Report to Congress

Annual Report
on Self-Insured Group Health Plans

March 2019

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Annual Report to Congress on Self-Insured Group Health Plans

Executive Summary

The Patient Protection and Affordable Care Act (Affordable Care Act) (P.L. 111–148) requires the Secretary of Labor to provide Congress with an annual report (*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 (Form 5500), which many self-insured health plans are required to file annually with the Department of Labor (Department). The first *Report* was provided to Congress in March 2011.[1]

Along with this *Report*, the Department is submitting two detailed appendices produced under contract. Appendix A, *Group Health Plans Report: Abstract of 2016 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 2019: Based on Filings through Statistical Year 2016*, 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 that filed the Form 5500.[3]

Approximately 56,200 group health plans filed a Form 5500 for 2016, an increase of 3 percent from the number of plans that filed a Form 5500 for 2015. Of plans that filed a 2016 Form 5500, about 23,700 were self-insured and 4,100 mixed self-insurance with insurance ("mixed-insured"). Self-insured plans that filed a Form 5500 covered approximately 34 million participants in 2016 and held assets totaling about $82 billion. In 2016, there were nearly 28 million participants covered by mixed-insured group health plans; these plans held roughly $141 billion in assets. The table below summarizes aggregate statistics for self-insured and mixed-insured group health plans that filed a Form 5500 for 2015 and for 2016.

[1] Available at https://www.dol.gov/sites/default/files/ebsa/researchers/statistics/retirement-bulletins/annual-report-on-self-insured-group-health-plans-2011.pdf. The 2012–2018 *Report*s are also available online, though it should be noted that because of changes to the algorithm and methodology beginning with the 2013 *Report*, the *Report*s are not 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.

Table 1. Group Health Plans That Filed Form 5500 for 2015 and 2016, Reflecting Statistical Year Filings*

Plan type	2015		2016	
	Self-Insured Plans	Mixed-Insured Plans	Self-Insured Plans	Mixed-Insured Plans
All Plans	22,900	3,900	23,700	4,100
Participants	34 million	26 million	34 million	28 million
Active Participants**	30 million	22 million	31 million	23 million
Large plans*** not holding assets in trusts	17,400	2,700	18,400	2,900
Participants	21 million	16 million	22 million	17 million
Active Participants	20 million	15 million	21 million	16 million
All Plans holding assets in trust	5,400	1,200	5,300	1,200
Participants	13 million	10 million	12 million	10 million
Active Participants	10 million	8 million	10 million	8 million
Assets	$84 billion	$135 billion	$82 billion	$141 billion
Contributions	$59 billion	$84 billion	$59 billion	$87 billion
Benefits	$56 billion	$85 billion	$56 billion	$86 billion

NOTES: All figures in table have been rounded. Totals may not equal the sum of the components due to rounding.
* 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.
** Defined as any individuals who are currently in employment covered by the plan and who are earning or retaining credited service under the plan. See https://www.dol.gov/sites/default/files/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500/2018-instructions.pdf.
*** Plans with at least 100 participants.
SOURCE: 2015 and 2016 Form 5500 filings.

Sponsors of self-insured plans pay their plans' covered health expenses directly (either from their general assets or from a trust), 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. Sponsors of mixed-insured plans retain claims-paying 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, in part 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.

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.[4] 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 significant but unknown number of small, self-insured plans—are not included in this *Report*. The Department estimates that in 2016 there were about 2.2 million ERISA-covered group health plans covering approximately 135 million people.[5] Only about 56,200 plans covering more than 75 million participants filed a 2016 Form 5500.[6] Of those group health plans, about 32,500 filed at least one Schedule A (Insurance Information) for a group insurance policy covering health benefits;[7] roughly 6,900 plans reported holding assets and filed a Schedule H (Financial Information) or Schedule I (Financial Information–Small Plan).[8]

This *Report* presents data on health benefit plans covering private-sector employees that filed a 2016 Form 5500, the latest year for which complete data are available. As noted above, private-sector plans with fewer than 100 participants that are either fully insured or self-insured with benefits paid directly from the general assets of the employer or employee organization that sponsors the plan rather than from a trust are not required to file a Form 5500. Also, governmental and church plans are not required to file a Form 5500, regardless of size or assets held in trust. 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 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 when using aggregated 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.[9] The financial strength of these plan sponsors varies considerably. Similar variation is found among employers that sponsor self-insured plans, among those that sponsor mixed-insured plans, and among those that sponsor fully insured plans.

