Act"), which sets minimum attachment points defining what constitutes legitimate stop-loss insurance. The purpose of setting attachment point limits is to demarcate when stop-loss insurance offers such comprehensive coverage as to in effect become medical insurance, rendering a plan fully-insured rather than self-insured. The minimum individual at-

98. Mark A. Hall, *Regulating Stop-Loss Coverage May Be Needed to Deter Self-Insuring Small Employers from Undermining Market Reforms*, 31 HEALTH AFF. 316, 317-18 (2012).

tachment point recommended by the NAIC in 1995 was \$20,000, but a number of states allow attachment points as low as \$10,000.⁹⁹

However, the pace of medical inflation since these levels were set would easily warrant a several-fold increase in these minimum attachment points. An NAIC subcommittee interpreted an actuarial analysis, recently commissioned by the NAIC,¹⁰⁰ as justifying tripling the specific attachment point to make the proportion of risk that employers retain equivalent to the level in 1995. This increase would align current attachment levels with the level of risk that the NAIC determined was appropriate when it first recommended a stop-loss boundary.¹⁰¹

Another logical reference point for minimum attachment points is the stop-loss attachment point levels typically purchased by larger, genuinely self-insured employers. In 2011, the average attachment point for employers with 50-200 employees was \$73,824, and for groups of 200-1000 employees, it was \$136,710.¹⁰² Based on these figures, the California legislature considered a bill that would ban the sale of stop-loss with an attachment point less than \$95,000.¹⁰³

Yet another line-drawing approach that states employ is to use the same line that defines the normal regulated insurance market: small versus medium or large groups. Thus New York and Oregon prohibit the sale of stop-loss insurance to groups with fifty or fewer employees, and Delaware does the same for firms with fewer than fifteen employees.¹⁰⁴ North Carolina prohibits insurers from serv-

99. NAT'L ASS'N OF INSURANCE COMM'RS, *Stop-Loss Insurance Model Act*, in NAIC MODEL LAWS, REGULATIONS AND GUIDELINES I-92-1 (2012).

100. JAMES T. O'CONNOR & ERIK C. HUTH, NAT'L ASS'N OF INSURANCE COMM'RS, *STATISTICAL MODELING AND ANALYSIS OF STOP-LOSS INSURANCE FOR USE IN NAIC MODEL ACT* (May 24, 2012), *available at* http://www.naic.org/documents/committees_b_hcra_wg_120606_milliman_stop_loss_report.pdf.

101. Memorandum from Frank Horn, Chair of the Self-Ins. (B) Subgrp. to Jay Ripps, Chair of the Health Care Reform Actuarial (B) Working Grp. (May 30, 2012), *available at* http://www.naic.org/documents/committees_b_hcra_wg_120606_milliman_interpretations.pdf. The subgroup also recommends substantial increases to the aggregate attachment point minimums. *Id.*

102. KFF/HRET, *supra* note 2, at 179.

103. Chad Terhune, *Proposed Limits on Health Self-Insurance Plans Debated*, L.A. TIMES (April 21, 2012), articles.latimes.com/2012/apr/21/business/la-fi-small-business-health-20120421.

104. *See* DEL. CODE ANN. tit. 18, § 7218(e) (West 2011); N.Y. INS. LAW §§ 3231(a)-(b), 4317(e)(1) (McKinney 2012); OR. REV. STAT. § 742.065(3) (2011). Delaware's restriction only applies to groups fewer than fifteen, and only to stop-loss sold by insurers who also market small-group coverage.

ing as third-party administrators for self-funded small employers.¹⁰⁵ The apparent logic is that although small employers are legally entitled to self-insure, doing so threatens states' market regulatory scheme. Accordingly states use their regulatory authority over insurers to prohibit them from assisting employers with self-funding. Without stop-loss insurance or third-party administration, self-insurance becomes too risky and burdensome for small employers.

Short of banning stop-loss insurance, other states choose to impose some or all of the same requirements on stop-loss insurance sold to small employers as those that apply to normal small-group health insurance. For instance, New Jersey's insurance commissioner ruled recently that it constitutes an unfair trade practice for insurers to refuse to sell stop-loss insurance to small employers based on health risk or conditions.¹⁰⁶ By statute, North Carolina requires that stop-loss insurance sold to small employers comply with all of the underwriting, rating, and other standards of its small-group health insurance reform law.¹⁰⁷

A. ERISA Preemption

States' efforts to regulate or restrict stop-loss insurance might be resisted based on claims of ERISA preemption, with opponents arguing that *any* regulation of stop-loss is impermissible if it is motivated by an attempt to *influence* employers' decisions about self-insuring. Some employers (or their stop-loss insurers) who view ERISA as protecting a right to self-insure will likely oppose any law that substantially burdens that choice. Despite loose language in some judicial opinions that appears to support this employer-burden challenge under ERISA,¹⁰⁸ this challenge should not succeed.

