

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-12

Subject: Small Businesses and Health Reform

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Referred to: Reference Committee G
(Jerry D. McLaughlin, II, MD, Chair)

1 The Patient Protection and Affordable Care Act (ACA, PL 111-148, as amended by the Health
2 Care and Education Reconciliation Act of 2010, PL 111-152) makes fundamental changes to the
3 availability and cost of health insurance coverage for small businesses. The ACA provides small
4 businesses with more opportunities to offer health insurance to their employees by issuing tax
5 credits to small businesses and by requiring states to establish Small Business Health Options
6 Program (SHOP) exchanges.

7
8 Certain provisions of the ACA, however, may provide an increased incentive for small businesses
9 to self-insure, in order to avoid costs associated with state regulation, as well as the ACA
10 requirements concerning the essential health benefits package and modified community rating.
11 Self-insured plans have long been a concern for the American Medical Association (AMA),
12 because the preemption of state law in the Employee Retirement Income Security Act of 1974
13 (ERISA) also preempts key physician and patient protections. Other key issues associated with
14 small businesses self-insuring at a greater rate include the impact on the viability of SHOP
15 exchanges, and the adequacy of coverage of enrollees of self-insured plans.

16
17 This report provides a summary of legislative activity, highlights the potential impact of the ACA
18 on the decision of small businesses to self-insure, outlines how self-insuring impacts physicians
19 and patients, summarizes relevant AMA policy, and presents policy recommendations.

20 21 LEGISLATIVE ACTIVITY

22
23 The ACA includes a number of provisions that will affect whether small businesses with fewer
24 than 100 employees decide to offer health insurance to their employees. Since 2010, firms with
25 fewer than 25 employees and average annual wages of less than \$50,000 have been eligible for tax
26 credits if they subsidize at least half of the cost of health insurance for their employees. Starting in
27 2014, firms with 50 or more employees will face penalties if they do not offer affordable health
28 insurance coverage to their employees. Additionally, the health insurance marketplace for small
29 businesses will change significantly when firms with fewer than 100 employees become able to
30 compare health insurance options and purchase coverage through SHOP exchanges.

31
32 Small group plans both inside and outside of the exchanges face additional requirements under the
33 ACA. Starting in 2010, small group plans are required to provide first-dollar coverage on
34 preventive benefits, are prohibited from placing lifetime limits on essential health benefits, and are
35 required to phase out annual limits on essential benefits until the prohibition of such limits in 2014.
36 Also in 2014, small employer plans will be required to cover at least the essential health benefits
37 package and will be subject to guaranteed issue and modified community rating. Deductibles for

1 new small employer health plans will be limited to \$2,000 for individuals and \$4,000 for families
2 in 2014.

3
4 The individual responsibility requirement, effective in 2014, is expected to place additional
5 pressure on small employers to offer health insurance to their employees so their employees can
6 avoid paying any penalty associated with the requirement. The individual responsibility
7 requirement also is expected to contribute to the size and strength of the individual and small group
8 markets.

9
10 IMPLEMENTATION OF THE ACA: PROSPECTS FOR SELF-INSURING

11
12 Despite the many improvements of the ACA to the small group marketplace, some provisions may
13 give small businesses greater incentive to self-insure. The ability for all businesses, including
14 small businesses, to self-insure is provided for under ERISA. Rather than paying premiums to an
15 insurer to assume responsibility for employees' covered health care expenses, employers that self-
16 insure with ERISA plans bear the financial risk of covering their employees themselves, relying on
17 insurers simply as third-party administrators to assist with claims management and similar
18 activities. Self-insuring exempts the offered plans from many requirements of the ACA, including
19 those related to modified community rating and the essential health benefits package. ERISA also
20 has a preemption clause that states "[ERISA] shall supersede any and all State laws insofar as they
21 relate to any employee benefit plan" – which includes health care. Therefore, ERISA plans are not
22 directly subject to state regulation. As a result, none of the patient and physician protections
23 included in state laws apply to self-insured plans.