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[4] 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.

[5] EBSA estimates are based on the Current Population Survey and the Medical Expenditure Panel Survey, Insurance Component.

[6] See Appendix A, Table A1.

[7] See Appendix A, Table B1.

[8] See Appendix A, Table A2.

[9] This analysis is done using Capital IQ data, which culls Form 10-K filings and other sources to collect data on companies with public financial statements, which generally includes companies with publicly-traded stock or bonds.

Introduction

Section 1253 of the Patient Protection and Affordable Care Act (Affordable Care Act) (P.L. 111–148) requires the Secretary of Labor to prepare an aggregate annual report (*Report*) that includes certain general information on self-insured group health plans using data collected from the Annual Return/Report of Employee Benefit Plan (Form 5500), as well as certain data from financial filings of self-insured employers.[10]

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, who, in turn, assume the responsibility of paying claims. Sponsors of "mixed-insured" plans retain this responsibility for a subset of benefits, but transfer the risk for the remaining benefits to health insurers—that is, they finance benefits using a mixture of self-insurance and insurance.

The March 2011 *Report* discusses certain key, qualitative differences between the three categories of funding mechanisms: self-insured plans, fully insured plans, and mixed-insured plans.[11] Currently, the Form 5500 does not explicitly disclose whether a health plan

[10] 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 United States 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; and
- 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 Revenue 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.) In addition, plans that are multiple employer welfare agreements (MEWAs) required to file the Form M-1 must file the Form 5500, regardless of plan size. See https://www.dol.gov/sites/default/files/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/forms/m1-2018.pdf.

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

is self-funded, so the Department of Labor (Department) created an algorithm using filing characteristics to sort plans as self-insured, fully insured, or mixed-insured.[12]

The methodology for determining the plan universe for analysis and the funding mechanism for group health plans has undergone revisions periodically since the March 2013 *Report*. Because of these changes, one cannot identify trends over time by comparing this year's *Report* with previous *Reports*. However, using current methodology, the Department has incorporated previous years' data into this report for the purpose of comparison.[13]

In some instances, the sponsor of an ERISA-covered health plan is not the direct employer of the plan's participants, but an association of multiple such employers, which acts as the single, sponsoring employer for purposes of the plan. Such a plan constitutes a multiple employer welfare arrangement (MEWA) under ERISA, and is required to file Form 5500, regardless of size or holding of assets. In 2018, the Department expanded access to affordable health coverage options for America's small businesses and their employees through Association Health Plans (AHPs). Such plans generally are included, but not separately quantified, in this report. Future reports will separately identify AHPs.

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[12] A version of this algorithm was first developed by contractors in consultation with DOL for the 2011 Self-Insured Report to Congress. The algorithm has been revised multiple times since in order to better reflect the Department's understanding of how self-insured group health plans file the Form 5500. A description of the current algorithm can be found in Figure 2 of Appendix B to this report, *Self-Insured Group Health Benefit Plans 2019*.

[13] 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, direct filing entity (DFE) filings (including group insurance arrangements [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. Because some GIAs provide fully insured group health benefits, the number of participants receiving fully insured group health benefits that are covered by Title I of ERISA and reported on the Form 5500 may be understated in this regard.
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) have been excluded from the analysis. Specifically, filers with fewer than 100 beginning of year (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 end of year (EOY) participants have been included.
5. For plans with missing EOY participants that are nonterminating, BOY participants have served as a proxy for EOY total and active participants.

The Department published a final regulation on June 21, 2018 (83 Fed. Reg. 28912)[14] that establishes additional, alternative criteria under ERISA section 3(5) for determining when employers may join together in a group or association of employers that will be treated as the "employer" sponsor of a single multiple-employer "employee welfare benefit plan" that is a "group health plan," as those terms are defined in Title I of ERISA. By establishing a more flexible "commonality of interest" test and otherwise removing certain restrictions on the establishment and maintenance of AHPs under ERISA, the regulation is intended to facilitate the adoption and administration of AHPs and expand access to affordable health coverage, especially for employees of small employers and certain self-employed individuals.[15]

While plans that would meet the definition of AHP under the final regulation have existed for years, they have historically comprised a small fraction of all group health plans and were not reported as a separate type on this and other reports.[16] Because of the Administration's increased focus on these plans, the Department is currently working to revise how it classifies and reports plans by their employer arrangements. These revisions will not be included in this year's *Report*, but will be finalized and incorporated in the 2020 *Report*.[17]

Section I of this report presents aggregate statistics describing self-insured plans that file a Form 5500—generally, private-sector employee group 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.