105. See N.C. GEN. STAT. § 58-50-130(a)(5) (2011).

106. Memorandum from Thomas B. Considine, Comm'r of the N.J. Dep't of Banking and Ins., to All Authorized and Admitted Insurers Writing Stop Loss Ins. to Small Emp'rs and All Licensed Ins. Producers (Oct. 3, 2011), *available at* http://www.state.nj.us/dobi/bulletins/blt11_20.pdf.

107. See N.C. GEN. STAT. § 58-50-130(a)(5) (2011).

108. The Fourth Circuit for instance has said that "state insurance regulation may not directly or indirectly regulate self-funded ERISA plans," and that states may not use "stop-loss insurance policies as a vehicle to impose the requirements . . . on self-funded ERISA plans These effects impermissibly intrude on the relationship between an ERISA plan and its participants and beneficiaries." *Am. Med. Sec. Inc. v. Bartlett*, 111 F.3d 358, 361-65 (4th Cir. 1997). Those statements were made however in the context of a law that aimed to force employers to cover mandated benefits. For other forms of stop-loss regulation, the court was careful to note: "[t]his is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states." *Id.* at 358.

In support of state regulation, both the Department of Labor and federal courts have ruled that when a purportedly self-insured group plan purchases stop-loss covering 100% of its risk, this is an insured plan subject to state regulation.¹⁰⁹ Federal courts have also recognized that even if the plan sponsor of an employee benefits plan retains some risk, the plan can still be regarded as an insured rather than self-insured plan if it bears only a small portion of risk. Thus in *Brown v. Granatelli*,¹¹⁰ the Fifth Circuit observed:

[W]e are wary lest an overly literal reading of the statute frustrate an otherwise manifest legislative purpose. We do not suggest that [Texas insurance regulation] can be avoided by naming an employee benefit plan as the insured on a policy which in reality insures the plan participants. If, for example, a plan paid only the first \$500 of a beneficiaries' health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants.¹¹¹

Many state courts and regulators have similarly held that stop-loss insurance is subject to state regulation. The Texas Supreme Court recently held that stop-loss insurance is subject to the state's premium tax that applies to normal health insurance, even though stop-loss insurance covers only employers and not patients directly.¹¹² Courts from California,¹¹³ Indiana,¹¹⁴ Iowa,¹¹⁵ Kansas,¹¹⁶

109. See *McDaniel v. N. Am. Indem.*, No. 1:02-cv-0422-LJM-JMS, 2008 WL 1336832, at *2 (S.D. Ind. Apr. 8, 2008); *Home Health Care Affiliates of Miss., Inc. v. Am. Heartland Health Adm'rs, Inc.*, No. 1:01-cv-00489-D-A, 2003 WL 24046753, at *6 (N.D. Miss. Mar. 21, 2003); EMP. BENEFITS SEC. ADMIN, U.S. DEP'T OF LABOR, 2003-03A, ADVISORY OP. (2003), available at <http://www.dol.gov/ebsa/regs/aos/ao2003-03a.html>; PENSION AND WELFARE BENEFITS ADMIN., DEP'T OF LABOR, 92-21A, ADVISORY OP. (1992), available at <http://www.dol.gov/ebsa/programs/ori/advisory92/92-21a.htm>.

110. 897 F.2d 1351 (5th Cir. 1990).

111. *Id.* at 1355. The court concluded that the fact that the stop-loss insurer had only paid four claims in five years confirmed that in fact it was true stop-loss insurance.

112. See *Tex. Dep't of Insurance v. Am. Nat'l Ins. Co.*, No. 10-0374, 2012 WL 1759457, at *9 (Tex. May 18, 2012).

113. See *Gen. Motors Corp. v. Cal. State Bd. of Equalization*, 815 F.2d 1305, 1309-11 (9th Cir. 1987).

Minnesota,¹¹⁷ Missouri,¹¹⁸ and Wisconsin¹¹⁹ have also adopted this or very similar positions. These cases have repeatedly upheld state regulation of stop-loss health insurance based both on interpretations of governing state laws and on the absence of any pre-emption by ERISA.

