Self-Insurance and the Affordable Care Act

By Mark L. Stulmaker

Over the past decade, there has been steady growth in the percentage of employees covered by health plans that are self-insured by their employers.[1] Rising health care costs, state-mandated coverage requirements, and premium taxes have encouraged many large employers to evaluate their plans and to opt out of the insurance market in favor of the self-funding of their benefit programs. The Patient Protection and Affordable Care Act (ACA)[2] contains additional incentives for employers, both large and small, municipal and private, to self-insure their health benefit programs and will likely accelerate this trend.[3]

However, self-insurance creates financial risks for any employer and raises issues under New York law that are unique to municipal employers. For example, New York's General Municipal Law prohibits the establishment of a reserve fund to accumulate money for the payment of uninsured health care expenses. It also regulates the contractual relationship that a municipality may have with an administrator of a self-insured program.[4] Furthermore, New York law specifically recognizes only two funding arrangements for a self-insured plan sponsored by a government employer: a municipal cooperative health benefit plan authorized by article 5-G of the General Municipal Law and regulated under Article 47 of the Insurance Law, and a collectively bargained welfare fund recognized by case law and Article 44 of the Insurance Law. Both of these funding arrangements require complicated legal and bargaining relationships that may not coincide with a municipality's own goals and finances.

This article begins with a description of self-funded health plans. It then briefly outlines the federal mandates and requirements that apply to those plans before discussing in detail those changes to be ushered in by the ACA. The article then turns to the special considerations of New York municipalities in connection with offering a self-insured health plan, including the funding options available to municipalities for such plans.

Self-Funded Health Plans

A self-funded health plan is an insurance arrangement in which an employer directly assumes the risk of paying the health expenses incurred by participants in the plan.[5] This contrasts with an insured arrangement, by which the employer contracts with a health insurance company or Health Maintenance Organization ("HMO") to assume these risks.[6]

Self-funded plans are most prevalent among large employers that can spread the risk of large claims over a greater number of participants. Of those employed by employers with 200 or more employees in 2012, 81% received their health benefits from plans in which the employer directly assumed some or all the risk, versus only 15% of those employed by employers with less than 200 employees.[7] Overall, 72% of all employees employed by a state or local government were covered by a plan in which their employer self-insured some of the risk.[8]

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In the past, consultants and actuaries have recommended that employers consider a self-funded arrangement when they have 1,000 or more employees.[9] Claims become more predictable at that level, and any one large claim is not a material financial risk. The New York State Comptroller recommends that municipal employers should consider a self-insured health plan only if they have 500 or more employees.[10] However, as noted above, the majority of employers with 200 or more employees now self-insure at least a portion of their health benefit programs.[11]

Smaller employers can purchase stop-loss insurance to protect themselves against the risk of large claims. Stop-loss coverage reimburses the insured employer for claims exceeding a set attachment point for individual large claims and is also available to insure against a large number of claims over a single plan year.[12] In 2012, 58% of workers covered by self-insured plans were in plans covered by stop-loss insurance.[13]

While stop-loss insurance reduces the financial risk associated with self-insuring health benefits, it does not eliminate those risks.[14] Consultants and human resource professionals report that "lasering"—the practice of excluding high-risk individuals from coverage under the stop-loss policy—is often a problem, especially in a tight insurance market.[15]

Further, stop-loss insurance may create cash flow problems for an employer. Beginning in 2014, the ACA prohibits health plans from imposing an annual cap on essential health benefits for any individual.[16] Claims

from any single illness will only grow larger and the stop-loss contract may require the employer to lay out these claim dollars, even to the extent they exceed the policy's attachment point, prior to being reimbursed by the insurance company after a determination process. Some policies provide for these reimbursements to be advanced by the insurer as claims are paid and reconciled at year-end.[17] Clearly, such a provision would be beneficial to an employer concerned that available cash may fall short of what is needed to timely pay health care providers.