Along with this report, the Department is submitting two detailed appendices produced under contract.[18] Appendix A, *Group Health Plans Report: Abstract of 2016 Form 5500 Annual Reports Reflecting Statistical Year Filings*, provides detailed statistics describing group health plans that file a Form 5500.[19] Appendix B, *Self-Insured Health Benefit Plans 2019: Based on Filings through Statistical Year 2016*, explores statistical issues associated

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[14] Available at https://www.gpo.gov/fdsys/pkg/FR-2018-06-21/pdf/2018-12992.pdf.

[15] On March 28, 2019, the U.S. District Court for the District of Columbia entered an order that vacated certain provisions of the final rule. We disagree with the Court's ruling and have appealed.

[16] Of the 56,211 group health plans which filed a Form 5500 in 2016, just 754 (1.3 percent) indicated they were multiple-employer plans in their filings.

[17] AHPs are a subset of multiple employer welfare association arrangements that constitutes single plans (or Plan MEWAs). For purposes of this report and convenient grouping of data, historically, plans have been grouped either a "single employer plan" or "multiemployer plan" based on whether or not they are collectively bargained. Of the 754 plans which indicated in their filing they were multiple employer plans, 30 also indicated they were collectively bargained and were classified for the purposes of this report as "multiemployer" plans. The remaining 724 were classified for the purposes of this report as "single employer" plans.

[18] A standardized method to determine each health plan's funding mechanism is used in both appendices. However, slight differences in other plan characteristics may occur due to the editing of inconsistent fields on Form 5500 filings.

[19] 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.

with Form 5500 health plan data and analyzes available data on the financial status of employers that sponsor group health plans.[20]

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

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:[21]

- 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, hold assets in trust, or constitute a MEWA. Governmental and church plans, regardless of size, also are not required to file a Form 5500. Therefore, information concerning such plans is not available in the Form 5500 data and is not included in the statistics provided in this report.

- Self-insured welfare plans, including group health plans, are generally 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 health benefits paid directly from the plan sponsors' general assets. Of the self-insured plans that filed a Form 5500 in 2016, 77 percent did not hold assets in trust, and thus did not report 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 determine how the different benefits are financed and whether the plan is self-insured or fully insured.[22] As a result, the estimates presented here are subject to substantial uncertainty.

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

[22] See report, *Strengths and Limitations of Form 5500 Filings for Determining the Funding Mechanism of Employer-Provided Group Health Plans* at https://www.dol.gov/sites/default/files/ebsa/researchers/analysis/health-and-welfare/strengths-and-limitations-of-form-5500-filings-for-determining-the-funding-mechanism-of-employer-provided-group-health-plans.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.

Table 2. Form 5500 Group Health Plans Summary Information, 2016
Reflecting Statistical Year Filings

