Report to Congress

Annual Report on Self-Insured Group Health Plans

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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, as amended) requires the Secretary of Labor to provide Congress with an annual 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 Department estimates that 12,000 health plans filing a Form 5500 for 2008 were self-insured and 5,000 mixed self-insurance with insurance ("mixed-insured"). These plans respectively covered 22 million and 25 million participants and held assets totaling $35 billion and $84 billion, the Department estimates. The table below summarizes aggregate statistics describing these plans.

Health Plans Filing Form 5500 for 2008

	Self-Insured Plans	Mixed-Insured Plans
All Plans	12,000	5,000
Participants	22 million	25 million
Active Participants	20 million	20 million
Large plans where sponsor pays benefits directly	9,000	3,000
Participants	11 million	10 million
Active Participants	11 million	9 million
Plans holding assets in trust	4,000	3,000
Participants	11 million	15 million
Active Participants	9 million	11 million
Assets	$35 billion	$84 billion
Contributions	$35 billion	$93 billion
Benefits	$32 billion	$94 billion

SOURCE: 2008 Form 5500 filings. Totals may not equal the sum of the components due to rounding.

Sponsors of self-insured plans generally bear the risk associated with paying their plans' covered health expenses. In contrast, sponsors of fully-insured plans generally pay premiums to insurers and transfer all such risk to them. Some sponsors retain the risk 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 play by somewhat different rules. State laws that govern group health insurance generally do not apply to self-insured 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 cover 100 or more participants or hold assets in trust. This report presents data on such plans for 2008, the latest year for which complete data are available. Smaller private-sector plans that do not hold assets and plans covering government employees are not required to file a Form 5500. 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. Therefore, 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.

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. 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 mix self-insurance with insurance, and among those sponsoring fully-insured plans.

Introduction

Section 1253 of the Patient Protection and Affordable Care Act (the "Affordable Care Act") (P. L. 111-148, as amended) 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.

Sponsors of self-insured plans generally bear the risk associated with paying their plans' covered health expenses. In contrast, sponsors of fully-insured plans generally pay premiums to insurers and transfer all such risk to them. Some sponsors retain the risk 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. 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 discusses certain key, qualitative differences between self-insured plans, fully-insured plans, and plans that combine self-insurance with insurance. Section IV explains how the Form 5500 reporting requirements affect the scope of the data presented in this report. Section V concludes.

Along with this report, the Department of Labor (the "Department") is submitting two detailed appendices produced under contract. Appendix A provides detailed statistics describing group health plans that file a Form 5500.[1] Appendix B presents a study that surveys the academic literature on self-insured health plans, explores statistical issues associated with Form 5500 data, and analyzes available financial data for the employers that sponsor group health plans filing the Form 5500.[2]

[1] This work was conducted for the Department by the Actuarial Research Corporation under contract number DOLB109330994.

[2] This work was conducted for the Department by Deloitte Financial Advisory Services LLP under contract number DOLB109330993.

Section I. Required Form 5500 Self-Insured and Mixed-Insured Group Health Plans Data

Section 1253 of the Affordable Care Act 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 this requirement should be interpreted with care for several reasons:[3]

- The Department has information for these data items only for those plans that are required to file a Form 5500. Generally, health benefit plans covering private-sector employees must file a Form 5500 only if they cover 100 or more participants or hold assets in trust. Smaller private-sector plans that do not hold assets and plans covering government employees 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 plans are required to file financial information with respect to assets they hold in trust.[4] 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.

- 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 makes it difficult to distinguish how the different benefits are financed and if the plan is self-insured or fully-insured. As a result, the estimates presented here are subject to substantial uncertainty. The Department's method for estimating whether health plans are self-insured, fully-insured, or mixed-insured based on the Form 5500 data is explained at the end of Section IV of this report.

[3] See Section IV for a more detailed summary of Form 5500 health plan filing requirements.
[4] Some welfare plans may invest plan assets in insurance investment contracts, either directly or through a trust. Such welfare plans would be required to include information on the insurance investment contract on the Schedule H or Schedule I filed with the plan's Form 5500.

The remainder of this section summarizes the Form 5500 data specified by Section 1253 of the Affordable Care Act. A detailed analysis of group health plans that filed a 2008 Form 5500 Return/Report is presented in Appendix A, Group Health Plans Report: Abstract of 2008 Form 5500 Annual Reports, and in Appendix B, *Self-Insured Health Benefit Plans*.

