Report to Congress

Annual Report
on Self-Insured Group Health Plans

March 2017

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Annual Report to Congress on Self-Insured Group Health Plans

Executive Summary

The Patient Protection and Affordable Care Act (the "Affordable Care Act") (P. L. 111-148) requires the Secretary of Labor to provide Congress with an annual report (the "*Report*") containing general information on self-insured employee health benefit plans and financial information regarding employers that sponsor such plans. The *Report* must use data from the Annual Return/Report of Employee Benefit Plan (the "Form 5500") which many self-insured health plans are required to file annually with the Department of Labor (the "Department"). The first *Report* was provided to Congress in March 2011.[1]

Methodological changes for this seventh annual *Report* mean that one cannot identify trends over time by comparing previous *Reports* with this *Report*. However, the Department has incorporated previous years' data into this *Report* using the revised methodology, which will allow for comparisons of data over time.

Along with this *Report*, the Department is submitting two detailed appendices produced under contract. Appendix A, *Group Health Plans Report: Abstract of 2014 Form 5500 Annual Reports Reflecting Statistical Year Filings*, provides detailed statistics describing group health plans that file a Form 5500.[2] Appendix B, *Self-Insured Health Benefit Plans 2017: Based on Filings through Statistical Year 2014*, presents a study that explores statistical issues associated with Form 5500 health plan data and analyzes available data on the financial status of employers that sponsor group health plans filing the Form 5500.[3]

Approximately 51,600 health plans filed a Form 5500 for 2014, an increase of nearly 3 percent from the health plans that filed a Form 5500 for 2013. Of health plans filing a 2014 Form 5500, about 21,200 were self-insured and approximately 3,800 mixed self-insurance with insurance ("mixed-insured"). Self-insured plans that filed a Form 5500 covered approximately 33 million participants in 2014 and held assets totaling about $87 billion. In 2014 there were nearly 26 million participants covered by mixed-insured group health plans; these mixed-insured group health plans held almost $137 billion in

[1] Available at https://www.dol.gov/sites/default/files/ebsa/researchers/statistics/retirement-bulletins/ACAReportToCongress032811.pdf. The 2012, 2013, 2014, 2015, and 2016 *Report*s are also available online, though it should be noted that revisions made to the algorithm and methodology beginning with the 2013 *Report* have resulted in the *Report*s not being comparable over time.

[2] This work was conducted for the Department by the Actuarial Research Corporation (ARC) under contract number DOL-OPS-14-D-0017.

[3] This work was conducted for the Department by Advanced Analytical Consulting Group (AACG) under contract number DOLJ139335145.

assets. The table below summarizes aggregate statistics for self-insured and mixed-insured health plans filing a Form 5500 for 2013 and for 2014.[4]

Group Health Plans Filing Form 5500 for 2013-2014, Reflecting Statistical Year Filings[5]

	2013		2014	
	Self-Insured Plans	Mixed-Insured Plans	Self-Insured Plans	Mixed-Insured Plans
All Plans	20,300	3,800	21,200	3,800
Participants	31 million	26 million	33 million	26 million
Active Participants	28 million	22 million	29 million	22 million
Large plans not holding assets in trusts	15,400	2,500	16,300	2,600
Participants	19 million	15 million	20 million	15 million
Active Participants	18 million	14 million	19 million	14 million
All Plans holding assets in trust	4,900	1,200	4,900	1,200
Participants	12 million	11 million	13 million	10 million
Active Participants	10 million	8 million	10 million	7 million
Assets	$77 billion	$137 billion	$87 billion	$137 billion
Contributions	$55 billion	$81 billion	$60 billion	$81 billion
Benefits	$52 billion	$83 billion	$55 billion	$83 billion

SOURCE: 2013 and 2014 Form 5500 filings. Totals may not equal the sum of the components due to rounding.

Sponsors of self-insured plans pay their plans' covered health expenses directly, as the plans incur claims. In contrast, sponsors of fully-insured plans generally pay premiums to insurers and transfer all the responsibility of paying claims to them. Some sponsors retain this responsibility for a subset of the benefits, but transfer the risk for the remaining benefits to health insurers – that is, they finance their plans' benefits using a mixture of self-insurance and insurance. Self-insurance is more common among larger sponsors, mainly because the health expenses of larger groups are more predictable and therefore larger sponsors face less risk.

Self-insured and fully-insured plans are governed by somewhat different rules. For example, State insurance laws generally do not apply to self-insured ERISA-covered plans. Likewise, some Affordable Care Act provisions apply to group health insurance but not to self-insured plans.

[4] The 2013 number of all plans and participants in the above table were calculated using the 2014 revised methodology and therefore do not match the summary numbers reported in the 2016 *Report*.
[5] The Department defines a "statistical year" Form 5500 filing population as all Form 5500 employee benefit plan filings with a plan year ***ending*** date between January 1 and December 31 of a given year.