Finally, employers relying on the protection afforded by stop-loss insurance must be aware of the financial condition of the company issuing the policy. Stop-loss insurance is not covered by any of New York's guaranty funds, which protect those insured by life, health, property and casualty insurance companies from a company's insolvency or default.[18]

Federal Mandates and the Affordable Care Act

The Employee Retirement Income Security Act of 1974 ("ERISA")[19] regulates non-governmental, self-insured health plans. Any state regulation of these health plans is preempted by ERISA.[20] States may regulate the content of any insurance policy issued to provide the benefits of a health plan,[21] but a state cannot "deem" an employer plan or trust to be an insurance company in order to mandate the benefits the employer provides.[22] For these reasons, employers can self-insure their health plans to customize and limit their health plan offerings and those employers operating in more than one state can avoid the expense of complying with multiple states' regulations.

Plans that are established or maintained by the government of the United States, by the government of any state or political subdivision, or by any agency or instrumentality of any of the foregoing, are excluded from coverage by ERISA.[23] While this exception for governmental plans would seem to allow more regulation by state legislatures, to date, New York has only mandated benefits offered through group insurance contracts,[24] and this seems to be the case with other states as well.[25]

New York, like many states, mandates insurance coverage for a number of benefits, including substance abuse, chiropractic, and autism-related services.[26] It imposes a number of fees and taxes for health services, some of which can be avoided by self-insured plans.[27]

Self-insured plans also avoid administrative charges and risk charges associated with insurance products. While most self-insured plans have administrative costs of their own, large employers frequently determine that they can administer the plan either on their own or hire a third-party administrator to do it on a cheaper basis.[28]

Although no one of these factors appear to drive employers to leave the insurance market for a self-insured plan, the combination seems to have moved employers over time.[29]

More recently, federal mandates have begun to even the regulatory environment surrounding self-insured and fully insured health plans. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)[30] improved access to coverage by allowing an employee or dependent who has lost his or her coverage to elect to continue the same benefits by paying a monthly premium. The Health Insurance Portability and Accountability Act (HIPAA)[31] limited the extent to which a health plan could exclude preexisting conditions from coverage, and limited premium variations based on health conditions.

Among the additional federal requirements imposed on health plans are those included in the Newborns' and Mothers' Health Protection Act of 1996,[32] mandating minimum covered hospital stays after child birth; the Women's Health and Cancer Rights Act[33] requiring the coverage of reconstructive surgery after a mastectomy; and the Mental Health Parity and Addiction Equity Act of 2008, requiring mental health benefits on a par with benefits for physical health.[34]

The ACA continues this trend, requiring that children be covered up to the age of 26[35] and that certain preventative services be provided without a deductible or co-pay.[36]

ACA Changes to the Small Insured Plan Market

But the ACA also brings changes to the small insured plan market and adds new fees, and it is these changes that may have unexpected results.

Small insured plans will be required to include a set of essential health benefits covering ten categories of claims, to be defined by Health and Human Services. These must include prescription drug coverage and mental health and substance abuse disorder services.[37] In order to improve access to coverage, the ACA imposes new rating requirements on plans in the small group market. The ACA defines a small employer as one that employs an average of at least one but not more than 100 employees on business days during the preceding calendar year.[38] The ACA requires that all fully insured, small group plans (other than plans that have been grandfathered) not vary the premiums they charge except for variations caused by the value of the benefits offered by the plan, the family size covered, the geographic location of those covered, and tobacco use status.[39] Any rating variation based on health status or claim history is prohibited.

Beginning January 1, 2014, a health insurance issuer that offers health insurance coverage in the individual or group markets (regardless of whether the coverage is offered in the large or small group market)

is required to accept every employer and individual in the state that applies for that coverage.[40] This is called guaranteed issue, and it removes a big concern for employers considering a move to a self-insured plan. After January 1, 2014, if a small employer's health claim experience is worse than that of the community's, it can always return to a community-rated policy.