24
25 The combination of the ACA's guaranteed issue provision and the expected availability of
26 comprehensive stop-loss coverage minimizes the risk of self-insuring for small businesses. Many
27 predict that the small businesses most likely to consider self-insuring will be those with low-cost
28 employees (i.e., healthier employees who will not incur high health care costs), because these
29 companies will likely be the most negatively impacted by the ACA's modified community rating
30 requirement, which allows for premiums to vary by a ratio of only 3 to 1 based on age and 1.5 to 1
31 based on tobacco use. Therefore, small employers with healthier employees will likely be
32 subsidizing individuals in the small group market that are more costly. Also, many small
33 employers expect health premiums to increase on implementation of the essential health benefits
34 package provision of the ACA, because it may require them to offer more comprehensive health
35 insurance coverage than what they would otherwise offer.

36
37 Small businesses choosing to self-insure can purchase stop-loss coverage to minimize their risk of
38 paying for high, catastrophic health care expenses incurred by their employees. Businesses that
39 have stop-loss coverage are still exempt from relevant federal and state regulations. Stop-loss
40 coverage can either be based on the expenses of a covered individual or the insured group as an
41 aggregate. Stop-loss coverage becomes effective once expenses reach a predetermined amount,
42 known as the "attachment point." Above the attachment point, typical stop-loss coverage policies
43 pay for 100 percent of the cost of the claims. Therefore, its function is similar to a deductible for
44 employers. A common attachment point for individual-specific stop-loss policies for small firms is
45 \$20,000; a common attachment point for aggregate stop-loss coverage is 125 percent of expected
46 claims for the group.

47
48 The National Association of Insurance Commissioners (NAIC) developed a model law addressing
49 stop-loss coverage, the Stop Loss Insurance Model Act. The model law, last revised in 1999 before
50 the enactment of the ACA, identifies different stop-loss requirements for groups with 50 or fewer

1 employees, and groups with more than 50 employees. For groups of 50 or fewer employees, the
2 NAIC's model stop-loss law sets a minimum aggregate attachment point to the greater of:
3 a) \$4,000 times the number of group members, b) 120 percent of expected claims, or c) \$20,000.
4 For groups with more than 50 employees, the model act dictates that aggregate attachment points
5 should not be lower than 110 percent of expected claims. Because the model law was last updated
6 more than a decade ago, there is growing support for adjusting the law's minimum attachment
7 point limits for inflation, to account for the escalation in health insurance premiums and medical
8 costs.

9
10 RAND Corporation predicts that if available stop-loss policies starting in 2014 are comprehensive
11 and offered at a low cost (i.e., an attachment point of \$20,000 for individuals and comparable in
12 price to fully insured plans), the percentage of firms with 100 or fewer employees that choose to
13 self-insure will increase from four percent to 33 percent. This translates into a 10 percent increase
14 in the segment of employees at firms that self-insure. Without such comprehensive and affordable
15 stop-loss coverage, self-insurance for small firms would remain risky, and therefore RAND
16 projects only a slight increase in self-insurance.

17
18 If comprehensive and low-cost stop-loss coverage is available, small employers will face low risk
19 by self-insuring. They would be able to purchase very affordable stop-loss coverage and avoid the
20 costs associated with federal and state regulations. Should their health care expenses increase
21 unexpectedly, they could join SHOP exchanges at any time, because such exchanges must accept
22 them at any time they apply for coverage. Also, starting in 2014, health plans will be prohibited
23 from refusing to offer health insurance coverage to small groups with very unhealthy and high-cost
24 employees. This combination of rules can be construed as a win-win for small employers, but may
25 have unintended consequences for physicians and their patients, as well as the viability of SHOP
26 exchanges.

27 28 IMPLICATIONS OF SELF-INSURANCE FOR PHYSICIANS AND PATIENTS

29
30 If an increasing number of small firms choose to self-insure, their employees would have access to
31 different health care benefits and consumer protections than in health plans that are fully insured,
32 as well as individuals enrolled in plans through exchanges. Under the ACA, new self-insured plans
33 would be exempt from offering their employees the essential health benefits package. Therefore,
34 the coverage offered to employees of self-insured firms could be less comprehensive than the
35 essential health benefits package. However, new self-insured plans still would have to follow
36 many of the private health market reforms of the ACA. New self-insured plans will have to adhere
37 to the ACA's prohibitions on lifetime benefit limits, coverage exclusions for preexisting conditions
38 and discrimination based on health factors. New self-insured plans also will have to cover
39 preventive services with no enrollee cost-sharing.