Generally, health benefit plans covering private-sector employees must file a Form 5500 if they have 100 or more participants or, regardless of size, if they hold assets in trust.[6] However, because most small ERISA-covered group health plans do not hold assets in a trust and therefore are not required to file a Form 5500, a large majority of small health benefit plans, including a large but unknown number of small, self-insured plans, are not included in the statistics of this *Report*. The Department estimates that in 2014 there were approximately 2.3 million ERISA-covered health plans covering approximately 135 million people.[7] In contrast, approximately 51,600 health plans covering 71 million participants filed a Form 5500 for 2014. Among health plans that filed a 2014 Form 5500, about 30,500 filed at least one Schedule A for a group insurance policy covering health benefits; roughly 6,500 plans reported holding assets and filed a Schedule H or Schedule I.[8]

This *Report* presents data on health benefit plans covering private-sector employees that filed a Form 5500 for 2014, the latest year for which complete data are available. As noted above, private-sector plans with less than 100 participants that pay benefits directly from the general assets of the employer or employee organization that sponsors the plan or are fully-insured and do not use a trust are not required to file a Form 5500. Also, government or church plans are not required to file a Form 5500, regardless of size. Therefore, data for such plans are not available for this *Report* and are not included in the statistics provided in this *Report*. In addition, self-insured plans are required to file financial information only with respect to assets they hold in trust. Thus, the aggregate financial statistics reported above are understated insofar as they do not include amounts associated with benefits paid directly from plan sponsors' general assets.

Where a plan sponsor provides multiple types of benefits as part of a single plan, health benefits may be reported together with certain other benefits, such as disability or life insurance benefits, on a single Form 5500. This makes it difficult to distinguish how the different benefits are financed, especially using aggregate data. As a result, the estimates presented here are subject to substantial uncertainty.

The Form 5500 does not collect data on plan sponsors' finances. However, financial data are available from other sources for the subset of sponsoring employers that issue publicly traded equity or debt. The financial strength of these plan sponsors varies considerably. Similar variation is found among employers whose Form 5500 indicates that they sponsor self-insured plans, among those sponsoring plans that include both self-insured and traditionally insured components, and among those sponsoring fully-insured plans.

[6] Beginning with 2009 plan year filings made on or after January 1, 2010, certain small plans have been able to file the Form 5500-SF.
[7] EBSA estimates are based on the Current Population Survey and the Medical Expenditure Panel Survey, Insurance Component.
[8] See Appendix A, Table A2 and Table B1.

Introduction

Section 1253 of the Patient Protection and Affordable Care Act (the "Affordable Care Act") (P. L. 111-148) requires the Secretary of Labor to prepare an aggregate annual report that includes certain general information on self-insured group health plans using data collected from the Annual Return/Report of Employee Benefit Plan (the "Form 5500"), as well as certain data from financial filings of self-insured employers.[9]

Sponsors of self-insured plans pay their plans' covered health expenses directly, as the plans incur claims. In contrast, sponsors of fully-insured plans generally pay premiums to insurers and transfer all the responsibility of paying claims to them. Some sponsors retain this responsibility for a subset of benefits, but transfer the risk for the remaining benefits to health insurers – that is, they finance their plans' benefits using a mixture of self-insurance and insurance.

The March 2011 Report discusses certain key, qualitative differences between self-insured plans, fully-insured plans, and plans that combine self-insurance with insurance.[10]

Currently, the Form 5500 does not explicitly disclose whether a health plan is self-funded, and so the Department created an algorithm using filing characteristics to sort plans as "self-insured," "fully-insured," or "mixed-insured." The latter category contains elements of the former two categories. Prior to this year's report, plans which indicated evidence of a health insurance contract and benefit payments from a trust were

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[9] The following welfare plans, including group health plans, are not required to file a Form 5500, due to statutory exemptions from ERISA or regulatory exemptions:

- Welfare plans with fewer than 100 participants as of the beginning of the plan year ("small" plans) that are unfunded, fully-insured, or a combination of insured and unfunded;
- Welfare plans maintained outside the U. S. that serve mostly nonresident aliens;
- Governmental plans;
- Unfunded or insured welfare plans maintained for a select group of management or highly compensated employees only;
- Plans maintained only to comply with workers' compensation, unemployment compensation, or disability insurance laws;
- Welfare benefit plans that participate in a group insurance arrangement that files a Form 5500 on behalf of the plan;
- Apprenticeship or training plans meeting certain conditions;
- Certain unfunded welfare benefit plans financed by dues;
- Church plans;
- Welfare benefit plans maintained solely for only the owner and/or spouse who wholly own a trade or business or the partners and/or spouses of partners in a partnership.