For plan years beginning before January 1, 2016, each state may elect to define a small employer as an employer with less than 50 employees on business days during the preceding calendar year.[41] New York continues to define a small employer as one in this manner and the Governor's proposed legislation directs the New York Health Benefit Exchange to determine whether to increase the size of small employers to not more than 100 employees prior to January 1, 2016.[42]

The ACA has created a series of new fees to help fund various aspects of the law.[43] The most significant is an annual fee on insurers and certain multiple-employer welfare arrangements.[44] The amount payable by each insurance company for a calendar year is the company's proportionate share of the aggregate fee based on net premiums written. The aggregate fee is set by statute and will be $8 Billion in 2014. The first fee payment is due by September 30, 2014, and it has been estimated to add 2.5-3% to premiums in years 2014 to 2018.[45]

In 2016, the ACA's guaranty-issue requirements will apply to employers with less than 100 employees. As a result, there is concern that the move to self-insurance may accelerate.[46] The concern is that younger, healthier groups will leave the insurance market, thereby increasing average claims and premiums for those left behind.[47] Stop-loss insurance with low attachment points can blur the line between insurance and self-insurance, and carriers have begun to market these products.[48]

In New York, stop-loss insurance cannot be sold to a small employer group.[49] This should forestall movements by groups under 50 to self-insured products. It has been recommended that the law be amended in 2016 to provide that stop-loss insurance not be provided to employers with less than 100 employees.[50] Smaller towns and villages should be careful to monitor legislation if they are self-funded or are considering such a move.

The end result of these mandates and fees is to encourage consultants and their clients, regardless of size, to seriously consider self-insurance.

Special Funding Considerations of New York Municipalities

The annual budget process for municipalities in New York is governed by statute.[51] Budgets are prepared under the cash method of accounting, meaning that transactions are recognized only when they occur, either when an expense is paid or when revenue is received.[52] An expense incurred late in a prior fiscal year, such as a medical bill, is budgeted for payment in the subsequent fiscal year, when the bill is paid. This is in contrast with an accrual method of accounting, generally used for a municipality's financial statements, where the medical bill incurred in the prior fiscal year would be recorded as a liability in that prior year.[53]

The budget process for health care expenses under an insured arrangement is quite simple. Premium rates are provided by the insurance company before the fiscal year, and the budget process is completed by estimating the number of employees who will qualify for insurance.[54]

When budgeting for a self-funded program, the employer must estimate claims that have been incurred during the prior fiscal year that will need to be paid in the subsequent fiscal year. These incurred but not reported (IBNR) claims usually amount to 20-25% percent of total annual claims, meaning that during the first three months of the fiscal year payments will need to be made for claims incurred in the prior fiscal year.[55]

In the first year of a self-insured plan, the employer does not have an obligation for insurance premiums so it can take the opportunity in the first few months to begin to set aside funds that will be needed in subsequent years. Unfortunately, New York law does not allow the municipality to set aside a reserve for these claims. Under the various budget provisions, revenues received in one fiscal year may be reserved and carried over into a subsequent fiscal year only for "stated purposes pursuant to law."[56] Fund balances may be carried over to subsequent fiscal years only if established as a legal reserve fund.[57]

Article 2 of the General Municipal Law does allow for local governments to establish reserve funds for certain purposes, but none would apply here. In particular, General Municipal Law Section 6-n authorizes municipal corporations to establish an insurance reserve fund, but this type of fund explicitly carves out payments for claims for which a municipal corporation can obtain insurance. Further, General Municipal Law Section 6-p authorizes the establishment of an "employee benefit accrued liability reserve fund." In this case, employee benefits are defined to mean payments for the monetary value of accrued but unused and unpaid sick leave, personal leave, holiday leave, vacation time, and time allowances granted in lieu of overtime compensation. These are payments in the nature of wages and not reimbursements for health claims.

There is no provision under New York law allowing for a reserve by a municipal corporation for the payment of health care costs.[58] While this may not be an issue on an on-going basis, it can severely limit a municipality's options in the future. Should a mu-

nicipality wish to switch back to an insured arrangement, it would have a liability for claims incurred in the prior year that would need to be paid in the first part of its next plan year, together with its liability for insurance premiums. If not funded in advance, the municipality would start with a 20-25% percent increase in health care costs.