Form 5500 Group Health Plans Summary Information, 2008

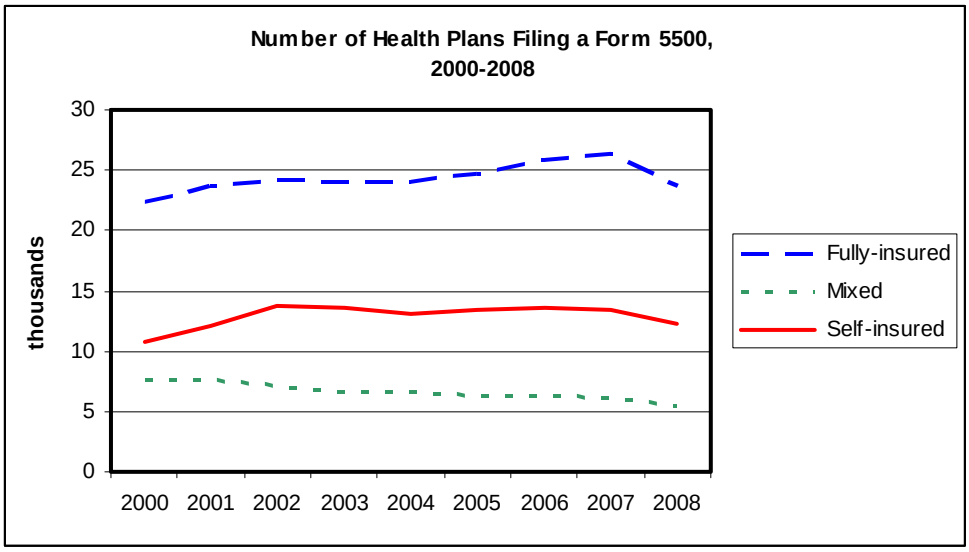
	All Plans	Self-Insured Plans	Mixed-Insured Plans	Fully-Insured Plans
All Plans	42,000	12,000	5,000	24,000
Participants	65 million	22 million	25 million	18 million
Active Participants	56 million	20 million	20 million	16 million
Large plans where sponsor pays benefits directly	34,000	9,000	3,000	23,000
Participants	37 million	11 million	10 million	16 million
Active Participants	35 million	11 million	9 million	15 million
Plans holding assets in trust	7,000	4,000	3,000	1,000
Participants	28 million	11 million	15 million	2 million
Active Participants	21 million	9 million	11 million	2 million
Assets	$125 billion	$35 billion	$84 billion	$7 billion
Contributions	$137 billion	$35 billion	$93 billion	$9 billion
Benefits	$135 billion	$32 billion	$94 billion	$9 billion

SOURCE: 2008 Form 5500 filings. Totals may not equal the sum of the components due to rounding.

Plan Type (single-employer plans versus multi-employer plans)

- Approximately 11,000 of the self-insured group health plans filing a 2008 Form 5500 were sponsored by a single employer; approximately 1,000 plans were multiemployer plans. Approximately 5,000 of the mixed-insured group health plans filing a 2008 Form 5500 were sponsored by a single employer; approximately 1,000 plans were multiemployer plans. See Appendix A Table A2.

- On average, 44,000 group health plans filed a Form 5500 in the years 2000-2008. The fraction of group health plans that are self-insured or mixed-insured has declined slightly from 45 percent in 2000 to 43 percent in 2008. See Appendix B Table 2 and Table 7.