A small plan that receives employee (or former employee) contributions during the plan year and does not use the contributions to pay insurance premiums or uses a trust or separately maintained fund to hold plan assets or act as a conduit for the transfer of plan assets during the year is required to file; except that, a small plan with employee contributions that are used to pay benefits instead of insurance premiums and is associated with a cafeteria plan under Internal Revue Code section 125 may be treated for annual reporting purposes as an unfunded welfare plan if it meets certain Department requirements. *See* 29 C.F.R. 2520.104-1 et seq.

[10] March 2011 Report, Section III. *What is a Self-Insured Group Health Plan?*

categorized as mixed-insured. Upon reviewing a sample of plan descriptions, it was observed that some fully-insured plans use a trust to pass through insurance premiums. These plans, which should be considered fully-insured, however were inaccurately identified as mixed-insured.

To address this issue, additional refinements were made to the existing algorithm comparing insurance payments to benefit payments from trusts. Instances where the reported benefit payments from trusts were (1) made only to insurance carriers and not directly to participants ***and*** (2) within 10 percent of reported insurance payments, were deemed to be "pass through" payments and the plans were identified as fully-insured. This refinement affected 334 plans in 2014.

Additionally, the plan universe this year excludes "one-participant plans" which by definition are pension plans. This exclusion affected eight plans that filed a form 5500 in 2014.

These changes mean that one cannot identify trends over time by comparing this year's report to previous Self-Insured Reports to Congress, however the Department has incorporated previous years' data into this report, using the revised methodology, in order to provide comparisons within this report.[11]

Section I of this report presents aggregate statistics describing self-insured plans that file a Form 5500 – generally, private-sector employee health plans that cover 100 or more participants or hold assets in trust. Section II presents certain available financial information on employers that sponsor such plans. Section III is the conclusion.

[11] Subject to the following criteria, the analysis for this Self-Insured Report to Congress is based on health benefit plans that filed a Form 5500 or Form 5500-SF:

1. Test filings, DFE filings (including GIAs, which can only file on behalf of participating plans if fully-insured), duplicative filings, and filings for "one-participant" retirement plans with health plan features have been removed from the raw dataset prior to analysis.
2. "Voluntary" filers (i.e., those that appear to meet the exception from the requirement to file based on the information provided, but still filed (see footnote 10)) have been excluded from the analysis. Specifically, filers with fewer than 100 BOY participants and no assets held were dropped from the universe, including those with the following fields equal to zero or left blank on their Form 5500-SF or Schedule I or H:
    a. Beginning/End of Year Assets, Liabilities, and Net Assets
    b. Income, Expenses, and Net Income
3. With regard to Form 5500-SF filers with fewer than 100 BOY participants and showing financial information, we have assumed that it was an appropriate filing and that the plan must be self-insured.
4. Terminating trusts and terminating plans that file 0 EOY Participants have been included.
5. For plans with missing EOY participants that are non-terminating, BOY participants have served as a proxy for EOY Total and Active Participants.

Along with this report, the Department is submitting two detailed appendices[12] produced under contract. Appendix A, *Group Health Plans Report: Abstract of 2014 Form 5500 Annual Reports Reflecting Statistical Year Filings*, provides detailed statistics describing group health plans that file a Form 5500.[13] Appendix B, *Self-Insured Health Benefit Plans 2017: Based on Filings through Statistical Year 2014*, explores statistical issues associated with Form 5500 health plan data and analyzes available data on the financial status of employers that sponsor group health plans filing the Form 5500.[14]

The Department, together with the Internal Revenue Service and the Pension Benefit Guaranty Corporation, published a Notice of Proposed Forms Revisions for the Form 5500 on July 21, 2016 (81 Fed. Reg. 47534), along with proposed regulations to implement the forms revisions published by the Department (81 Fed. Reg. 47496).[15] If adopted as proposed, the proposed revisions would require all plans that provide group health benefits to file a Form 5500 and a new Schedule J that would collect more detailed information about various aspects of plan administration, such as funding and benefit offerings. The proposed revisions would also eliminate the annual reporting exemption for small unfunded and insured group health plans, but such small plans would only be required to answer a limited number of questions on the Form 5500 and the Schedule J. Among other things, the proposal would require filers to report information on total premium payments made for any ''stop loss'' coverage, as well as information on the attachment points of coverage, individual claim limits, and/or the aggregate claim limit contained in the policy. If adopted, these proposed changes would significantly enhance the Department's ability to describe the full universe of self-insured plans and how they compare to fully-insured health plans.

[12] While the Department requested a standardized method to determine each health plan's funding mechanism in both appendices, slight differences in other plan characteristics may occur due to the editing of inconsistent fields on Form 5500 filings.