40
41 Before the ACA, there were large differences in consumer recourse options between self-insured
42 and fully-insured plans, including with respect to internal appeals and external review. However,
43 the ACA and subsequent regulations issued in July 2010 jointly by the US Departments of Health
44 and Human Services, Labor, and Treasury have partially closed the gap that existed before the
45 law's enactment. Still, differences between self-insured and fully-insured plans will likely remain,
46 because the federal external review process for self-insured plans might not offer the same level of
47 protection as some state-run external review programs.

48
49 Concerns have been raised regarding the financial security of small firms with self-insured plans
50 should stop-loss coverage be low-cost and prevalent. If a self-insured plan becomes insolvent,
51 there are major repercussions for plan beneficiaries (employees) and their physicians. First and

1 foremost, there is concern with the financial solvency of the small firms that choose to self-insure,
2 because such firms will need to manage the risk of self-insuring and choose a reliable stop-loss
3 insurer. Due to the inconsistent regulation of stop-loss insurers in the states, there is also the
4 potential for patients to have what is equivalent to “sham” health insurance coverage (i.e., coverage
5 that is unable to finance a catastrophic illness). Small firms may view sham coverage as
6 “traditional” health insurance if attachment points are very low or zero-dollar.

7
8 If many small businesses opt to self-insure, the viability of SHOP exchanges may be impacted due
9 to the potential for adverse selection. SHOP exchanges will likely start off small to begin with, so
10 a large number of healthy employees exiting the market would likely adversely affect the strength
11 of small group risk pools, which includes SHOP exchanges. In addition, small employers may
12 only put their employees in exchanges once their costs become too high. Ultimately, that scenario
13 would lead to higher, potentially unaffordable, premiums in SHOP exchanges, threatening their
14 long-term sustainability.

15
16 Self-insured plans do not typically have to follow state laws related to fair contracting, prompt pay
17 and other physician protections. Therefore, the prospect of more individuals being covered by self-
18 insured plans may negatively affect physician practices in two ways. First, physicians themselves
19 will not have the protections outlined in state law when interacting with those plans. In addition,
20 physicians may increasingly see patients with inadequate health insurance coverage, and coverage
21 that may not have solid financial backing.

22 23 RELEVANT AMA POLICY

24
25 AMA policy has consistently advocated for the elimination of the ERISA pre-emption of self-
26 insured health plans from state insurance laws, and for additional patient protections for those
27 covered by self-insured plans (Policy H-285.915, AMA Policy Database). With respect to
28 physician protections, Policy D-383.984 states that our AMA will actively support federal
29 legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues.
30 Policy D-385.973 supports federal legislation that would modify ERISA law to incorporate a
31 clause that addresses timely payment of medical claims of health care practitioners who provide
32 treatment in good faith to the members of self-funded group employer-sponsored health plans.
33 Similarly, Policy D-385.984 supports pursuing legal avenues for advancing the case against ERISA
34 preemption of state prompt pay laws. Policy H-285.945 supports changes in federal law to prohibit
35 the exemption from liability of managed care organizations, including ERISA plans, for damages
36 resulting from their policies, procedures, or administrative actions taken in relation to patient care.

37
38 Regardless of whether a health plan is fully insured or self-insured by the employer, employer
39 expenditures on employees’ health care coverage are excluded from the insured employee’s federal
40 income tax. For more than a decade, the AMA has advocated expanding health insurance coverage
41 and choice by replacing the existing employee income tax exclusion for employer-sponsored
42 coverage with individual tax credits for health insurance that are refundable, inversely related to
43 income, and applicable to coverage of the recipient’s choice (Policy H-165.920). Policy H-165.851
44 supports incremental steps toward financing individual tax credits for the purchase of health
45 insurance, including but not limited to capping the tax exclusion for employment-based health
46 insurance.

47
48 To determine the adequacy of health insurance options, Policy H-165.846 supports using existing
49 federal guidelines regarding types of health insurance coverage [e.g., Title 26 of the US Tax Code
50 and Federal Employees Health Benefits Program (FEHBP) regulations] as a reference when
51 considering if a given plan would provide meaningful coverage. The policy also supports using the

1 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program as the model for any
2 essential health benefits package for children. Policy D-180.986 encourages local, state, and
3 federal regulatory authorities to aggressively pursue action against “sham” health insurers.