The only possible funding for claim run-outs are those amounts that may be set aside as part of the unappropriated, unreserved fund balance. A "reasonable amount" of unappropriated, unreserved fund balance may be carried each year if consistent with prudent budgeting practices and if necessary to ensure the orderly operation of government.[59]

While towns, villages and counties are permitted to retain a "reasonable amount" of any remaining estimated, unappropriated, unreserved fund balance for each of their legal funds, school districts are limited to retaining 4% of the current school budget in unreserved, unappropriated fund balance.[60]

In making a determination of a "reasonable" amount, the following factors may be considered by a town, village or county:

- the size of the fund (a set percentage may not be appropriate);
- cash flow requirements (the timing of receipts and disbursements in an ensuing fiscal year);
- the certainty with which revenues and expenditures may be estimated (the greater the uncertainty, the greater the need may be for unappropriated funds); and
- the government's experience in prior fiscal years.[61]

There is no guidance from the State Comptroller as to what portion, if any, of a municipality's health claim liability might be funded through unappropriated fund balance.

Prudent financial planning would suggest that the IBNR liability be monitored and set aside to insure that a big increase in appropriations is not needed if the municipality wishes to change funding arrangements in the future. Municipal employers should be ready to document claim payments and trends to support any reserve balances they may wish to retain. They may need to retain a consultant to provide an independent report in support of added reserves, especially in the early years of a self-funded arrangement. The State Comptroller has provided links to state procurement contracts for actuarial consulting services in its guidance for the financial reporting of post-employment health costs.[62]

Special Contractual Considerations of New York Municipalities

In addition to funding restrictions placed on municipalities by New York law, New York law also regulates the contractual relationship between the employer sponsor of a self-funded health plan and its contract administrator. Paragraph 6 of Section 92-a of the General Municipal Law requires that any such agreements be entered into pursuant to competitive bidding, or written requests for proposals, in accordance with Section 104-b of the General Municipal Law.

In addition, GML Section 92-a prescribes provisions that must be included in any agreement with a health plan's contract administrator. They include:

- a statement that payment of services will be made only after the services are rendered;
- a provision that the contract administrator will be liable to the public corporation for any loss or damage that may result from any failure of the contract administrator to discharge their duties, or from any improper or incorrect discharge of those duties, and reserves to the public corporation all legal rights are set off;
- a requirement for the contract administrator to hold the public corporation harmless from any loss occasioned by or incurred in the performance of its services for the public corporation;
- a requirement that the administrator post a surety bond, letter of credit or other security to secure its performance under the agreement;
- a requirement that the contract administrator undergo an annual audit by an independent certified public accountant of its accounting procedures and controls; and
- a limit on the term of the agreement of five years but allowing the municipal corporation to terminate the agreement upon 30 days' notice.[63]

These provisions will likely be at odds with the standard service agreement to be proposed by a third-party administrator. These administrators invariably ask for a "gross negligence" standard with respect to imposing liability for their mistakes. Further, the need for an independent audit will eliminate smaller companies that do not currently undergo that process. In order to be sure that their service agreement conforms to General Municipal Law requirements, the employer should enclose a proposed service agreement, with the required provisions, in its requests for proposals from third-party administrators.

Funding Options

New York does recognize two arrangements that will allow for the appropriate funding for a self-insured health plan.

Article 47 of the New York State Insurance Law allows for the establishment of a municipal cooperative health benefit plan (MCHBP), a shared funding arrangement among municipalities to provide health benefits for their employees. The standards for establishing a MCHBP are set forth in detail in Article 47.

Article 47 requires that at least three municipal corporations participate in the plan and that there be at least 2,000 covered employees (including retirees, but not including dependents).[64] The plan must have a written commitment for stop-loss insurance and must have premium rates established by an actuary, evidencing that its premiums will be sufficient to meet its contractual obligations and satisfy reserve and surplus requirements.[65]

A MCHBP must have a reserve fund for the payment of claims and related expenses reported but not yet paid, and claims and related expenses incurred but not yet reported, no less than 25% of the expected incurred claims and expenses for the current plan year.[66]

Section 4706 of the Insurance Law allows a MCHBP to reduce the 25% minimum reserve based upon a demonstration by a qualified actuary that a lesser amount would be adequate. The Superintendent of the Insurance Department must approve the application for a lower reserve.[67]