[13] This work was conducted for the Department by the Actuarial Research Corporation (ARC) under contract number DOL-OPS-14-D-0017. The Department defines a "statistical year" Form 5500 filing population as all Form 5500 employee benefit plan filings with a plan year ***ending*** date between January 1 and December 31 of a given year.

[14] This work was conducted for the Department by Advanced Analytical Consulting Group (AACG) under contract number DOLJ139335145.

[15] Available at https://www.gpo.gov/fdsys/pkg/FR-2016-07-21/pdf/2016-14893.pdf.

Section I. Required Form 5500 Group Health Plan Data

Section 1253 of the Affordable Care Act (codified 42 U.S.C. 18013) requires the Department to submit information on several data items from the Form 5500:

a) "general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements)" and

b) "data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses)."

The Form 5500 data presented below in response to these requirements should be interpreted with care for several reasons:[16]

- The Department has information for these data items only for those plans that are required to file a Form 5500. Generally, group health plans covering private-sector employees must file a Form 5500 only if they cover 100 or more participants or hold assets in trust. Governmental or church plans, regardless of size, also are not required to file a Form 5500. Therefore, data for such plans are not available in the Form 5500 data and are not included in the statistics provided in this report.

- Self-insured welfare plans, including group health plans, generally are required to file financial information only with respect to assets they hold in trust. Thus, the aggregate financial statistics provided in this report are understated insofar as they do not include amounts associated with health benefits paid directly from the plan sponsors' general assets. Of the self-insured plans that filed a Form 5500 in 2014, 77 percent did not hold assets in trust, and thus did not report their financial information.

- In cases where a single plan provides several different types of welfare benefits, health benefits provided under the plan may be reported together with certain other welfare benefits, such as disability or life insurance benefits, on a single Form 5500. This can make it difficult to distinguish how the different benefits are financed and if the plan is self-insured or fully-insured. [17] As a result, the estimates presented here are subject to substantial uncertainty.

[16] See the Section titled "The Definition of Self-Insurance" in Appendix B for a detailed description of the Department's method for estimating whether health plans are self-insured, fully-insured, or "mixed-insured," based on the Form 5500 data.

[17] See report, *Strengths and Limitations of Form 5500 Filings for Determining the Funding Mechanism of Employer-Provided Group Health Plans* at http://www.dol.gov/ebsa/pdf/deloitte2012-5.pdf for a discussion of the sensitivity of plans' funding categorizations. This work was conducted for the Department by Deloitte Financial Advisory Services LLP under task order number DOLB109330993.

Form 5500 Group Health Plans Summary Information, 2014
Reflecting Statistical Year Filings

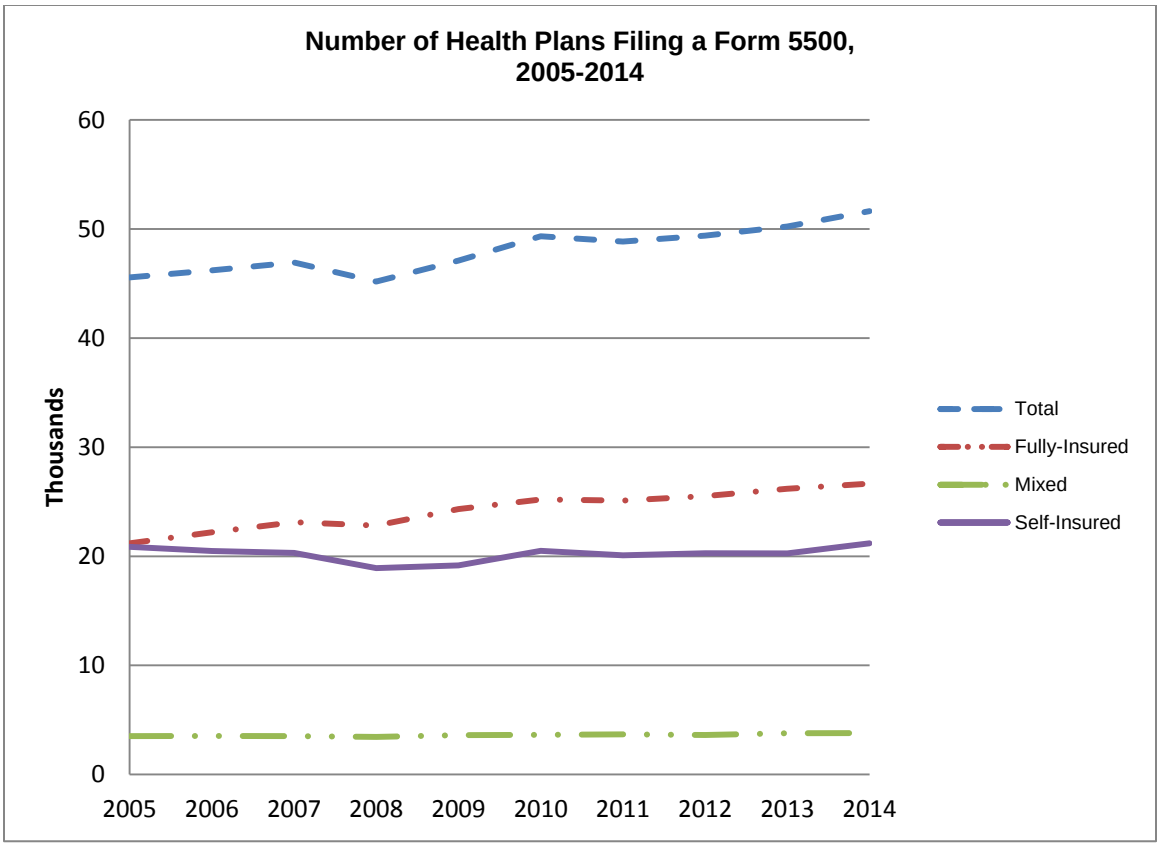
	All Plans	Self-Insured Plans	Mixed-Insured Plans	Fully-Insured Plans
All Plans	51,600	21,200	3,800	26,700
Participants	71 million	33 million	26 million	12 million
Active Participants	62 million	29 million	22 million	12 million
Large plans not holding assets in trusts	45,200	16,300	2,600	26,300
Participants	47 million	20 million	15 million	12 million
Active Participants	44 million	19 million	14 million	11 million
All Plans holding assets in trust	6,500	4,900	1,200	400
Participants	23 million	13 million	10 million	400,000
Active Participants	18 million	10 million	7 million	400,000
Assets	$226 billion	$87 billion	$137 billion	$2 billion
Contributions	$143 billion	$60 billion	$81 billion	$3 billion
Benefits	$141 billion	$55 billion	$83 billion	$3 billion