4
5 Policy H-165.856 outlines principles for health insurance market regulation that support the
6 replacement of strict community rating with modified community rating, risk bands, or risk
7 corridors; and guaranteed issue within the context of an individual mandate, in addition to
8 guaranteed renewability. AMA policy also is supportive of the general concept of creating health
9 insurance exchanges, and provides principles for the operation of exchanges (Policy H-165.839).
10 Council on Medical Service Report 6-I-11 established additional policy addressing health insurance
11 exchanges, including supporting the open marketplace model for any health insurance exchange.
12 Policy H-165.838 states that insurance coverage options offered in a health insurance exchange
13 should be self-supporting; have uniform solvency requirements; not receive special advantages
14 from government subsidies; include payment rates established through meaningful negotiations and
15 contracts; not require provider participation; and not restrict enrollees’ access to out-of-network
16 physicians.

17 DISCUSSION

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19
20 As 2014 approaches, it is expected that stop-loss insurers will develop additional, low-cost
21 products specifically for small businesses. The Council is concerned with the impact of small
22 businesses self-insuring at a much greater rate due to the availability of low-cost and
23 comprehensive stop-loss insurance coverage with low attachment points. While the AMA supports
24 private market innovation in product development and purchasing arrangements, the adequacy and
25 financial security of health insurance coverage of patients employed by small businesses is
26 paramount. The Council believes that stop-loss attachment points need to be high enough to both
27 appropriately convey the risk of self-insuring to small businesses, and help ensure the security and
28 solvency of health insurance coverage of employees of small employers.

29
30 The AMA has long been concerned with the ERISA pre-emption of self-insured health plans from
31 state insurance laws that protect physicians and patients. The Council believes that the AMA needs
32 to continue its advocacy in favor of the elimination and appropriate modification of the ERISA
33 preemption of self-insured health plans from state insurance laws consistent with long-standing
34 AMA policy (Policies H-285.915, D-383.984, D-385.973 and D-385.984).

35
36 However, as the ACA provisions related to small businesses are implemented, the Council believes
37 it will be imperative to monitor the rate at which small employers self-insure, and the impact of
38 such self-insurance on the viability and purchasing power of SHOP exchanges. The Council views
39 SHOP exchanges as a stepping stone to allow employees to have individually selected and owned
40 health insurance coverage, as outlined in Policy H-165.920. As such, states need to continuously
41 assess the risk profiles and pools of their SHOP exchanges to ensure that the exchanges remain
42 sustainable for the long term with affordable premiums.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted and the remainder of
4 the report be filed:

- 5
6 1. That our American Medical Association (AMA) reaffirm Policy H-285.915, which advocates
7 additional requirements for self-insured plans and the elimination of ERISA preemption of
8 self-insured health plans from state insurance laws consistent with current AMA policy.
9 (Reaffirm HOD Policy)
10
11 2. That our AMA reaffirm Policy D-383.984, which supports federal legislation clarifying that
12 ERISA preemption does not apply to physician/insurer contracting issues and requiring all
13 third party payers serving as administrators for ERISA plans to accept assignment of benefits
14 by patients to physicians. (Reaffirm HOD Policy)
15
16 3. That our AMA reaffirm Policy D-385.973, which supports federal legislation that would
17 modify ERISA law to incorporate a clause that addresses timely payment of medical claims of
18 health care practitioners who provide treatment in good faith to the members of self-funded
19 group employer-sponsored health plans. (Reaffirm HOD Policy)
20
21 4. That our AMA reaffirm Policy D-385.984, which advocates the use of legal avenues for
22 advancing the case against ERISA preemption of state prompt pay laws. (Reaffirm HOD
23 Policy)
24
25 5. That our AMA reaffirm Policy H-165.920, which supports a system of individually selected
26 and owned health insurance. (Reaffirm HOD Policy)
27
28 6. That our AMA advocate that stop-loss coverage of self-insured plans have minimum
29 attachment points that are high enough to ensure the adequacy and financial security of health
30 insurance coverage of enrollees, and be provided by stop-loss insurers that are legitimate and
31 financially secure and solvent. (Directive to Take Action)
32
33 7. That our AMA encourage states to monitor the rate at which small employers self-insure, and
34 the impact of such self-insurance on the viability and purchasing power on SHOP exchanges.
35 (Directive to Take Action)

Fiscal Note: Less than \$500.

References are available from the AMA Division of Socioeconomic Policy Development.