Because of the need to pre-fund these reserves prior to the establishment of a MCHBP, there are currently only eleven of these certified plans in New York State. Only one, the Greater Tompkins County Municipal Health Insurance Consortium, has been certified since 2003. As a result, the Department of Financial Services issued a report on the impact of the claim reserve requirements under Section 4706 of the Insurance Law, recommending additional flexibility in the initial reserves required.[68] That report recommends separate reserve determinations by actuaries for medical claims and prescription drug claims and a reserve of no less than 17% of incurred claims for medical claims and no less than 5% for prescription drug claims. To date, the Insurance Department (now the Department of Financial Services) has agreed to reduce the 25% reserve minimum to a level no less than 17% of expected incurred claims and expenses for all but two MCHBPs now operating in the state.[69]

The second method by which a municipality may set aside funds to self-insure benefits is through payments, pursuant to a collective bargaining agreement, to a union welfare fund that would provide those benefits to its members.[70] The State Comptroller has recognized that municipalities may contract to make fixed contributions under a collective bargaining agreement to a union fund for the purchase of health insurance benefits.[71]

Union welfare funds are governed by Article 44 of the New York Insurance Law and are defined to include any trust fund established or maintained jointly by one or more employers together with one or more labor organizations.[72] Unlike in the private sector, where such funds must be governed by a joint board with an equal number of representatives from employers and unions, many of these welfare funds established by municipal unions are administered solely by union-designated trustees.[73]

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Because welfare funds administered only by union trustees are exempt from registration with the State, there is little information on the number of these welfare funds and the assets they hold.[74] Jointly administered welfare funds must file annual financial statements with the New York State Department of Financial Services.[75] As of 2012, there were twenty-two such welfare funds registered with the State.[76]

Article 44 of the Insurance Law does not contain any reserve requirements or any other requirements as to premiums or funding similar to those imposed on municipal cooperative health benefit plans. The bargaining parties must agree upon contribution levels that will cover current costs and maintain adequate reserves. For that reason, any employer that contributes to such a fund should obtain assurances that the fund has adequate reserves to pay any claim run-outs so that employees are adequately protected.

In order for a welfare fund to be considered as maintained pursuant to collective bargaining agreement, the Department of Financial Services looks to federal regulations.[77] These regulations only allow 10% of the employees covered by the fund to be non-union employees.[78] Therefore, this arrangement may not be an option for the employer's entire workforce.

Conclusion

While many public employers may be enticed to consider self-funding their health benefit plans to control costs in the new regulatory environment brought about by the Affordable Care Act, the fiscal controls

placed on these employers by New York law make budgeting and planning for these changes difficult and compound the risks that apply to any employer that self-insures. The lack of an established funding mechanism for reserves needed for incurred but unpaid medical claims and possible changes in the stop-loss insurance market should make employers cautious. Existing funding arrangements permitted by New York Insurance Law require the employer to affiliate with other employers or unions and may not fit the employer's needs.

