



**Self-Insured Group Health Plans,
Stop-Loss Insurance and Adverse Selection**

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Introduction

In the course of considering changes to its Stop-Loss Model Act, the National Association of Insurance Commissioners (NAIC) has received formal comments containing substantive inaccuracies regarding self-insured group health plans, stop-loss insurance, and how smaller self-insured group health plans may contribute to adverse selection in the health insurance marketplace. Similar comments have been made by federal regulators responsible for implementing the Affordable Care Act (ACA).

This White Paper identifies and corrects several inaccurate comments in order to assist policy-makers at both the state and federal level to properly assess legislative/regulatory proposals related to self-insured group health plans.

Comment #1:

When small employers purchase self-insured packages from insurers, including stop-loss coverage with very low attachment points and administrative services, they are essentially purchasing conventional health insurance, except that it is free from state regulation.

Response:

Employers do not purchase “self-insured packages” from insurers, or from any other entity. Self-insurance is an alternative approach to finance the delivery of health benefits to group health plans participants. Once an employer determines that it intends to sponsor a self-insured group health plan based on a variety of considerations, it will normally contract with separate entities for administrative services and stop-loss insurance based on its specific needs.

When an employer purchases a conventional, fully-insured group health insurance policy, the financial risk and legal liability is transferred to the insurance carrier that issues the policy. By contrast, a self-insured employer that funds its own health plan retains all the risk and liability. The availability of stop-loss insurance does not mitigate the risk assumption of the employer when electing to self-insure.

Stop-loss insurance does not insure the patient or the benefit provided by a health plan; rather it is a product that insures the employer against expenditures in excess of defined limits or expectations. As such, it provides for a reimbursement mechanism as opposed to direct, first dollar coverage. Self-insured employers are responsible for paying all qualified claims before seeking reimbursements from stop-loss carriers, so they retain exclusive financial responsibility with regard to their plan participants. To further clarify this financial arrangement, stop-loss reimbursements are never made to individual plan participants, nor to their providers, so there is no direct linkage between an insurance company and plan participants.

In addition to being responsible for all financial liabilities, a self-insured employer also subjects itself to all legal and regulatory requirements under ERISA that would not necessarily apply if they chose to purchase conventional health insurance. While state mandates are not enforceable under ERISA plans, several studies have shown that there are no significant differences in what is covered by self-insured plans versus fully-insured plans.

Self-insurance does, however, allow an employer to provide a standardized set of benefits across state jurisdictions. Further, the avoidance of state mandates is largely overshadowed by the requirements of PPACA, which places minimum requirements on all plans – whether fully-insured or self-insured.

Most importantly, employers that sponsor self-insured group health plans must designate individual plan fiduciaries who are responsible for ensuring that the plan is being administered in the best interests of the employees (plan participants). Any breach in this fiduciary responsibility will subject these

individuals (normally company executives) to strict civil and/or criminal penalties as specified by Section 401 (c) (5) of the Employee Retirement Income Security Act (ERISA). A more detailed discussion of the legal/regulatory environment for self-insured group health plans is provided later in this statement.

Finally, despite unilateral statements to the contrary, existing legal precedent is clear that stop-loss attachment point levels cannot be used as a factor to conclude that a self-insured employer is actually fully-insured. A more detailed legal discussion of this topic is provided later in this statement.

Comment #2:

The regulatory problem of self-insurance exists primarily because of the availability of generous stop-loss coverage

Response:

Setting aside the puzzling observation that a regulatory problem inherently exists because self-insured employers can provide health benefits more cost effectively because they are able to utilize an alternative risk transfer mechanism (and when 27 states have already adopted minimum stop-loss thresholds), it is important to discuss the realities of the stop-loss insurance marketplace.

It is estimated that more than 90% of stop-loss insurance is issued by fewer than 10 carriers nationwide. The business model of these carriers incorporates an underwriting and administrative approach that assumes a low frequency of catastrophic claims. In this regard, they are simply not equipped to deal with a high volume of low dollar claims. Any concern that the marketplace is being flooded by overly “generous” stop-loss insurance policies reflects a lack of familiarity with stop-loss marketplace realities. Further, stop-loss carriers are very protective of their status as insurers of financial risk – not health risk.