The logic of the opposing argument would bar virtually any regulation of stop-loss insurance since almost all regulation creates at least some burden on employers and thus may influence employers' health benefits decisions, but clearly that is not ERISA's intent or effect. Instead ERISA was intended to preserve states' traditional authority to regulate insurance.¹²⁰ Moreover, as noted above, ERISA nowhere expresses a right of employers to self-insure; indeed it does not even mention the term. Despite ERISA's complexity, its relevant provision—the deemer clause—is actually quite clear: the deemer clause simply expresses the technical limitation that states may not regard employers as insurers, even if they happen to bear their own insurance risk.¹²¹ This bar against regulating employers applies regardless of whether they are insured or self-insured. Declaring them self-insured is only judicial shorthand for understanding when regulation of *employees'* coverage is directed at employers rather than insurers. If employers provide workers' coverage themselves rather than purchasing it, ERISA's bar against regulating employers means that states cannot regulate *employees'* coverage. However, this bar presents no obstacle to states regulating insurance that employers purchase for themselves, such as stop-loss insurance.

This fairly clear-cut analysis is cast in doubt by *American Medical Security Inc. v. Bartlett*,¹²² which is considered the leading case on this issue. There, the Court of Appeals for the Fourth Circuit struck Maryland's attempt to require small employers that had purchased

114. See *Avemco Ins. Co. v. State ex rel McCarty*, 812 N.E.2d 108, 116–17 (Ind. Ct. App. 2004).

115. See *Magellan Health Serv., Inc. v. Highmark Life Ins. Co.*, 755 N.W.2d 506, 514 (Iowa 2008).

116. See *Am. Trust Adm'ns v. Sebelius*, 44 P.3d 1253, 1259 (Kan. 2002); *Am. Trust Adm'ns v. Sebelius*, 981 P.2d 248, 254–55 (Kan. 1997).

117. See *BCBSM, Inc. v. Minn. Comprehensive Health Ass'n*, 713 N.W.2d 41, 47–48 (Minn. Ct. App. 2006).

118. See *Fidelity Sec. Life Ins. Co. v. Dir. of Revenue*, 32 S.W.3d 527, 530–31 (Mo. 2000).

119. See *Safeco Life Ins. Co. v. Musser*, 65 F.3d 647, 652–54 (7th Cir. 1995).

120. See 29 U.S.C. § 1144(b)(1)(2)(B) (2006).

121. See *id.* § 1144(b)(2); *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

122. *Am. Med. Sec., Inc. v. Bartlett*, 111 F.3d 358, 363–365 (4th Cir. 1997).

stop-loss insurance plans with low attachment points to cover the same benefits mandated for ordinary health insurance. The court explained its decision by observing that the “purpose and effect” of the regulation’s provisions “are directed at self-funded employee benefit plans.”¹²³ As the court explained, by “aiming at the plan-participant relationship, Maryland law violates the ERISA provision that no ERISA plan ‘shall be deemed to be an insurance company . . . for purposes of any law of any State purporting to regulate insurance companies [or] insurance contracts.’”¹²⁴

This precedent should not deter states from regulating stop-loss insurance in similar or other ways. First, the *Bartlett* court’s reasoning has been thoroughly criticized and therefore may not be convincing to other circuits. For instance, the leading and most recent scholarly analysis by Professor Korobkin suggests a bright-line rule based on whether insurers or employers are the object of regulation. Such analyses are more consistent with ERISA’s purpose and easier for insurance regulators and courts to administer than rules that make pre-emption turn on whether the state’s intent is to affect employers’ benefits decisions.¹²⁵ Therefore the fact that stop-loss regulation might indirectly affect the benefits that employers provide to their workers should be legally inconsequential. The Supreme Court has stated this principle explicitly in the context of health insurance regulation,¹²⁶ but the same principle should apply to stop-loss regulation. The line of ERISA cases that inquire whether state law burdens employers’ benefit decisions is aimed at the threshold question of whether the law “relates to” employee benefits at all,¹²⁷ and not at the deemer clause issue.

Another good reason for other courts to decline to follow *Bartlett* is that, since the *Bartlett* decision, the Supreme Court has broadened its interpretation of ERISA’s insurance savings clause, which is the basis on which states are authorized to regulate stop-loss insurance. In 2003, the Court made “a clean break” from its earlier, narrower decisions about the scope of the insurance savings clause and

123. *Id.* at 363.