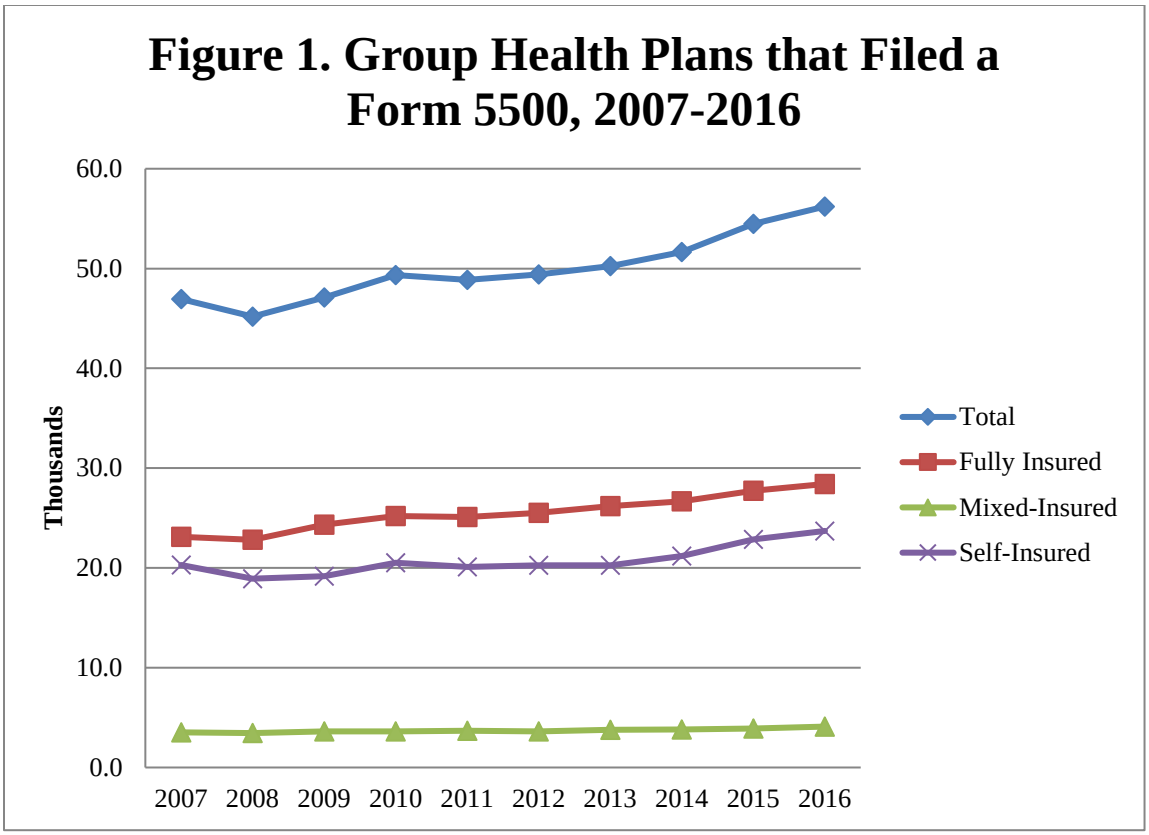
Plan type	All Plans	Self-Insured Plans	Mixed-Insured Plans	Fully Insured Plans*
All Plans	56,200	23,700	4,100	28,400
Participants	75 million	34 million	28 million	13 million
Active Participants	67 million	31 million	23 million	13 million
Large plans not holding assets in trusts	49,300	18,400	2, 900	28,000
Participants	52 million	22 million	17 million	13 million
Active Participants	49 million	21 million	16 million	12 million
All Plans holding assets in trust	7,000	5,300	1,200	400
Participants	23 million	12 million	10 million	500,000
Active Participants	18 million	10 million	8 million	400,000
Assets	$225 billion	$82 billion	$141 billion	$2 billion
Contributions	$149 billion	$59 billion	$87 billion	$3 billion
Benefits	$145 billion	$56 billion	$86 billion	$3 billion

NOTES: All figures in table have been rounded. Totals may not equal the sum of the components due to rounding.
* 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.
SOURCE: 2016 Form 5500 filings.

Plan Type by Funding Mechanism

- Approximately 22,700 of the self-insured group health plans that filed a 2016 Form 5500 were sponsored by a single employer; 1,000 plans were multiemployer plans. About 3,500 of the mixed-insured group health plans that filed a 2016 Form 5500 were sponsored by a single employer; approximately 600 plans were multiemployer plans. (See Appendix A, Table A2.)

- On average, about 49,900 group health plans filed a Form 5500 in the years 2007–2016. While the number of plans that filed a Form 5500 has increased over this period, the share that are self-insured or mixed-insured has been relatively stable, slipping from 51 percent in 2007 to 48 percent in 2013, and rebounding to 50 percent in 2016. See (Appendix B, Table 2 and Table 6.)