Endnotes

1. *See* THE HENRY J. KAISER FAMILY FOUNDATION, *Section 10: Plan Funding*, Kaiser / HRET Survey of Employer-Sponsored Health Benefits, (Sept. 11, 2012), http://kff.org/report-section/ehbs-2012-section-10 (hereinafter Kaiser / HRET Survey).
2. *See generally* Protection and Affordable Care Act (PPACA), PUB. L. NO. 111-148, 124 Stat. 119 (2010); Health Care and Education Reconciliation Act (HCERA) of 2010, PUB. L. NO. 111-152, 124 Stat. 1029 (2010)(providing the statutory requirements for health care reform).
3. *See* Robert Pear, *Some Employers Could Opt Out of Insurance Market, Raising Others' Costs*, N.Y. TIMES, Feb. 17, 2013, at A9, *available at* http://www.nytimes.com/2013/02/18/us/allure-of-self-insurance-draws-concern-over-costs.html?pagewanted=all&_r=0; *see also* Christopher Weaver & Anna Wilde Mathews, *One Strategy for Health-Law Costs: Self Insure*, WALL ST. J., May 27, 2013, *available at* http://online.wsj.com/article/SB10001424127887323336104578503130037072460.html.
4. Reserve Fund for Health Insurance, Op. State Comp. 2004-8 (Oct. 12, 2004), *available at* http://osc.state.ny.us/legal/2004/op2004-8.htm.
5. Kaiser / HRET Survey, *supra* note 1.
6. *Id. See also* N.Y. Public Health Law §4401(1) and (2) (McKinney 2013) (providing a program of comprehensive health services to its enrolled members in exchange for periodic payment); *see also* N.Y. Public Health Law §4406 (1) (McKinney 2013) (providing that under New York law, the contract between the enrollee and the health maintenance organization is treated as an insurance contract).
7. Kaiser / HRET Survey, *supra* note 1, at Exhibit 10.3.
8. *Id.*
9. Dean C. Hatfield & Andrew D. Sherman, *Self-Funding Health Benefits Can Help Plan Sponsors Lower Costs*, BENEFITS & COMPENSATION DIG., Aug. 2009, at 1, 11.
10. OFFICE OF THE STATE COMPTROLLER, *Local Government & School Accountability, Cost-Saving Ideas: Containing Employee Health Insurance Costs*, http://www.osc.state.ny.us/localgov/costsavings/emphealth.htm (as visited on August 25, 2013).
11. *See* Kaiser / HRET Survey, *supra* note 1.
12. *Id.*
13. *See* Kaiser / HRET Survey, *supra* note 1, at Exhibit 10.9.
14. Christine Eibner, Federico Girosi, Amalia Miller, Amado Cordova, Elizabeth McGlynn, Nicholas Pace, Carter Price, Raffaele Vardavas, & Carole Gresenz, EMPLOYER SELF-INSURANCE DECISION AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND RECONCILIATION ACT OF 2010 (ACA) 6 (The Rand Corporation 2011) (hereinafter referred to as RAND Report).
15. Unfortunately, there is no comprehensive data on stop-loss insurance so conclusions must be drawn from informal conversations with consultants and brokers in the health insurance market. RAND Report, *supra* note 14, at 27.
16. Public Health Service Act (PHSA), ch.373, §2711, 58 Stat. 682 (codified as amended at 42 U.S.C.A. §300gg-11 (West 2010)) (prohibiting lifetime caps on essential benefits since 2011). *Id.*
17. RAND Report, *supra* note 14, at 14.
18. N.Y. DEP'T FIN. SERV., Stop-Loss Insurance Provider in Rehabilitation & Insured's Dishonored Claims, Op. O.G.C. No. 02-09-03, *available at* www.dfs.ny.gov/insurance/ogco2002/rg020903.htm.
19. 29 U.S.C.A. §§1001-1003 (West 1974) (amended 1978).
20. 29 U.S.C.A. §1144(a) (West 2006).
21. *Id.*
22. 29 U.S.C. §1144(b)(2)(B) (West 2006).
23. 29 U.S.C.A. §1003(b) (West 2002).
24. *See* N.Y. INS. LAW §§3217-21, 4303 (McKinney 1999). *See also* Opinion of the Office of General Counsel, New York State Department of Financial Services, OGC Op. No. 03-02-24 (concluding that a governmental welfare fund was not required to offer certain benefits mandated for group insurance contracts or HMOs), *available at* www.dfs.ny.gov/insurance/ogco2003/rg/030224.htm.
25. RAND Report, *supra* note 14, at 11.
26. N.Y. DEP'T FIN. SERV, *Mandated and Make Available Benefits: Commercial, HMO and Article 43 Insurance Contracts*, http://www.dfs.ny.gov/insurance/health/lbenall.htm (last updated Jun. 6, 2013).
27. The covered lives assessment, varying by region from $8.33 to $196.49 per covered life in 2013, funds graduate medical expenses and is paid by both insured and self-insured plans. *See* N.Y. PUB. HEALTH LAW §2807-t (McKinney 2012), *available at* https://www.health.ny.gov/regulations/hcra/gme/2013_surcharges_and_assessments.htm. A surcharge on hospital services to fund charity care, estimated to be 9.2% of hospital bills in 2013, is paid both by self-funded health plans and insurers for 2012-2013. *See* N.Y. PUB. HEALTH LAW §2807-j (McKinney 2012) (providing that an assessment on insurers under Section 332 of the Tax Law funds operations of the New York Department of Financial Services. This is not paid by self-funded health plans); *See also* N.Y. TAX LAW §1502-a (McKinney 2011) (providing that commercial insurers pay a 1.75% tax on premiums).
28. *See* Hatfield & Sherman, *supra* note 9, at 11.
29. RAND Report, *supra* note 14, at 11.
30. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), PUB. L. NO. 99-272, 100 Stat. 82 (1986).
31. Health Insurance Portability and Accountability Act of 1996 (HIPAA), PUB. L. NO. 104-191, 110 Stat. 1936 (1996).
32. Newborns' and Mothers' Health Protection Act of 1996, PUB. L. NO. 104-204, 110 Stat. 2935 (codified as amended at 29 U.S.C.A. §1185, 42 U.S.C.A. §§300gg-4, -51 (West 1996)).
33. Women's Health and Cancer Rights Act of 1998, PUB. L. NO. 105-277, §101(f), 112 Stat. 2681-436 (codified as amended at 29 U.S.C.A. §1185(b), 42 U.S.C.A. §§300gg-6, -52 (West 1998)).
34. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, PUB. L. NO. 110-460, §1, 122 Stat. 5123 (codified as amended at 42 U.S.C.A. §300gg-5 (West 2008)). There is an opt-provision for non-federal government self-insured plans. *See* Public Health Service Act (PHSA), ch. 373, §2723, 58 Stat. 682 (codified as amended at 42 U.S.C.A. §300gg-22 (West 1996)).