SOURCE: 2014 Form 5500 filings. Totals may not equal the sum of the components due to rounding.
Note: Plans that report benefit payments are only classified as fully-insured if there is evidence that these payments were to insurance companies for the provision of benefits and not made directly to participants.

Plan Type

- Approximately 20,100 of the self-insured group health plans filing a 2014 Form 5500 were sponsored by a single employer; 1,100 plans were multiemployer plans. About 3,300 of the mixed-insured group health plans filing a 2014 Form 5500 were sponsored by a single employer; approximately 500 plans were multiemployer plans. See Appendix A Table A2.

- On average, about 48,000 group health plans filed a Form 5500 in the years 2005-2014. While the number of health plans filing a Form 5500 has increased over this period, the fraction of group health plans that are self-insured or mixed-insured has declined somewhat from about 54 percent in 2005 to 48 percent in 2014. See Appendix B Table 2 and Table 6.



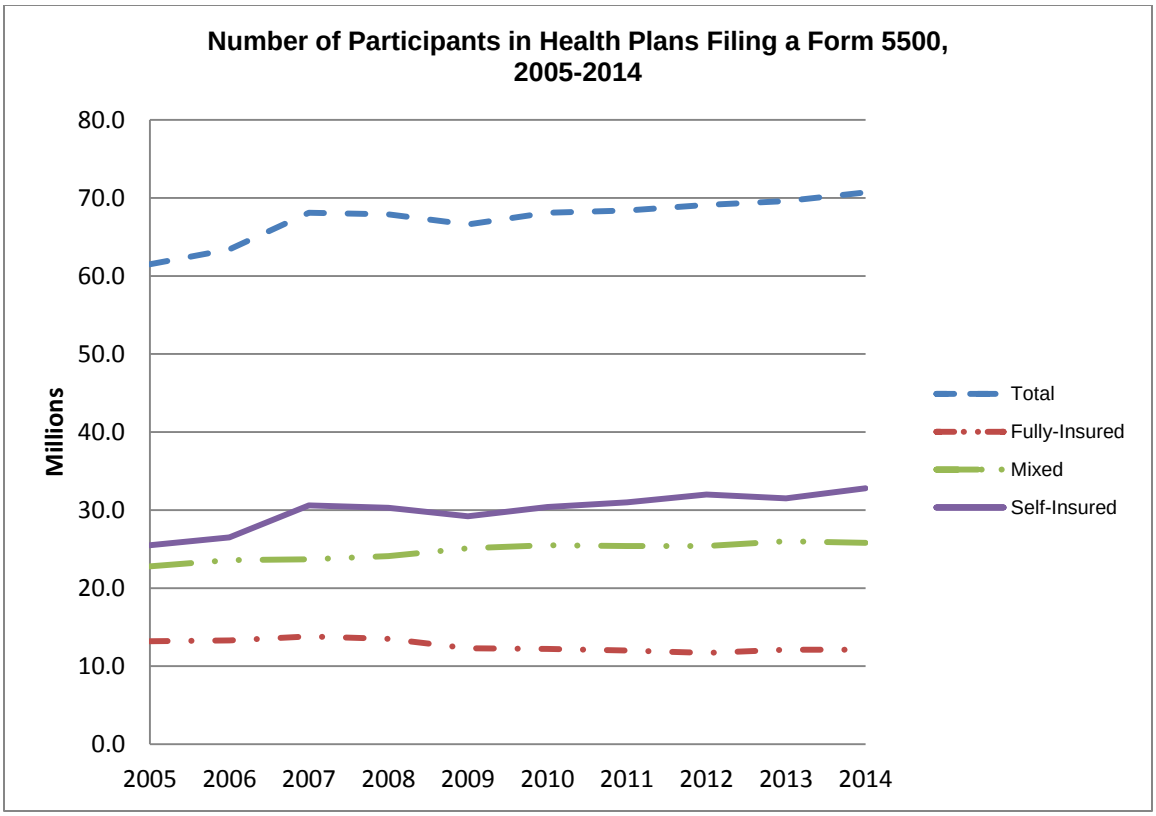
SOURCE: Appendix B, Table 7.