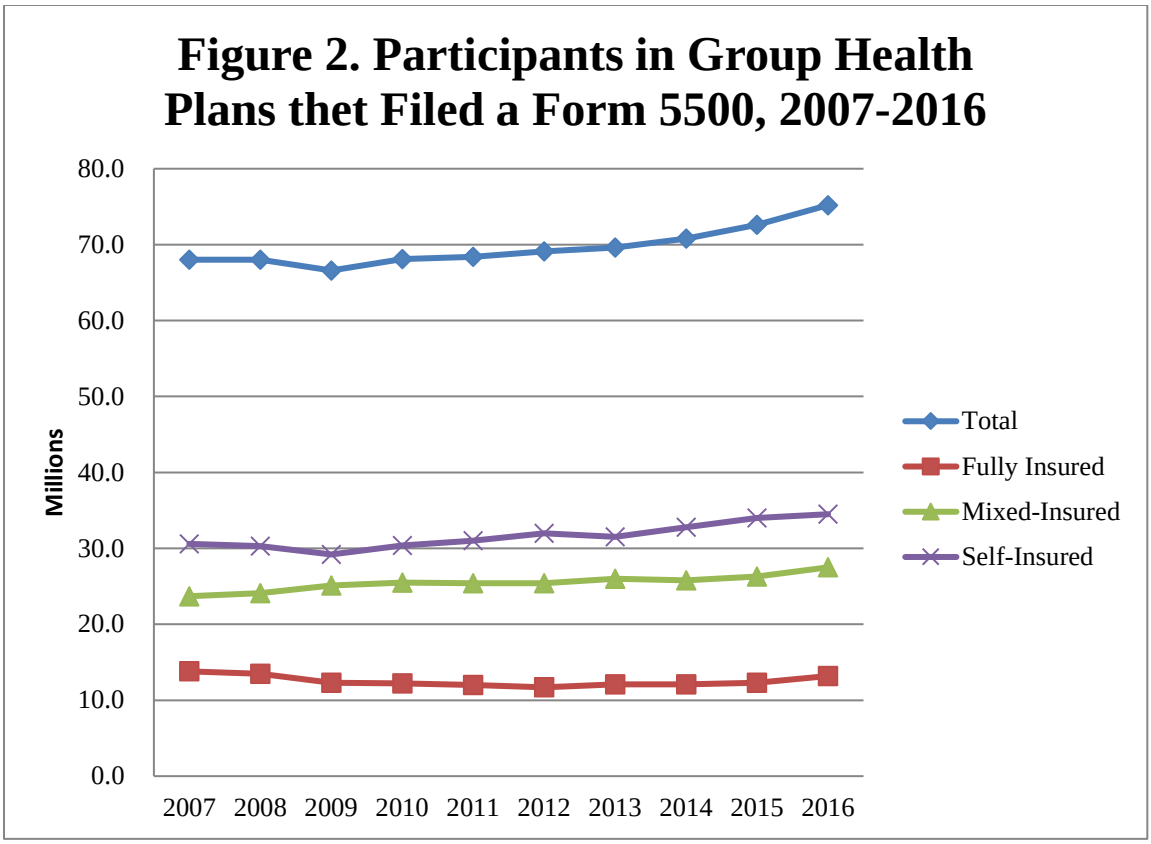
SOURCE: Appendix B, Table 7.

Number of Participants

- Overall, the approximately 23,700 self-insured group health plans that filed a 2016 Form 5500 covered about 34 million participants, 31 million of whom were active participants. The nearly 4,100 mixed-insured group health plans that filed a 2016 Form 5500 covered approximately 28 million participants, 23 million of whom were active participants. (See Appendix A, Table A1.)

- In general, plans covering a larger number of participants are more likely to be self-insured than plans with fewer participants. While 51 percent of plans were fully insured, only 18 percent of participants were covered by these plans. (See Appendix B, Table 6.)

- From 2007 to 2016, an average of about 49,900 group health plans, covering an average of approximately 70 million participants filed a Form 5500 each year. The share of plan participants covered by self-insured or mixed-insured plans has been fairly stable over this period. (See Appendix B, Table 2 and Table 6.)



SOURCE: Appendix B, Table 7.

New Plans

- Of the approximately 4,600 *new* health plans that filed a 2016 Form 5500, 35 percent were self-insured, 3 percent were mixed-insured, and 62 percent were fully insured.[23] 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.[24]

- Participants in new group health plans that filed a 2015 Form 5500 were more evenly split among funding mechanisms, with 36 percent of the participants covered under a self-insured group health plan, 26 percent in a mixed-insured plan, and 38 percent in a fully insured plan.[25]

[23] Special runs performed for DOL by AACG based on 2016 Form 5500 filings.
[24] 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. Consequently, the number of "new" plans in the current Self-Insured Report to Congress is not comparable to reports prior to 2013.
[25] Special runs performed for DOL by AACG based on the 2016 Form 5500 filings.