35. Public Health Service Act (PHSA), ch.373, §2714, 58 Stat. 682 (codified as amended at 42 U.S.C.A. §300gg-14 (West 2010)).

36. *Id.* §2713, 58 Stat. (codified as amended at 42 U.S.C.A. §300gg-13 (West 2010)).

37. *Id.* §2707, 58 Stat. (codified as amended at 42 U.S.C.A. §300gg-6 (West 2010)).

38. *Id.* §2791(e)(4), 58 Stat. (codified as amended at 42 U.S.C.A. §300gg-91(e)(1) (West 2010)).

39. *Id.* §2701, 58 Stat. (codified as amended at 42 U.S.C.A. §300gg (West 2010)).

40. *Id.* §2702, 58 Stat. (codified as amended at 42 U.S.C.A. §300gg-1 (West 2010)).

41. *Id.* §2791(e)(6), 58 Stat. (codified as amended at 42 U.S.C.A. §300gg-91 (West 2010)).

42. A. 8514, 234th Sess. (N.Y. 2011).

43. Two of those fees, the Patient-Centered Outcome Research Institute Fee (PCORI) and the fee to establish a re-insurance program for the individual market, apply to both self-insured and insured plans. The PCORI fee, equal to $2.00 times the number of covered lives under the plan, would fund the research of the Patient-Centered Outcome Research Institute to enhance the quality of care. I.R.C. §4376 (2010). The re-insurance payment, operating 2014 through 2016, is a program to shift some of the risk of covering high expenses from the primary insurer to a re-insurer. This latter fee is $5.25 per covered life per month for 2014. PPACA §1341.

44. Patient Protection and Affordable Care Act, PUB. L. NO. 111-148, §§9010, 10905, 124 Stat. 119 (2010).

45. Draft HCRAWG State Rate Review Subgroup Discussion Paper on Inclusion of ACA Fees in 2013 Premium Rates, National Association of Insurance Commissioners, http://www.naic.org/documents/committees_b_ha_tf_related_docs_aca_fees.pdf.

46. Deborah J. Chollet, *Self-Insurance and Stop Loss For Small Employers*, MATHEMATICA POL'Y RES., 2012, at 1, 8, *available at* http://www.naic.org/documents/committees_b_erisa_120626_chollet_self_insurance.pdf.

47. *Id.*

48. *See* Pear, *supra* note 3; *see also* Weaver & Mathews, *supra* note 3.

49. N.Y. INS. LAW §3231(h)(1) (McKinney 2013).

50. HEALTH MGMT. ASSOC., NEW YORK INSURANCE MARKETS AND THE AFFORDABLE CARE ACT 10 (2012), *available at* http://healthbenefitexchange.ny.gov/sites/default/files/Insurance%20Markets%20Study.pdf.

51. *See* N.Y. COUNTY LAW §350 (McKinney 2013); *see also* N.Y. TOWN LAW §100 (McKinney 2013).