124. *Id.* at 364 (quoting 29 U.S.C. § 1144(b)(2)(B)).

125. See Korobkin, *supra* note 36, at 126–28.

126. See *Holliday*, 498 U.S. at 53 (explaining that “employee benefit plans that are insured are subject to indirect state insurance regulation. An insurance company that insures a plan remains [subject to] . . . state laws ‘purporting to regulate insurance’ . . . [despite] the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently affected by state insurance regulations insofar as they apply to the plan’s insurer.”).

127. See, e.g., *Retail Indus. Leaders Ass’n v. Fielder*, 475 F.3d 180, 191 (4th Cir. 2007).

endorsed a more “common sense” approach that asks whether the state law is “specifically directed toward entities engaged in insurance,” and whether the state law “substantially affect[s] the risk pooling arrangement between the insurer and the insured.”¹²⁸

States can also avoid the *Bartlett* precedent by writing their stop-loss laws to avoid the red flags that caused that court to reject Maryland’s particular statute. Preemption under ERISA depends on precise analysis of the technical statutory or regulatory language. Therefore laws that appear to have largely the same intent and effect can fall on different sides of the preemption line depending entirely on seemingly minor differences in their exact wording. In Maryland for instance, the state revised its stop-loss law to avoid any mention of employers’ decisions regarding mandated benefits. It adopted a version of the revised NAIC Model Act described above, which simply forbids insurers from selling stop-loss with an attachment point below \$10,000.¹²⁹ Because the law targets only insurers and makes no reference to employers, it, like the NAIC Model Act, is thought to avoid any preemption problems.¹³⁰ In fact state laws based on this act have never been challenged in court.

B. Federal Responses

Although the states clearly have the authority to deal with the problems posed by the proliferation of self-insured plans in the small-group market, a better solution might be a federal response. A federal solution would avoid any questions of ERISA preemption, and would also obviate the need for fifty state legislatures to act independently to address the problem. Given the political division and gridlock that currently affect many state legislatures as well as the disinclination of many states to facilitate the smooth functioning of the ACA, federal action, if possible, is preferable.

Under federal law, prohibiting the sale of stop-loss insurance would appear to require congressional action, but federal agencies have other bases for regulatory authority. The ACA uses the term “self-insured” repeatedly, without definition, and the Secretary of Health and Human Services (“HHS”) has full authority to promulgate regulations defining the term.¹³¹ Moreover, the Secretary has

128. *Ky. Ass’n of Health Plans v. Miller*, 538 U.S. 329, 339–42 (2003).

129. MD. CODE ANN., INS. § 15-129 (LexisNexis 2011).

130. Knowledgeable sources whom we consulted confidentially in August 2011 believe that U.S. Department of Labor officials provided the NAIC informal guidance that its revised Model Act would not be preempted.

131. The Secretary has authority under ACA § 1311(a) and 42 U.S.C. § 300gg-92 to define terms under the ACA and the Public Health Services Act.

authority to define the term “health insurance issuer,” which also is used throughout the ACA to describe entities subject to the ACA insurance reforms.¹³² The law broadly defines this term as “an insurance company, insurance service, or insurance organization . . . which is licensed to engage in the business of insurance in a State.”¹³³ This describes stop-loss insurers and so the Secretary has authority to clarify which stop-loss insurers qualify as “health insurance issuers.” The definition is key, as a number of important provisions of the ACA, such as the essential health benefits requirement, only apply to “issuers” and thus by implication not to self-insured plans.

Federal regulations drafted by HHS should be developed in coordination with the Department of Labor, which has authority to promulgate regulations defining terms under ERISA,¹³⁴ and the Department of the Treasury, the only agency that currently has regulations defining “self-insured.” These agencies have indicated their interest in considering just such a move by issuing a joint “Request for Information Regarding Stop Loss Insurance” in spring 2012.¹³⁵ The request seeks information about the prevalence and nature of self-insured arrangements for medium and small groups, including attachment point levels, and trends in the market in response to the ACA.