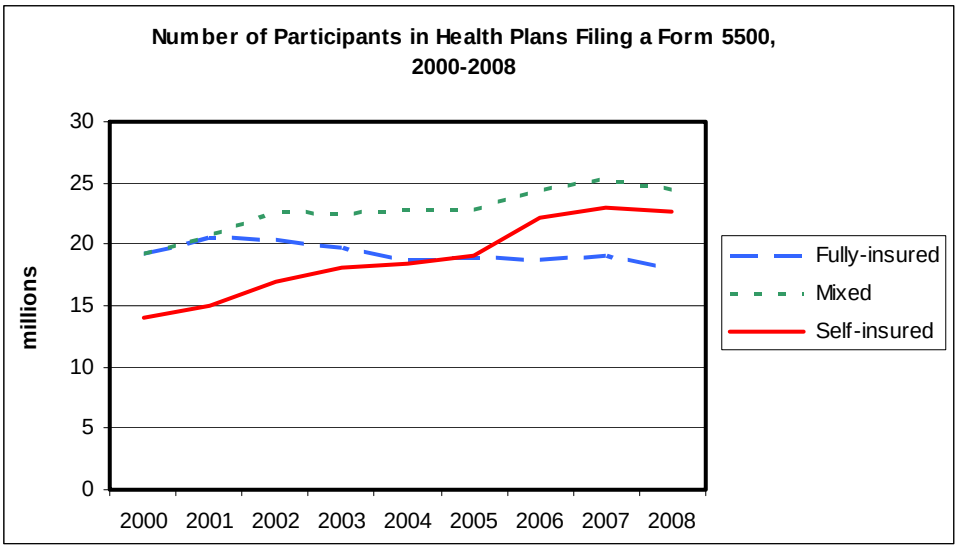


Number of Participants

- Overall, the 12,000 self-insured group health plans filing a 2008 Form 5500 covered approximately 22 million participants, 20 million of whom were active participants. The 5,000 mixed-insured group health plans filing a 2008 Form 5500 covered approximately 25 million participants, 20 million of whom were active participants. See Appendix A Table A2 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 57 percent of plans are fully-insured, only 28 percent of participants are covered by these plans. See Appendix B Table 6.

- On average, 44,000 group health plans, covering an average of 61 million participants, filed a Form 5500 in the years 2000-2008. Although, the fraction of group health plans that are self-insured or mixed-insured has declined slightly from 2000 to 2008, the number of plan participants covered by self-insured or mixed-insured plans has increased over this period. See Appendix B Table 2 and Table 7.



Benefits Offered

- Of the self-insured group health plans, approximately 4,000 offered only health benefits and approximately 8,000 offered other benefits in addition to health benefits.[5] Of the mixed-insured group health plans, approximately 600 offered only health benefits and approximately 5,000 offered other benefits in addition to health benefits. See Appendix A Table A1.

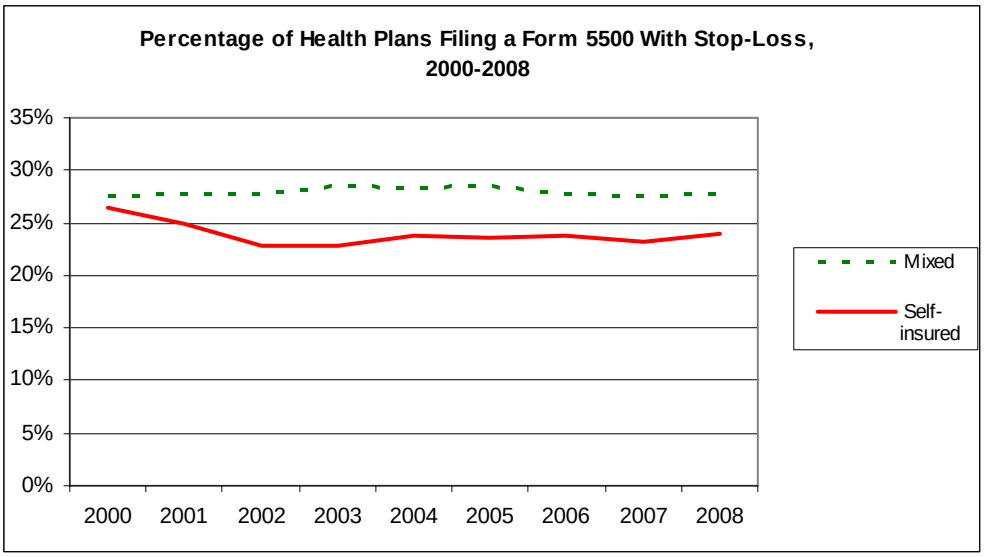
Funding and Benefit Arrangements

- With respect to funding arrangements, of the 12,000 self-insured group health plans that filed, slightly more than 2,000 indicated a funding arrangement of a trust only, approximately 4,600 indicated a funding arrangement of general assets of the sponsor only, and nearly 4,400 indicated a funding arrangement of general assets of the sponsor combined with insurance. The remaining 1,200 filers indicated some other combination of funding arrangements or did not report any arrangement. Of the 5,000 mixed-insured group health plans, nearly 1,400 indicated a funding arrangement of insurance only, more than 600 indicated a funding arrangement of a trust only, about 1,200 indicated a funding arrangement of trust with insurance, and more than 1,800 indicated a funding arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated some other combination of funding arrangements or did not report any arrangement. See Appendix A Table A7.