Number of Participants

- Overall, the 21,200 self-insured group health plans filing a 2014 Form 5500 covered approximately 33 million participants, 29 million of whom were active participants. The 3,800 mixed-insured group health plans filing a 2014 Form 5500 covered approximately 26 million participants, 22 million of whom were active participants. See Appendix A Table A1 and Table A3.

- In general, plans covering a larger number of participants are more likely to be self-insured than plans with fewer participants. While 52 percent of plans are fully-insured, only 17 percent of participants in plans that file the Form 5500 are covered by these plans. See Appendix B Table 6.

- Between the years 2005 and 2014, an average of 48,000 group health plans, covering an average of 67 million participants, filed a Form 5500 annually. Although the fraction of group health plans that are self-insured or mixed-insured has declined slightly from 2005 to 2014, the share of plan participants covered by self-insured or mixed-insured plans has increased over this period. See Appendix B Table 7.



SOURCE: Appendix B, Table 7.

New Plans

- Of the approximately 3,500 *new* health plans filing a 2014 Form 5500, 30 percent were self-insured group health plans, 3 percent were mixed-insured, and 67 percent were fully-insured.[18] *New* health plans are defined here as health plans that checked the "first return/report filed for the plan" box on their Form 5500 filing.[19]

- Participants in new health plans filing a 2014 Form 5500 were fairly evenly split among funding types, with 34 percent of the participants covered under a self-insured group health plan, 35 percent in a mixed-insured plan, and 31 percent covered by a fully-insured plan.[20]

[18] Special runs performed for DOL by AACG based on 2014 Form 5500 filings.
[19] Beginning with the 2013 Self-Insured Report to Congress, plans were identified as "new" if they checked the "first return/report filed for the plan" box on their Form 5500. Prior to this, plans were identified as "new" if they could not be matched to a plan filing in a prior year, going back to 2001. As such, the number of "new" plans in the 2017 Self-Insured Report to Congress is not comparable to reports prior to 2013.
[20] Special runs performed for DOL by AACG based on the 2014 Form 5500 filings.

Benefits Offered

- Of the 21,200 self-insured group health plans in 2014, 4,600 offered only health benefits and approximately 16,600 offered other benefits in addition to health benefits.[21] Of the 3,800 mixed-insured group health plans, approximately 200 offered only health benefits and about 3,600 offered other benefits in addition to health benefits. See Appendix A, Table A1.

Funding and Benefit Arrangements[22]

- With respect to <u>funding</u> arrangements, of the 21,200 self-insured group health plans that filed, approximately 1,700 indicated a funding arrangement of a trust only, 5,000 indicated a funding arrangement of general assets of the sponsor only, and 10,700 indicated a funding arrangement of general assets of the sponsor combined with insurance.[23] The remaining 3,800 filers indicated some other combination of funding arrangements or did not report any arrangement. Of the 3,800 mixed-insured group health plans, about 400 indicated a funding arrangement of a trust only[24], 500 indicated a funding arrangement of trust with insurance, and roughly 2,500 indicated a funding arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated some other combination of funding arrangements. See Appendix A, Table A7.