Comment #3:

Self-insurance provides health benefit coverage primarily to healthy groups

Response:

There is no valid basis to support an assertion that ERISA-based, employer sponsored self-funded plans cover only healthy employees. In fact, federal laws prohibit plan sponsors—whether insured or self-funded—from selecting only the most favorable risks among individuals in their health plans. There is no evidence that shows that self-insured plans as a group have any different morbidity characteristics from fully-insured plans taken as a group. What has been proven is that administrative costs are significantly lower in self-insured plans. This does not indicate better risk but it does indicate a more efficient process for financing the cost of providing employee health benefits.

From a legal perspective, the ACA expressly bars plan coverage denials by insured and self-funded plans based on pre-existing conditions and prohibits discrimination based on health status, including such factors as claims experience, medical history, genetic data, evidence of insurability and disability. These strict prohibitions apply to self-insured plans as well as commercially insured plans. Additionally, these practices have been prohibited for both insured and self-insured group health plans for over 20 years since passage of HIPAA.

Reports issued by the U.S. Department of Labor and the U.S. Department of Health & Human Services earlier this year confirmed that self-insured group health plan membership, like insured plan membership, is comprised of a broad cross-section of participants with health risks that mirror workforce risks seen in larger populations within specific industries. Employers in industries more likely to self-fund include those in agriculture, mining, construction, manufacturing, transportation, utilities, and finance/insurance real estate, according to the report.

In other words, the population health characteristics of self-funded plans are generally no different than the health risks (low, medium and high risks) in a cross section of industries that cover their employee health benefits through conventional insurance. Thus, any assertion that self-funded plans currently enroll a more favorable selection of health risk is not supported by objective reports.

Finally, it is important to note that fully-insured employers with fewer than 100 employees do not normally have access to the health claim information of their workforce, so they don't even know how healthy their workforce is when considering a transition to become self-insured.

Comment #4:

ACA creates incentives for small employers to self-insure which results in a potential for adverse selection in connection with the proposed state-operated Health Insurance Exchanges (HIEs).

Response:

In this current economic environment, it can be expected that employers of all sizes faced with spiraling health costs will continue to examine the self-funded option in the post-ACA world as a way to provide more cost-efficient health benefits to employees and their families. According to the Kaiser Family Foundation, the recent trend of small employers (3-199 workers) moving to self-insurance started in the early 1990s and accelerated slightly in the decade, rising from 13% in 1999 to 15% in 2009. This increase, which has continued in the early post-ACA years, is fueled primarily by the ever escalating health cost push and the understandable search by plan sponsors for a more cost-effective alternative to commercial health insurance. Again, it is the efficiencies inherent in providing employee benefits outlined above that draw employers to self-insure – not a difference in the morbidities among fully-insured versus self-insured employee benefit plans.

Looking ahead to 2014 when the HIEs are implemented, small employers (up to as many 100 employees) that decide to continue their plans are likely to choose the funding method that does the most to lower costs and improve employee health care quality. Some insurers have announced they will not participate in the HIEs but will offer their products only outside HIEs. Under ACA, some employers not going into the HIEs can be expected to continue funding health benefits through insured arrangements. Other employers remaining outside HIEs may opt to continue offering self-funded plans. In other words, many small employers are likely to continue self-funding not necessarily because of new ACA incentives but due to greater cost effectiveness and flexibility offered under ERISA to tailor plans to specific workforce needs.

It is generally recognized that adverse risk selection occurs when large numbers of individuals with unhealthy risk profiles elect to move into insurance pools. The risk profile of participants in self-funded plans generally mirrors the profile of participants in insured plans. Thus, any assertion that employers who self fund under ACA will have a negative impact on HIEs starting in 2014 is highly speculative and inconsistent with 25 years of empirical experience under ERISA.

Comment #5:

Self-insured plans are subject to fewer regulatory requirements

Response:

Since self-funded plans are not in the business of insurance, they are not subject to a vast array of varying and often conflicting state insurance laws and mandates as well as taxes applicable to insurers. Instead, self-funded plans are regulated under the ERISA federal structure which provides greater regulatory uniformity, particularly for multi-state employers that provide coverage across state lines.

While not subject to state insurance regulation, self-funded plans are subject to a whole host of federal laws including, among others, the Affordable Care Act (ACA), the Employee Retirement Income Security Act (ERISA), the Health Insurance Portability and Accountability Act (HIPAA), and the Consolidated Omnibus Budget Reconciliation Act (COBRA).