[5] 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 dental plan for which a separate Form 5500 filing exists. This report does not include information on welfare plans that do not include health benefits.

- With respect to benefit arrangements, of the 12,000 self-insured group health plans that filed, about 1,600 indicated a benefit arrangement of a trust only, more than 1,300 indicated a benefit arrangement of trust with insurance, more than 4,500 indicated a benefit arrangement of general assets of the sponsor only, and more than 4,400 indicated a benefit arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated some other combination of benefit arrangements or did not report any arrangement. Of the 5,000 mixed-insured group health plans that filed, nearly 1,500 indicated a benefit arrangement of insurance only, more than 1,700 indicated a benefit arrangement of trust with insurance, and less than 1,900 indicated a benefit arrangement of general assets of the sponsor combined with insurance. The remaining filers indicated some other combination of benefit arrangements or did not report any arrangement. See Appendix A Table A7.

- Self-insured plans can purchase stop-loss insurance to mitigate the risk of unexpectedly large medical claims. Between 2000 and 2008, the percentage of group health plans filing a Form 5500 that reported having stop-loss insurance[6] has remained in the range of approximately 23 percent to 27 percent for self-insured plans and approximately 28 percent to 29 percent for mixed-insured plans. Smaller plans are more likely to report stop-loss insurance than larger plans. See Appendix B Table 11.



[6] 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.

Plan Assets and Liabilities of Plans That Financed Benefits via Trusts

- Self-insured group health plans that financed benefits via trusts reported approximately $35 billion in assets and $7 billion in liabilities. Mixed-insured group health plans that financed benefits via trusts reported approximately $84 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 $35 billion in contributions and paid approximately $32 billion in benefit payments: $26 billion of these benefit payments were paid directly to participants or beneficiaries, $4 billion to insurance carriers for the provision of benefits and $2 billion to others. Mixed-insured group health plans that financed benefits via a trust received approximately $93 billion in contributions and paid approximately $94 billion in benefit payments: $66 billion of these benefit payments were paid directly to participants or beneficiaries, $25 billion to insurance carriers for the provision of benefits, and $3 billion to others. See Appendix A Table A4 and Table A5.

- Self-insured group health plans that financed benefits via a trust also reported paying approximately $2 billion in administrative expenses, with approximately $400 million reported as professional fees, less than $1 billion reported as administrator fees, $80 million as investment advisory and management fees, and $1 billion as other administrative expenses. Mixed-insured group health plans reported paying approximately $5 billion in administrative expenses, with approximately $700 million reported as professional fees, $3 billion as contract administrator fees, $170 million as investment advisory and management fees, and more than $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 33 percent of assets in cash and U.S. Government Securities, 18 percent in direct filing entities ("DFEs"),[7] 17 percent in mutual fund companies (registered investment companies), 10 percent in debt instruments, and 8 percent in stock. Mixed-insured group health plans covering 100 or more participants that financed benefits via a trust held 17 percent in cash and U.S. Government Securities, 35 percent in DFEs, 10 percent in mutual fund companies (registered investment companies), 7 percent in debt instruments, and 12 percent in stock. See Appendix A Table A6.

[7] 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.

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

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 financial data available for a select group of companies with publicly-traded equity or debt. Analysis of financial measures including revenue, market capitalization, net income, and number of employees show that companies offering self-insured or mixed-insured health plans tend to be bigger than companies offering fully-insured health plans.[8]

As discussed in Section III below, employers who self-insure group health plans face considerable financial risk. It is therefore relevant to consider the financial position of employers that self-insure health benefits. The financial position of a select group of such employers was examined by matching the Form 5500 filers with Capital IQ financial data.[9]