Benefits Offered

- Of the approximately 23,700 self-insured group health plans in 2016, about 5,100 offered only health benefits and 18,600 offered other benefits in addition to health benefits.[26] Of the roughly 4,100 mixed-insured group health plans, approximately 200 offered only health benefits and 3,900 offered other benefits in addition to health benefits. (See Appendix A, Table A1.)

Funding and Benefit Arrangements[27]

- Of the more than 23,700 self-insured group health plans that filed, approximately 1,700 indicated a *funding* arrangement (the method for the receipt, holding, investment, and transmittal of plan assets prior to the time the plan actually provides benefits) of a trust only, 4,900 indicated a funding arrangement of general assets of the sponsor only, and 12,900 indicated a funding arrangement of general assets of the sponsor combined with insurance.[28] The remaining 4,200 indicated insurance alone, some other combination of funding arrangements, or did not report any arrangement. Of the roughly 4,100 mixed-insured group health plans, about 400 indicated a funding arrangement of a trust only,[29] 500 indicated a funding arrangement of trust with insurance, and 2,700 indicated a funding arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated insurance alone or some other combination of funding arrangements. (See Appendix A, Table A7.)

- Of the more than 23,700 self-insured group health plans that filed, about 1,100 indicated a *benefit* arrangement (the method by which the plan provides benefits to participants) of a trust only, 2,100 indicated a benefit arrangement of trust with insurance, 4,500 indicated a benefit arrangement of general assets of the sponsor only, and 13,100 indicated a benefit arrangement of general assets of the sponsor

[26] 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.
[27] 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.
[28] 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.
[29] The 400 plans that were identified as mixed-insured and indicated a funding arrangement of a trust only also filed a Schedule A and reported a health insurance contract. Under the current methodology, 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 11–13).

combined with insurance.[30] The remaining 2,900 indicated insurance alone, some other combination of benefit arrangements or did not report any arrangement. Of the roughly 4,100 mixed-insured group health plans that filed, approximately 900 indicated a benefit arrangement of trust with insurance and 2,800 indicated a benefit arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated insurance or trust alone, or 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 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. 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 arrangement for the plan is understated, especially for those plans that do not use a trust. From 2007 to 2016, the percentage of group health plans that filed a Form 5500 reported having stop-loss insurance gradually declined, from approximately 31 percent to 25 percent for self-insured plans and 24 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 11 and Figure 13.)

Plan Assets and Liabilities of Plans That Financed Benefits through Trusts

- The roughly 5,400 self-insured group health plans that financed benefits through trusts reported approximately $82 billion in assets and $10 billion in liabilities. The more than 1,200 mixed-insured group health plans that financed benefits through trusts reported nearly $141 billion in assets and $15 billion in liabilities. (See Appendix A, Table A2.)

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

- Self-insured group health plans that financed benefits through a trust received approximately $59 billion in contributions and paid approximately $56 billion in benefit payments: $44 billion was paid directly to participants or beneficiaries and $7 billion was paid to insurance carriers for the provision of benefits.[31] The

[30] 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.
[31] Plans that self-insure health benefits may make payments to insurance companies for administrative services, stop-loss contracts, or insurance premiums for other types of benefits (such as dental or disability).

remaining $5 billion cannot be categorized. Mixed-insured group health plans that financed benefits through a trust received approximately $87 billion in contributions and paid approximately $86 billion in benefit payments: $60 billion was paid directly to participants or beneficiaries and $24 billion was paid to insurance carriers for the provision of benefits. The remaining $2 billion cannot be categorized. (See Appendix A, Table A4 and Table A5.)

- Self-insured group health plans that financed benefits through a trust also reported paying about $4 billion in administrative expenses, with approximately $500 million reported as professional fees, approximately $2 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, $2 billion as contract administrator fees, $300 million as investment advisory and management fees, and over $1 billion as other administrative expenses. (See Appendix A, Table A5.)