With few exceptions, under the ACA self-insured group plans are subject to the same federal mandates and requirements as insured plans. For example, ACA prohibits coverage denial based on pre-existing conditions, extends dependent coverage to child dependents under age 26, eliminates lifetime and annual caps and requires first dollar coverage for preventive services. In light of their operation as non-profit entities, the ACA exempts self-insurance from Medical Loss Ratio rules and rating restrictions—provisions that apply exclusively to insurers.

In spite of the differing federal-state regulatory structures, in most cases, participants in self-funded plans receive either comparable or a wider array of covered benefits compared to participants in commercial plans. Studies show little difference in plan generosity when comparing self-funded and insured plans of the same size. Rand researchers found that self-funded plans offered by small and medium-sized firms covered approximately the same proportion of expenses as conventionally insured plans. The study also found no evidence of systematically higher or lower out-of-pocket employee payments in self-funded plans compared with insured plans.

Comment #6:

Federal court cases interpreting ERISA have held that self-insured plans do not lose their self-insured status simply because the plans have stop-loss coverage. Moreover, a federal court in Maryland has held that a state may not attempt to regulate the coverage of self-insured plans by regulating stop-loss insurance. On the other hand, stop-loss coverage is insurance, and states may regulate stop-loss coverage just as they do any other form of insurance as long as they do not try to impose requirements on self-insured plans by doing so.

Response:

This conclusion misinterprets ERISA preemption relative to state regulation of insurance. While the ERISA “savings clause” retains state authority over insurance, the “business of insurance” typically refers to state licensing, plan solvency, marketing, consumer grievances and the taxing of insurance premiums. However, with respect to self-insured group health plans, state-mandated minimum attachment points impact ERISA plan risk transfer arrangement points therefore affecting plan administration details. Thus, consistent with current legal precedent attachment point regulation “relate to” to ERISA covered plans and is not “saved” from federal preemption.

It is acknowledged that following the adoption of the original NAIC Model Stop-Loss Model Act more than 15 years ago 27 states have passed laws establishing minimum attachment points, purportedly within the context of regulating “the business of insurance.” While these laws are clearly subject to an ERISA preemption challenge, such legal action has simply not been initiated. The addendum that

follows provides a detailed discussion of case law supporting the legal assertions contained in this white paper.

Conclusion

On behalf of the thousands of self-insured employers throughout the country who rely on the ability to access stop-loss insurance appropriate for the level of their risk tolerance to provide affordable health benefits for their employees, the Self-Insurance Institute of America, Inc. (SIIA) requests that the NAIC rejects any proposal that would further regulate stop-loss insurance. We would also oppose any efforts at the federal level to restrict the ability of employers to self-insure based on stop-loss insurance arrangements. As supported by the objective information provided herein, such legislative/regulatory proposals are unnecessary, represent bad public policy and conflict with existing legal precedent.

About SIIA

The Self-Insurance Institute of America, Inc. (SIIA) is a non-profit trade association that represents the business interest of companies involved in the self-insurance/alternative risk transfer marketplace. Additional information about the association can be accessed on-line at www.siaa.org, or by calling 800/851-7789.

Stop-Loss Case Law Discussion Addendum Follows This Page

ADDENDUM

The following provides a summary of relevant case law supporting SIIA's position that self-insured group health plans cannot be defined as insured plans regardless of stop-loss insurance arrangements

and that state regulation of stop-loss insurance attachment points is preempted by the Employee Retirement Income Security Act (ERISA).

*In the Wisconsin case of *Ramsey County Medical Center, Inc., Ramsey County Medical Center, Inc. v. Hartzell Corp. Emp. Trust Fund*, 189 Wis.2d 269, 523 N.W.2d 321 (Ct. App. 1994), the issue was whether or not this was an ERISA-qualified Plan so as to preempt the Wisconsin “made whole doctrine.” The trial court concluded that ERISA did not preempt the application of Wisconsin law because Hartzell’s purchase of stop-loss insurance rendered the Hartzell Plan to be “insured.” The trial court therefore concluded that under Wisconsin subrogation law, the Hartzell Plan was not entitled to subrogation until the beneficiary had been made whole. On appeal, the Court of Appeals indicated that sole issue in the case was whether or not the purchase of stop-loss insurance rendered the Plan an “insured Plan” subject to state law. The stop-loss policy, they held, was not health insurance as it did not pay benefits directly to the participants. Rather, the policy was designed to protect Hartzell (“the Plan sponsor”) from catastrophic losses. The policy did not cover participants of the Plan, but instead covered the Plan itself. Therefore, they concluded that the stop-loss insurance did not alter the uninsured status of the Hartzell Plan, and that ERISA preempts the application of the made whole doctrine in Wisconsin as to this Plan.