52. Kevin M. Bronner, The Budget Crisis Associated with State and Local Government Employee Health Care Costs, 6 ALB. GOV'T. L. REV. 83, 92 (2012).

53. *Id.* at 92.

54. *Id.* at 93.

55. *See* Hatfield and Sherman, *supra* note 9, at 12.

56. *See, e.g.*, Authority to Supersede Village Budget Procedures, Op. State Comp. No. 2007-4 (Mar. 20, 2007), *available at* http://osc.state.ny.us/legal/2007/op2007.4.htm.; *see also,* N.Y. COUNTY LAW §355(1)(g) (McKinney 2013).

57. OFFICE OF THE STATE COMPTROLLER: DIV. OF LOCAL GOV'T & SCH. ACCOUNTABILITY, Understanding the Budget Process, at 13 (2008), *available at* www.osc.state.ny.us\localgov\pubs\lgmg\budgetprocess.pdf.

58. Reserve Fund for Health Insurance, Op. State Comp. 2004-8 (Oct. 12, 2004), *available at* http://osc.state.ny.us/legal/2004/op2004-8.htm.

59. N.Y. COUNTY LAW §355 (1)(g) (McKinney 2013).

60. N.Y. REAL PROP. TAX LAW §1318 (1) (McKinney 2007).

61. OFFICE OF THE STATE COMPTROLLER: DIV. OF LOCAL GOV'T & SCH. ACCOUNTABILITY, *supra* note 56, at 13; N.Y. COUNTY LAW §355 (1)(g) (McKinney 2013); N.Y. VILLAGE LAW §5-506 (1)(c) (McKinney 2000); N.Y. TOWN LAW §107 (1)(McKinney 2000).

62. *See* Local Government and School Accountability, Office of the State Comptroller, Actuarial Valuation and Services, www.osc.state.ny.us\localgov\pubs\oped45faqs.htm as visited on August 29, 2013. Unfortunately, municipalities are also faced with the requirements of General Accounting Standards Board (GASB) 45, which requires them to report on their financial statements the annual required contribution to fund retiree health benefits. *Id.*

63. N.Y. GEN. MUN. LAW §92-a (6)(c) (McKinney 2011).

64. N.Y. INS. LAW §4704(a) (McKinney 2009).

65. *Id.*

66. *Id.*

67. N.Y. INS. LAW §4706(a)(1) (McKinney 1994).

68. See N.Y. DEP'T FIN. SERV.,REPORT ON MUNICIPAL COOPERATIVE HEALTH BENEFIT PLANS: IMPACT OF CLAIM RESERVE REQUIREMENTS UNDER SECTION 4706 OF THE INSURANCE LAW (Dec. 9, 2011), *available at* http://www.dfs.ny.gov/reportpub/muni-coop-resv.pdf.

69. *Id.* at 6.

70. Local 456 Intern. Broth. of Teamsters v. Town of Cortland, 327 N.Y.S.2d 143, 146 (1971).

71. Op. State Comp. No. 1980-281 (N.Y. 1980).

72. N.Y. INS. LAW §4402(a) (McKinney 2012).

73. Labor Management Relations Act, 29 U.S.C.A. §186(b) (West 2013).

74. Gotbaum v. Lewis, 68 N.Y.2d 686, 689 (1986).

75. N.Y. INS. LAW §4408 (McKinney 2013).

76. N.Y. DEP'T FIN. SERV., ANN. REP, at 59 (2012), *available* http://www.dfs.ny.gov/reportpub/annual/dfs_annualrpt_2012.pdf; as visited September 2, 2013.

77. N.Y. DEP'T FIN. SERV., Multiple Employer Welfare Arrangement, Evasion of Community Rating Requirement, Op. O.G.C. No. 02-09-21 (2002), *available at* http://www.dfs.ny.gov/insurance/ogco2002/rg020921.htm.

78. 29 C.F.R. §2510.3-40(b)(2) (2013).

Mark L. Stulmaker is a senior partner in the Buffalo, New York law firm Lipsitz Green Scime Cambria LLP where he counsels employee benefit plans in the public and private sector. He is a graduate of Rensselaer Polytechnic Institute, Albany Law School, and the Graduate Tax Program of New York University School of Law.