- Self-insured group health plans covering 100 or more participants that financed benefits through a trust held approximately 17 percent of assets in cash and U.S. government securities, 23 percent in direct filing entities (DFEs),[32] 23 percent in mutual funds (registered investment companies), 9 percent in debt instruments, and 10 percent in stock. Mixed-insured group health plans covering 100 or more participants that financed benefits through a trust held about 17 percent in cash and U.S. government securities, 14 percent in DFEs, 11 percent in mutual funds (registered investment companies), 11 percent in debt instruments, and 23 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

Section 1253 of the Affordable Care Act (42 U.S.C. 18013) requires this *Report* to include data from the financial filings of self-insured employers, including information on assets, liabilities, contributions, investments, and expenses. 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

[32] 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. A Form 5500 *must* be filed for a master trust investment account. A Form 5500 is not *required* but may be filed for all other DFEs. Each DFE lists the plans whose assets it holds on Schedule D Part 2.

equity or debt.[33] Analysis of financial measures—including revenue, market capitalization, net income, and number of employees—shows that companies offering self-insured or mixed-insured group health plans tend to be bigger than companies offering fully insured plans.[34]

The results of matching the 2016 Form 5500 data to the Capital IQ financial data were similar to the results of the matching for 2015. Approximately 4,000 Form 5500 filers, or 7 percent in the 2016 Form 5500 health plan data, were matched to the Capital IQ data. Eighty-seven percent of the participants in matched plans were covered through a plan with 5,000 or more participants.[35] There were approximately 2,000 employers matched to a self-insured health plan filing a Form 5500 in 2016. The employers sponsoring these matched self-insured group health plans reported a median employee count of 3,700, median revenue of approximately $1.5 billion, median market capitalization of approximately $2.7 billion, and a median net income of approximately $95 million. Approximately 1,000 employers matched to a mixed-insured plan that filed a Form 5500 in 2016. These plans were sponsored by employers reporting a median employee count of 9,000, median revenue of approximately $3.7 billion, a median market capitalization of approximately $5.2 billion, and a median net income of approximately $200 million.[36]

The financial health of the matched companies was measured using three financial metrics.[37] Overall the results are varied. 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 quartile and a higher percentage falling in the top quartile. However, firms sponsoring fully insured plans are more likely than other firms to fall in both the top and bottom quartile for operating income-to-debt ratio and the Altman Z-score. (The Altman Z-score is an index summarizing five financial measures that predict bankruptcy risk.) This variance makes it difficult to draw conclusions regarding the financial health of a company and its choice of funding mechanism for its health plan. It is noteworthy that, similar to prior years, firms sponsoring fully insured plans generally show a wider dispersion of financial health than those sponsoring mixed-funded or self-insured plans.

Plans filing a Form 5500 can also be matched longitudinally to determine what changes the plan has undergone over time. From 2007 to 2016, 85 percent of plans, on average,

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[33] 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.

[34] See Appendix B, Table 13 for the distribution of the measures for each of the three categories of plans.

[35] See Appendix B, Table 4. While this is a relatively small number, many companies that filed a Form 5500 are not represented in Capital IQ data because they may have no requirement to issue publicly available financial statements. Sponsors may be privately held, based overseas, or not-for-profit and without publicly issued bonds, or the plan may be a multiemployer or multiple-employer plan. As a result, this analysis is over-represented by large, publically-traded companies that are based in the United States.

[36] 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.

[37] See Appendix B, Figure 15.

were matched to their previous years' filing.[38] The majority of new plans that filed a Form 5500 remained fully insured, which has driven their increasing share of all group health *plans*. Since 2014, new plans that change their funding mechanism status within the first year are more likely to switch from fully insured to self- or mixed-insured.[39] Established plans—those that are not new and have continually filed a Form 5500—that change their funding mechanism status continue to be more likely to move away from being fully insured: 3.9 percent of established plans that were mixed- or self-insured in 2015 became fully insured in 2016, compared with 7.3 percent of established plans that became mixed- or self-insured.[40] This shift from fully insured to self- and mixed-insured over time may explain the increasing share of *participants* covered by mixed- and self-insured plans: established plans tend to be larger than new plans and, on net, move away from full insurance.[41]

Section III. Conclusion

This *Annual Report to Congress on Self-Insured Group Health Plans* (March 2019) provides the most detailed statistics currently available on self-insured group health plans that filed 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.

The Department recognizes the importance of quality data and will continue to improve this annual *Report* and its underlying statistics to better inform Congress on self-insured employee health benefit plans and financial information regarding employers that sponsor such plans.

[38] See Appendix B, Table 3.
[39] See Appendix B, Figure 8.
[40] See Appendix B, Figure 9.
[41] See Appendix B, Figure 9.