The Third Circuit also addressed the issue of whether a self-funded Plan becomes an “insured Plan” by the purchasing of stop-loss insurance; *Bill Gray Enter., Inc. Emp. Health & Welfare Plan v. Gourley*, 248 F.3d 206 (3rd Cir. 2001). The court differentiated between a self-funded Plan that purchased stop-loss insurance and a fully-insured Plan by noting, “When an ERISA Plan purchases stop-loss insurance, it retains liability to Plan participants for the full extent of their injuries. By purchasing stop-loss insurance, the Plan does not delegate its physical liabilities...to the insurance company.” The court noted that in the event of insolvency, a self-funded Plan could not rely upon the assets of an insurance company to cover Plan participants. Therefore, following other circuit courts, the court held that a self-funded Plan that purchases stop-loss insurance does not become an insured plan for purposes of ERISA.

In the Fourth Circuit, one court explained how stop-loss insurance provides protection to a self-funded Plan but does not elevate the Plan from funding all of the benefits promised:

“Under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan’s terms. That liability remains the employer’s even if it has purchased stop-loss insurance and even if the stop-loss insurer becomes insolvent. Conversely, if the employer becomes insolvent, the solvency of the stop-loss insurer may not benefit Plan participants and beneficiaries. This is because their claims against the insurer would be derivative of the Plan’s claim against the insurer, which arises only after the Plan actually makes benefit payments beyond the agreed attachment point. In contrast, when a Plan buys health insurance for participants and beneficiaries, the Plan participants and beneficiaries have a legal claim directly against the insurance company, thereby securing the benefit even in the event of the Plan’s insolvency. Participants and beneficiaries in self-funded plans may not have the security of the insurance company assets because stop-loss insurance insures the plan and not the participants.” *American Medical Security, Inc. v. Bartlett*, 111 F.3d 358 (4th Cir. 1997).

In the case of *Dewitt v. Proctor Hosp.*, 517 F.3d 944 (C.A.7 (Ill.) (February 27, 2008), Dewitt and her husband, Anthony, were covered under Proctor’s health insurance plan. Throughout Dewitt’s tenure at Proctor, Anthony suffered from prostate cancer and received expensive medical care. His covered medical expenses were paid by Proctor, which was self-insured. It paid for members’ covered medical

costs up to AND BEYOND \$250,000 per year. Anything above the “stop-loss” figure of \$250K, however, was covered by a policy issued by the Standard Security Life Insurance Company of New York. The Plan was forced to file a claim with their stop-loss carrier after it had paid all claims. The court stated, “ERISA knows nothing of ‘partially’ insured or self-funded plans,” and determined that the Plan was self-funded as far as the relationship between it and the insured employee was concerned.

The Fourth Circuit has explained the matter well on several other occasions. See: *Georgetown University Hosp. v. Reliance Standard Life Ins. Co.*, 175 F.3d 1014 (1999). In *American Medical Security Inc. v. Bartlett*, 111 F.3d 358, 360(4th Cir.1997), the court held that “under a self-funded plan, the employer who promises the benefit incurs the liability defined by the plan’s terms. That liability remains the employer’s even if it has purchased stop-loss insurance and even if the stop-loss insurer becomes insolvent.” Participants and beneficiaries in self-funded plans may not have the security of the insurance company’s assets because stop-loss insurance insures the plan and not the participants. *Id.*

“Stop-loss insurance does not convert a self-funded employee benefit plan into an insured plan. Even with the stop-loss coverage, the Plan is directly liable to the employees for any amount of benefits owed to them under the Plan’s provisions. The purpose of the stop-loss insurance is to protect the Plan from catastrophic losses, it is not accident and health insurance for employees.” *Id.*

The Ninth Circuit’s decision in *United Food & Commercial Workers & Employers Arizona Health & Welfare Trust v. Pacyga*, 801 F.2d 1157, 1161-62 (9th Cir.1986), supports this conclusion. The Ninth Circuit held that the stop-loss insurance provision in an ERISA plan did not render that plan insured for preemption purposes:

“The stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the Plan at the point when the aggregate amount is reached. Thus, no insurance is provided to the participants, and the Plan should properly be termed a non-insured plan, protected by the deemer clause....” 801 F.2d at 1161-62.