- With respect to <u>benefit</u> arrangements, of the 21,200 self-insured group health plans that filed, about 1,000 indicated a benefit arrangement of a trust only, 2,100 indicated a benefit arrangement of trust with insurance, 4,600 indicated a benefit arrangement of general assets of the sponsor only, and 10,900 indicated a benefit arrangement of general assets of the sponsor combined with insurance.[25] The remaining 2,600 filers indicated some other combination of benefit arrangements or did not report any arrangement. Of the 3,800 mixed-insured group health plans

[21] Note that a health-only plan does not imply that the employer only offers health benefits. For example, the employer could simultaneously offer a separate life insurance plan for which a separate Form 5500 filing exists. This report does not include information on welfare plans that do not provide health benefits.
[22] The Form 5500 instructions define a "funding arrangement" as the method for the receipt, holding, investment, and transmittal of plan assets prior to the time the plan actually provides benefits. A "benefit arrangement" is defined as the method by which the plan provides benefits to participants.
[23] The majority of these plans filed a Schedule A for a non-group health benefit. Additional reasons for a self-insured plan indicating a funding arrangement of general assets combined with insurance would be self-insured plans with stop-loss coverage or plans that check box 9a on the Form 5500 indicating insurance, but did not file a Schedule A.
[24] The 400 plans that were identified as mixed-insured but indicated a funding arrangement of a trust only, also filed a Schedule A and reported a health insurance contract. Under the revised methodology adopted this year, plans are deemed "mixed-insured" if the payments from trusts and the reported premium payments are more than 10 percent apart or the number of people covered by reported health insurance contracts is less than 50 percent of plan participants. (See Appendix B, pages 11-14).
[25] Similar to the funding arrangement, the self-insured plans that listed a benefit arrangement of general assets of the sponsor combined with insurance filed a Schedule A for a non-health benefit or stop-loss coverage, or checked box 9a on the Form 5500 indicating insurance but did not file a Schedule A.

that filed, 900 indicated a benefit arrangement of trust with insurance, and approximately 2,500 indicated a benefit arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated some other combination of benefit arrangements. See Appendix A, Table A7.

- Self-insured plans can purchase stop-loss insurance to mitigate the risk of unexpectedly large medical claims. Stop-loss insurance contracts protect against claims that are catastrophic or unpredictable in nature by covering claims costs that exceed a set amount – an attachment point – for either a single enrollee or for aggregate claims over a determined period. Between 2005 and 2014, the percentage of group health plans filing a Form 5500 that reported having stop-loss insurance[26] has gradually declined from approximately 31 percent to 26 percent for self-insured plans and approximately 25 percent to 17 percent for mixed-insured plans. Overall, reported stop-loss coverage increases with plan size up to 200-499 participants and decreases with plan size among larger plans. See Appendix B, Table 12 and Figure 13.

Plan Assets and Liabilities of Plans That Financed Benefits via Trusts

- Self-insured group health plans that financed benefits via trusts reported approximately $87 billion in assets and $11 billion in liabilities. Mixed-insured group health plans that financed benefits via trusts reported nearly $137 billion in assets and $13 billion in liabilities. See Appendix A, Table A2.

Contributions, Investments and Expenses of Plans That Financed Benefits via Trusts

- Self-insured group health plans that financed benefits via a trust received approximately $60 billion in contributions and paid approximately $55 billion in benefit payments: $43 billion of these benefit payments were paid directly to participants or beneficiaries and $7 billion to insurance carriers for the provision of benefits.[27] An additional $5 billion were paid but cannot be categorized. Mixed-insured group health plans that financed benefits via a trust received approximately $81 billion in contributions and paid approximately $83 billion in benefit payments: $57 billion of these benefit payments were paid directly to participants or beneficiaries and $25 billion to insurance carriers for the provision of benefits. An additional $2 billion were paid but cannot be categorized. See Appendix A, Table A4 and Table A5.

[26] If a sponsor purchases stop-loss insurance for its own benefit, the stop-loss insurance is generally not required to be reported on Schedule A. Accordingly, the existence of stop-loss insurance as part of the employer's arrangements for the plan is understated, especially for those plans that do not use a trust.
[27] Plans that self-insure health benefits may make payments to insurance companies for administrative services, stop-loss contracts, or for insurance premiums for other types of benefits (such as dental or disability).

- Self-insured group health plans that financed benefits via a trust also reported paying about $4 billion in administrative expenses, with approximately $500 million reported as professional fees, more than $1 billion reported as contract administrator fees, $100 million as investment advisory and management fees, and about $2 billion as other administrative expenses. Mixed-insured group health plans reported paying approximately $5 billion in administrative expenses, with approximately $500 million reported as professional fees, $3 billion as contract administrator fees, $400 million as investment advisory and management fees, and about $1 billion as other administrative expenses. See Appendix A, Table A5.

- Self-insured group health plans covering 100 or more participants that financed benefits via a trust held approximately 21 percent of assets in cash and U.S. government securities, 20 percent in direct filing entities ("DFEs"),[28] 20 percent in mutual fund companies (registered investment companies), 10 percent in debt instruments, and 10 percent in stock. Mixed-insured group health plans covering 100 or more participants that financed benefits via a trust held 20 percent in cash and U.S. Government Securities, 16 percent in DFEs, 14 percent in mutual fund companies (registered investment companies), 9 percent in debt instruments, and 24 percent in stock. See Appendix A, Table A6.