Slightly more than 5,000 Form 5500 filers were matched to the Capital IQ data. Most of the matched plans covered a large number of participants: almost 85 percent of the participants in matched plans were covered through a plan with 5,000 or more participants.[10] There were approximately 1,700 employers matched to a self-insured health plan filing a Form 5500 in 2008. The employers sponsoring these matched self-insured health plans reported a median employee count of approximately 4,000, median revenue of approximately $1.4 billion, a median market capitalization of approximately $1 billion, and a median net income of approximately $32 million.[11] Approximately 1,000 employers matched to a mixed-insured plan filing a Form 5500 in 2008. These mixed-insured matched health plans are sponsored by employees reporting a median employee count of approximately 8,000, median revenue of approximately $2.7 billion, a median market capitalization of approximately $1.7 billion, and a median net income of approximately $66 million. The financial health of these matched companies was measured using three financial metrics.[12] Overall the results are mixed. At the median, fully-insured firms have about as much cash flow relative to total debt as other firms, but lower operating income relative to debt than mixed-funded or self-insured firms. The distributions of financial metrics are somewhat more dispersed for fully-insured firms than for other firms: the 25th percentiles are lower and the 75th percentiles are higher.

[8] See Appendix B Table 12 for the distribution of the measures for each of the three categories of plans.
[9] Appendix B outlines this analysis. This work was also conducted for the Department by Deloitte Financial Advisory Services LLP. 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.
[10] See Appendix B Table 3.
[11] See Appendix B Table 12.
[12] See Appendix B Table 13.

Plans filing a Form 5500 can also be matched longitudinally to determine what changes the plan has undergone over time. Approximately 87 percent of the 2008 Form 5500 filings were matched with their accompanying 2007 filing.[13] Almost 39 percent of the longitudinally matched plans were estimated to be mixed-insured or self-insured in both 2007 and 2008 and about 54 percent of these plans were fully-insured in both 2007 and 2008.[14] Also in 2008, approximately 4 percent of the longitudinally matched plans had changed their estimated funding arrangement to become mixed-insured or self-insured plans and about 3 percent of the matched plans had become fully-insured. Over the years from 2001 to 2008, the percent of plans switching their estimated funding status reduced from about 10 percent to 7 percent.

Section III. What Is a Self-Insured Group Health Plan?

There is no single, bright line separating self-insured plans from fully-insured plans. Instead, plans can differ across a number of dimensions including who bears the risk, whether assets are set aside in a dedicated trust or drawn from the sponsor's general assets to finance the plan, and how administrative duties are allocated. These variables can affect what laws and regulations apply to the plan.

Who bears the risk?

Employers that provide health benefits for their employees fund those benefits in a variety of ways.[15] Sponsors of self-insured plans generally bear the risk associated with paying their plans' covered health expenses. In contrast, sponsors of fully-insured plans pay premiums to insurers and transfer all such risk to them. Some sponsors retain the risk 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 of the plan's aggregate health care claims exceeding their expectations.

To protect against unexpectedly high health expenses, both self-insured plans and employers sponsoring such plans sometimes purchase stop-loss insurance coverage. Stop-loss insurance policies generally do not guarantee specific benefits, but reimburse the plan or employer for their losses when health expenses exceed specified "attachment points." Attachment points may be specified with respect to the plan's aggregate health expenses for a given period or with respect to the amount of a particular expense.[16]

[13] See Appendix B Table 14.
[14] See Appendix B Table 15.
[15] Upon establishment of a welfare plan, the plan sponsor decides how the plan will be structured – including how the plan benefits will be paid.
[16] An employer may also purchase a "minimum premium" arrangement in which the employer pays a fraction of the fully-insured premium to cover non-claim expenses, such as administration and claims processing, and pays claims up to an agreed-upon limit, after which the insurance carrier is responsible.

Trust or Not?

A sponsor of a self-insured plan may pay health benefit expenses directly out of its general assets or may set aside funds in a dedicated plan trust, which will in turn pay such expenses. A sponsor of a fully-insured plan likewise may pay premiums directly from its general assets or via a dedicated plan trust. In general, plans with trusts have to file an annual Form 5500.

Who Administers the Plan?

Some self-insured plans are self-administered, but most rely on third party administrators (TPA) or insurers[17] to handle enrollment, pay claims, collect premiums, provide customer service, and perform other administrative duties.

What Laws Apply?