Federal definitions of “self-insured” and of “issuer” should recognize that a plan is not self-insured unless the plan sponsor in fact bears substantial risk for claims for which the plan is responsible. Such a definition would build on the Internal Revenue Service’s current regulation, which defines a self-insured plan as one that “does not involve the shifting of risk to an unrelated third party.”¹³⁶ As noted above, the Department of Labor has concluded that an arrangement in which a purportedly self-insured group plan purchases 100% stop-loss coverage is not self-insured, but rather an insured plan subject to state regulation.¹³⁷ Federal courts also acknowledge that an employee benefits plan with 100% stop-loss cov-

132. ACA § 1311(a); *see also* 42 U.S.C. § 300gg-92.

133. 42 U.S.C. § 300gg-91(b)(2). The current regulatory definition simply repeats this definition. 45 C.F.R. § 144.103 (2012).

134. *See* 29 U.S.C. § 1135 (2006).

135. Request for Information Regarding Stop Loss Insurance, 77 Fed. Reg. 25788 (May 1, 2012), *available at* <http://webapps.dol.gov/FederalRegister/HtmlDisplay.aspx?DocId=26054&AgencyId=8&DocumentType=3>.

136. Treas. Reg. § 1.105-11(b)(ii) (2012) (implementing IRC § 105(h)).

137. *See* EMP. BENEFITS SEC. ADMIN., U.S. DEP’T OF LABOR, 2003-03A, *supra* note 109; PENSION AND WELFARE BENEFITS ADMIN., DEP’T OF LABOR, 92-21A, *supra* note 109.

erage is an insured and not a self-insured plan.¹³⁸ Beyond this, federal courts have recognized that even if the plan sponsor retains risk, the plan can still be an insured rather than self-insured plan if too little risk is borne by the plan itself.¹³⁹

The federal agencies authorized to issue regulations and definitions under the ACA are capable, both legally and practically, of defining when enough risk is transferred to an insurer for a plan to be considered insured rather than self-insured. Federal agencies could use an updated version of the approach taken by the NAIC and the states described above or set a minimum attachment point based on stop-loss policies typically purchased by larger employers. Another conceptually coherent approach would be to determine whether an employer's plan retains a substantial majority of the risk of claims. This approach would allow attachment points for stop-loss coverage to vary, so long as they are high enough to ensure that most of the actuarial risk under a particular plan is borne by the employer or plan sponsor.

Under either approach, coverage that is not genuinely self-insured would become subject to all requirements of the ACA that pertain to issuers. Thus insurers that sell to groups whose retained risk falls below the definitional threshold would have to comply with all requirements of the ACA that apply to health insurance issuers, regardless of whether the policy is nominally written as a stop-loss or fully-insured plan. If an insurer writes "stop-loss" insurance for a group that does not qualify as self-insured, the insurer would, for example, have to comply with medical loss ratio requirements and justify unreasonable premium increases. The insurer also would not be allowed to impose annual or lifetime limits and would have to cover preventive services and provide the essential health benefits package to small groups.

A federal definition of "self-insured" that requires a self-insured plan to actually bear substantial risk makes sense from a public policy perspective. As noted at the outset, a major goal of the ACA was to ensure consumer protections and end risk underwriting in the small-group market. Requiring a group-plan sponsor to actually bear substantial risk, either as a proportion of total risk or by maintaining higher minimum stop-loss attachment points, would ensure that employees of small employers enjoy the protections in-

138. *McDaniel v. N. Am. Indem.*, No. 1:02-cv-0422-LJM-JMS, 2008 WL 1336832, at *2 (S.D. Ind. Apr. 8, 2008); *Home Health Care Affiliates of Miss., Inc. v. Am. Heartland Health Adm'rs, Inc.*, No. 1:01-cv-00489-D-A, 2003 WL 24046753, at *6 (N.D. Miss. Mar. 21, 2003).

139. *Brown v. Granatelli*, 897 F.2d 1351, 1355 (5th Cir. 1990).

tended by the ACA. It would also protect the exchanges and the small-group market generally from the risk of adverse selection. Large plans could still self-insure—nothing would be fixed that is not broken—but the small-group market would not be further broken.

CONCLUSION

Two central goals of the ACA are to ensure health insurance consumers adequate coverage and to end risk selection by insurance companies in the small-group market. The ACA fails, however, to extend a number of its significant small-group protections to self-insured plans. If small-group plans that are insured through stop-loss coverage against any substantial risk can claim to be self-insured, both the consumer protections and the risk underwriting prohibitions of the ACA will be greatly undermined. Both the state and the federal governments have the ability to address this problem. They must do so if the ACA is to attain its promise.

566 NYU ANNUAL SURVEY OF AMERICAN LAW [Vol. 68:539