



# findings brief

## State Variation in Insurance Laws a Major Driver of Employers' Self-Insurance Decisions

---

“It is the disparity in insurance mandates across states, not the level of mandates, that has been burdensome to employers and key to their self-insurance decisions.”

— *Gail Jensen,  
Wayne State University*

---

Some researchers and policy analysts have speculated that employers tend to self-insure their firms in an effort to circumvent compliance with evolving state mandates on coverage, which may require them to provide generous benefit packages. However, new research by Gail Jensen, Ph.D., at Wayne State University suggests otherwise. In collaboration with colleagues Michael Morrisey, Ph.D., of the University of Alabama at Birmingham and Jon Gabel at the Hospital Research and Educational Trust, Jensen found that employers are using self-insurance to avoid conflicts in insurance laws across states, rather than as a mechanism to avoid providing rich benefits.

“It is the disparity in insurance mandates across states, not the level of mandates, that has been burdensome to employers and key to their self-insurance decisions,” says Jensen. Factors such as a company’s presence in multiple states may compel that firm to self-insure. For example, employers with offices in multiple locations were much more likely to self-insure, the researchers found. “For them, coping with heterogeneity in regulation across states

appears to be more troublesome than complying with any given state’s laws.”

Through this research, Jensen and her colleagues hoped to learn what drives employers’ decision of whether to self-insure, and particularly the role that state and federal regulations play in influencing the size and nature of the self-insured segment. The investigators began by examining the decision to self-insure the range of health plans offered by employers. They found that, in addition to enabling them to avoid the administrative nightmare of having to comply with multiple states’ laws, firms may elect to self-insure in order to prevent the added hassle associated with outsourcing insurance for some plans but not others.

Indeed, firms that have used a strategy of self-insuring their conventional (fee-for-service) plan were much more likely to self-insure their managed care options, too. According to Jensen, this reflects a pattern of consistency in their business decision-making, and may also reflect satisfaction with their experiences self-insuring their conventional plan.



**AcademyHealth**

Advancing Research, Policy and Practice

AcademyHealth is the national program office for HCFO, an initiative of The Robert Wood Johnson Foundation.

## Background

Large employers have long had a tendency to self-insure their conventional plans, and, by the end of the 1990s, self-insurance had become common for managed care offerings as well. Among enrollees in point-of-service (POS) plans, for example, the percentage whose coverage was self-insured increased from 29 percent in 1991 to 52 percent in 1998.

Coinciding with employers' movement toward self-insurance among managed care options was a proliferation of state insurance laws—such as length-of-stay requirements for maternity care—that were designed to ensure that managed care plans provide adequate care. This confluence of trends led some people to believe that employers were opting to self-insure their managed care plans simply to avoid these new state mandates.

In fact, the researchers found that both self-insured plans and those that were purchased from insurers cost similar amounts and provide roughly the same benefits. Moreover, the findings indicated that self-insured health plans were actually more beneficial for employees than for employers themselves.

Cost sharing, however, was somewhat lower in self-insured preferred provider organization (PPO) plans. “During periods of rapid inflation over the 1990s, premiums increased more slowly for self-insured than for fully insured plans,” says Jensen. “This may be because some insurers were practicing ‘catch-up’ pricing with their fully insured products as a way of offsetting underwriting losses they had incurred over the 1993–1996 period.”

According to the findings, large firms are more likely to offer a self-insured plan than other employers, and firms with more than one location were much more inclined to offer at least one self-insured plan. The decision to self-insure differed markedly by industry: Firms in manufacturing, mining, wholesale trade, and transportation were much more likely to self-insure than those in the retail trade or the finance and services industries.

## The Data

The researchers used data from the 1993–1999 Annual Survey of Employer Health Benefits, conducted by KPMG Peat Marwick in 1993–1999, and by the Hospital Research and Educational Trust in 1999. The data are nationally representative of private-sector firms and local and state governments with 200 or more employees.

The investigators conducted telephone interviews with the benefits manager or the most knowledgeable individual in each firm. More than 1,000 organizations responded each year. The surveys gathered information on the firm and the characteristics of its largest conventional HMO, PPO, and POS health plans. They asked each of the plans whether the coverage was underwritten by an insurer or was self-insured. The response rate ranged from 50 to 77 percent, depending on the year.

Data on state managed care laws were drawn from a number of sources, including the National Conference of State Legislatures' Health Policy Tracking Service. The researchers coded data on several state regulations, including information on:

- ◆ whether the laws required that subscribers be allowed direct access to medical specialists;
- ◆ whether the mandates required insurers to make prompt payments to providers;
- ◆ whether the regulations required an external review of certain types of insurer denials of care;
- ◆ whether the legislation required plans to establish a formal grievance procedure whereby providers could contest a termination, non-renewal, or other plan decision altering the provider's contract; and
- ◆ whether the laws required that insurers offer employees a POS plan.

“We focused on these areas of managed care regulation because, for each of them, there were significant changes over the period 1993 – 1999,” says Jensen. “We expected that the presence of any of these laws might have made self-insurance more desirable.”

### The HIPAA Effect

The 1996 enactment of several mandates at the federal level may have created some obstacles to self-insurance, thereby encouraging a shift back to fully insured plans. For example, the Health Insurance Portability and Accountability Act (HIPAA) limited the use of preexisting condition clauses for both fully and self-insured plans. The Mental Health Parity Act and the Newborns and Mothers Protection Act, also enacted in 1996, likewise mandated specific benefits for both types of plans, thereby diluting the advantages of self-insurance.

The researchers found that, as a result of HIPAA, the use of pre-existing condition clauses in employers’ self-insured plans declined somewhat, narrowing the differences between self-insured and purchased plans. However, the data did not support the view that the 1996 federal mandates for employer plans reduced employer incentives for self-insuring by leveling the playing field for at least some mandated benefits. “Our findings indicate that, other things being equal, firms were just as likely to be self-insuring after 1996 as they were before then,” says Jensen.

### Conclusion

The decision to self-insure through managed care plans appears to be based on the same criteria as choices about self-insuring with traditional health insurance, including the effect on benefits and costs. This study shows that the costs of complying with a plethora of laws in different states are apparently very real and high

for many multi-state firms, and that they directly contribute to the decision to self-insure. The researchers concluded that continued enactment of disparate insurance regulations across the states will likely increase the efforts of multi-state firms to self-insure their benefit offerings.

The findings of this study have implications for the ongoing debate over whether to limit the Employee Retirement Income Security Act’s (ERISA) exemption of state insurance regulation for self-insured plans. If the courts further limit the reach of the ERISA exemption, as was the case in the recent U.S. Supreme Court decision on any-willing-provider laws (Kentucky Association of Health Plans, Inc. vs. Miller, 123 S.Ct.1471), multi-state firms will face greater regulatory disparity, and thus higher costs.

“Ultimately, it is the workers in these firms who will bear these higher costs in the form of lower wages and/or reductions in benefits,” says Jensen. “This should not be ignored.”

For more information, contact Gail Jensen, Ph.D., at 313.577.2297.

### Further Reading

For more information on this research project, please see:

Gabel, J., G. Jensen, and S. Hawkins. “Self-Insurance in Times of Growing and Retreating Managed Care,” *Health Affairs*, Vol. 22, No. 2, March/April 2003, pp. 202–10.

### About the Author

LeAnne DeFrancesco is production manager at AcademyHealth ([www.academyhealth.org](http://www.academyhealth.org)) and the managing editor of HCFO News & Progress. She can be reached at 202.292.6700, or [leanne.defrancesco@academyhealth.org](mailto:leanne.defrancesco@academyhealth.org).