The applicability of various federal and state laws and regulations to health plans depends in part on whether a plan is self-insured or fully-insured. For example, the federal Employee Retirement Income Security Act of 1974 ("ERISA") generally preempts state laws that relate to employee benefit plans, but preserves most state laws that govern insurers and insurance products. Consequently, such state laws do not apply to self-insured plans themselves but do apply to group insurance policies that plans purchase. Likewise, some provisions of the Affordable Care Act that apply to group insurance do not apply to self-insured plans. Funding arrangements also affect what, if any, information plans are required to report to the federal government. A full discussion of the interaction between funding arrangements and the application of federal and state rules is beyond the scope of this report. However, the implications of funding arrangements for Form 5500 reporting requirements are germane to this report and therefore detailed below.

Section IV. Form 5500 Health Plan Filing Requirements

ERISA and the Internal Revenue Code of 1986, as amended, establish certain reporting and filing obligations for private-sector employee benefit plans. Plans generally are required to file an annual return/report concerning, among other things, the financial condition and operations of the plan.

Under a minimum premium arrangement, the insurance carrier usually is responsible for processing claims and administrative services. *See e.g.*, U.S. Department of Labor, Bureau of Labor Statistics, *Definitions of Health Insurance Terms*, at *http://www.bls.gov/ncs/ebs/sp/healthterms.pdf*. Last viewed February 24, 2011.

[17] Under such an arrangement, commonly referred to as an Administrative Services Only ("ASO") contract, the insurer provides only administrative services. It does not issue a group insurance policy and does not assume risk for the plans' health expenses.

In 1975, the Department, the Internal Revenue Service, and the Pension Benefit Guaranty Corporation (collectively, the "Agencies") jointly developed the Form 5500 Series to allow employers who sponsor an employee benefit plan for their employees to satisfy the annual reporting requirements under Title I and Title IV of ERISA and under the Internal Revenue Code. Filing the Form 5500 Return/Report together with any required Schedules and Attachments generally satisfies these annual reporting requirements.[18]

ERISA generally requires all covered employee benefit plans to file an annual report. Congress, however, gave the Secretary of Labor the power to exempt or provide simplified reporting requirements for welfare benefit plans (which include plans providing benefits such as medical, dental, life insurance, severance pay, disability, etc.). Under current reporting rules, a number of exemptions or limits on reporting apply to welfare plans, depending on plan size and funding method.

In general, group health plans covering private-sector employees are required to file a Form 5500 with the Department only if the plan covers 100 or more participants ("large" plans) or if they hold assets in a dedicated trust.[19] Plans covering fewer than 100 participants ("small" plans) that do not hold assets in a dedicated trust (but rather provide benefits directly out of the employer's general assets or via health insurance policy) are not required to file a Form 5500.

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[18] *See* ERISA Section 101 *et seq.*, 29 U.S.C. 1021 *et seq*. and accompanying regulations. The data used for this report were taken from the Form 5500 data for plan years 2008 and earlier. For plan years beginning on or after January 1, 2009, certain eligible small plans are able to file the Form 5500-SF "Short Form Annual Return/Report of Small Employee Benefit Plan."

[19] The following welfare plans are not required to file a Form 5500:

- 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 which 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.

Among plans that must file a Form 5500, the plan size and funding arrangements determine what must be included with the filing. Large plans funding benefits via insurance must report information on each insurance policy or contract on separate Schedules A "Insurance Information." Small plans that are required to file because they have a trust that also provide benefits through health insurance policies are required to file a Schedule A.[20] Large plans holding assets in a trust must report certain financial information on the Schedule H. Small plans holding assets in a trust report certain financial information on the Schedule I.

A major goal of ERISA and its reporting provisions is the protection of money set aside to fund employee benefits. This priority is reflected in the Form 5500's emphasis on collection of financial information regarding plans' dedicated trusts.

The Form 5500 is an important source of information on ERISA-covered, private-sector employer-sponsored benefit plans and their operation, funding, assets, and investments. The information provided on the Form 5500 serves several purposes. It is disclosed to plan participants and beneficiaries, and to the public. The Department and other federal agencies use the information to assess compliance with applicable law and to target enforcement efforts. They and others use the information to track market trends and conduct research. The Department has long employed Form 5500 data to produce annual statistics on ERISA-covered pension plans, published in the annual *Private Pension Plan Bulletin Abstract*.[21] In the past, the Department has not routinely produced similar statistics using the Form 5500 welfare benefit plan data.