Section II. Additional Analysis of Financial Information on Employers Sponsoring Self-Insured, Mixed-Insured and Fully-Insured Group Health Plans

Employers who self-insure group health plans face considerable financial risk.[29] It is therefore relevant to consider the financial position of employers that self-insure health benefits. However, data on the financial position of the plan sponsor or employer are not included in Form 5500 filings. In order to provide data on financial filings of self-insured employers, data from the Form 5500 were matched to Capital IQ financial data available for a select group of companies with publicly-traded equity or debt.[30] Analysis of financial measures including revenue, market capitalization, net income, and number of employees shows that companies offering self-insured or mixed-insured health plans tend to be bigger than companies offering fully-insured health plans.[31]

[28] DFEs are pooled investment arrangements - master trust investment accounts, insurance company pooled separate accounts, bank common/collective trusts, other plan asset pooled investment funds ("103-12 investment entities"), and group insurance arrangements. Some DFEs are required to file a Form 5500 while others are permitted to file. Each DFE lists the plans whose assets it holds on Schedule D Part 2.
[29] See discussion in the March 2011 Report.
[30] Appendix B outlines this analysis. Capital IQ is a provider of financial and other data for private and public companies in the United States. The data include company characteristics, financial health and financial size.
[31] See Appendix B, Table 16 for the distribution of the measures for each of the three categories of plans.

The results of matching the 2014 Form 5500 data to the Capital IQ financial data were similar to the results of the matching for 2013. More than 4,000 Form 5500 filers were matched to the Capital IQ data. Most of the matched plans covered a large number of participants: 85 percent of the participants in matched plans were covered through a plan with 5,000 or more participants.[32] There were approximately 2,000 employers matched to a self-insured health plan filing a Form 5500 in 2014. The employers sponsoring these matched self-insured health plans reported a median employee count of 3,300, median revenue of approximately $1.4 billion, a median market capitalization of approximately $2.3 billion, and a median net income of approximately $90 million.[33] Approximately 1,000 employers matched to a mixed-insured plan that filed a Form 5500 in 2014. These mixed-insured matched health plans are sponsored by employers reporting a median employee count of 10,000, median revenue of approximately $3.9 billion, a median market capitalization of approximately $5.4 billion, and a median net income of approximately $200 million.

The financial health of these matched companies was measured using three financial metrics.[34] Overall the results are mixed. Firms sponsoring fully-insured plans have more cash flow relative to total debt than firms sponsoring mixed-funded or self-insured plans, as evidenced by a lower percentage of matched companies falling in the bottom — or "worst" — quartile and a higher percentage falling in the top — or "best" — quartile. However, firms sponsoring fully-insured plans are more likely than other firms to fall in both the worst and best quartile for operating income-to-debt ratio and the Altman Z Score, which is an index summarizing five financial measures that predict bankruptcy risk, making it difficult to draw conclusions regarding the financial health of a company and its choice of funding mechanism for its health plan.

Plans filing a Form 5500 can also be matched longitudinally to determine what changes the plan has undergone over time. Eighty-five percent of plans, on average, were matched between 2005 and 2014 to their previous years' filing.[35] The majority of new plans filing a Form 5500 continue to be fully-insured, which has driven their increasing share of all health plans. Contrary to previous years, in 2014 new plans that change funding status within the first year are more likely to switch from fully-insured to self- or mixed-insured.[36] Established plans — those that are neither new nor ceased filing Form 5500 – that change their funding status continue to be more likely to move away from being fully-insured: 4.3 percent of established plans that were mixed- or self-insured in 2013 became fully-insured in 2014, compared with 7.4 percent of established plans that became mixed- or self-insured.[37] This shift from fully-insured to self- and mixed-insured over time may explain the increasing share of participants covered by mixed- and self-

[32] See Appendix B, Table 4.
[33] See Appendix B, Table 14. Not all financial information for all employers was reported in the Capital IQ data and so the number of observations used to calculate the reported medians varies significantly.
[34] See Appendix B, Table 15.
[35] See Appendix B, Table 3.
[36] See Appendix B, Figure 8.
[37] See Appendix B, Figure 9.

insured plans: established plans tend to be larger than new plans and on net, move away from full insurance.[38]

Section III. Conclusion

This *Annual Report to Congress on Self-Insured Group Health Plans* (March 2017), together with its Appendices, provides the most detailed statistics currently available on self-insured group health plans filing a Form 5500 and on the sponsors of such plans that issue publicly-traded equity or debt. This report also documents the limited scope of such data and the complexities involved in interpreting the data that are available.

The Department recognizes the importance of quality data and looks forward to supplying Congress with annual updates on self-insured group health plans.

[38] See Appendix B, Table 11.