The Form 5500 collects no information on a large majority of small health benefit plans, including a large but unknown number of small, self-insured plans. Most small ERISA-covered group health plans do not hold assets in a trust and therefore are not required to file a Form 5500. Although some of these plans are self-insured, a large majority are fully-insured. The Department estimates that in 2008 there were approximately 2.8 million ERISA-covered health plans covering approximately 150 million people.[22] In contrast, in 2008, approximately 42,000 health plans covering 65 million participants filed a Form 5500. Among health plans that filed a 2008 Form 5500, about 29,000 filed at least one Schedule A for a group insurance policy covering health benefits; more than 7,000 plans reported holding assets and filed a Schedule H or Schedule I.[23]

Health plans that do file Form 5500 report a substantial amount of information on any dedicated trusts they set up to pay health and other benefits and on any group health insurance policies they purchase. However, the Form 5500 does not collect financial information from self-insured plans that do not use trusts, and it is not always possible to determine which reported information is associated with health benefits. A single

[20] Small plans using the Form 5500-SF for 2009 and later include information about total fees and commissions paid with respect to the purchase of insurance, but do not file a Schedule A.
[21] U.S. Department of Labor, Employee Benefits Security Administration, *Private Pension Plan Bulletin Abstracts*, at *http://www.dol.gov/ebsa/publications/form5500dataresearch.html*.
[22] EBSA estimates using the Current Population Survey and the Medical Expenditure Panel Survey.
[23] See Appendix A Table A2 and Table B1.

welfare plan that provides health benefits in combination with other welfare benefits - such as dental, vision, disability, or life insurance benefits - may report on all of the benefits together in a single Form 5500 filing. As a result, it is not always clear what share of participants or which funding arrangements reported on the main Form 5500 are associated with health benefits and which are associated with other welfare benefits. Each plan holding assets files a single financial Schedule; thus, for plans providing multiple benefits through a trust it is not always clear which assets and financial flows are associated with which benefits. In contrast, because a plan files a separate Schedule A for each insurance policy or contract, it is usually possible to extract separately certain information for health benefits that are insured.

For purposes of this report, Form 5500 health plans are categorized as either being self-insured, fully-insured, or a mix of both self-insured and fully-insured ("mixed-insured").[24] The Department used information from the 2008 Form 5500 on plans' funding arrangements, insurance contracts, and financial holdings to categorize plans as follows:[25]

1. Self-insured. The plan does not include information on a health insurance policy or contract in any Schedule A filed as part of the Form 5500 and the filing either:
    a. indicates the plan is funded through a trust or general assets of the sponsor, or
    b. the filing includes a Schedule H or Schedule I.

2. Mixed-insured. The plan does not meet the requirements in (1) and
    a. the number of individuals covered under insurance contracts as reported on the Schedule A is less than half of the total number of participants as of the end of the plan year, or
    b. the filing's Schedule H indicates that benefits were paid directly to participants, or
    c. the plan attaches a Schedule I.

3. Fully-insured. The plan does not meet the criteria in (1) or (2).

[24] These categorizations are based on the Form 5500 data and are not to be taken as legal definitions of self-insured, fully-insured, or mixed-insured health plans.

[25] This categorization represents the Department's current best effort to accurately determine plans' funding arrangements for health benefits based on information contained in Form 5500 filings. Some plans that provide health benefits in combination with other benefits may be incorrectly categorized. For example, consider a small plan that provides both health and disability benefits that is funded via both insurance and a trust and that files both a Schedule A for a health insurance contract and a Schedule I. If the number of covered individuals reported on the Schedule A is more than half as large as the number of participants reported on the Form 5500, the plan will be categorized as mixed-insured. This categorization may be correct: the plan may carve out and insure a subset of the health benefits while self-insuring the remaining health benefits. On the other hand, this categorization may be incorrect: the plan may fund its health benefits exclusively via insurance and pay only disability benefits from the trust. Additional inaccuracies might arise where information provided in Form 5500 filings is itself inaccurate. These and other data interpretation issues are explored further in Appendix B.

Section V. Conclusion

This first Annual Report to Congress on Self-Insured Group Health Plans, 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.