See also *Brown v. Granatelli*, 897 F.2d 1351, 1354-55 (5th Cir.1990) (state law does not regulate employer’s self-insured plan with stop-loss coverage; distinguishes between stop-loss insurance and primary coverage on basis that stop-loss only covers plan itself and plan is still liable to employees; does not reach ERISA preemption issue); *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922, 927 (9th Cir.1986) (holds that stop-loss insurance does not make self-funded ERISA plan insured plan under “saving clause” and “deemer clause;” ERISA therefore preempts state law).

The Ninth Circuit held that a self-funded employee benefit Plan does not lose its self-funded status merely by obtaining stop-loss insurance. It reasoned that because the stop-loss carrier does not pay benefits directly to participants, does not take over administration of the Plan at the point where the aggregate amount is reached, and no insurance is provided to the participants, such a Plan should be described as a “non-insured” Plan, and should be protected by the deemer clause and in this case, the Arizona anti-subrogation law. *United Food & Commercial Workers & Emp. Ariz. Health & Welfare Trust v. Pacyga*, 801 F.2d 1157 (9th Cir. 1986).

The stop-loss insurance does not pay benefits directly to participants, nor does the insurance company take over administration of the Plan at the point when the aggregate amount is reached. Thus, no insurance is provided to the participants, and the Plan should properly be termed a non-insured plan,

protected by the deemer clause... *Harvey v. Machigonne Benefits Administrators*, 122 F.Supp.2d 179 (D.Me. 2000).

This follows in line with a large number of other federal cases which hold that simply maintaining stop-loss insurance coverage and engaging a third party administrator to subrogate, does not transform a self-funded employee benefit Plan into an insured Plan for purposes of the ERISA preemption clause. *Thompson v. Talquin Bldg. Products Co.*, supra.; *Drexelbrook Eng'g. Co. v. Travel's Ins. Co.*, 710 F. Supp. 590 (E.D. Pa.) aff'd, 891 F.2d 280 (3rd Cir. 1989); *Cuttle v. Fed. Emp. Metal Trades Council*, 623 F. Supp. 1154 (D. Me. 1985); *Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922, 927 (9th Cir. 1986); *Lincoln Mut. Cas. Co. v. Lectron Prod., Inc. Health Plan*, 970 F.2d 206, 210 (6th Cir. 1992); *Health & Welfare Plan for Employees of REM, Inc. v. Ridler*, 942 F. Supp.431 (D. Minn. 1996), aff'd, 124 F.3d 207 (8th Cir. 1997) (Table); *Bone v. Ass'n Mgmt. Services, Inc.* 632 F. Supp. 493 (S.D. Miss. 1992); *Ins. Bd. Of Bethlehem Steel v. Muir*, 819 F.2d 408 (3rd Cir. 1987); *Minn. Chamber of Commerce & Inducs. v. Hatch*, 672 F. Supp. 393 (D. Minn. 1998); *Hampton Indus., Inc. v. Sparrow*, 981 F.2d 726 (4th Cir. 1992); *G.R. Herberger's, Inc. v. Erickson*, 17 F. Supp22d 932, 935 (D. Minn. 1998).

In the Eight Circuit case of *United of Omaha v. Business Men's Assurance Company of America*, 104 F.3d 1034, (8th Cir. 1997) the Court examined a self-funded ERISA plan, and determined that it was entitled to preempt state law. "In preemption analysis, the court's task is to ascertain congressional intent. The Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1001 et seq., ensures that plans and sponsors are subject to a uniform body of laws. The goal is to minimize the administrative and financial burden of complying with conflicting directives among states and the federal government and to prevent the potential for conflict in substantive law, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction." *Id.*

By classifying a plan as insurance and thus regulated by state law, for acquiring stop-loss protection, the courts would have to impose state-by-state obligations upon the employer, contrary to the legislative intent.

"ERISA contains a preemption provision, declaring that it shall supersede state laws insofar as they relate to employee benefit plans. 29 U.S.C.S. § 1144(a). The court construes this language broadly, finding that a state law relates to employee benefit plans if it refers to or has a connection with covered benefit plans, even if the law is not specifically designed to affect such plans, or the effect is only indirect, and even if the law is consistent with ERISA's substantive requirement." *Id.*

"If a state law falls within the scope of the preemption clause of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S. § 1144(a), it may nonetheless be excepted under what has become known as the "savings clause." 29 U.S.C.S. § 1144(b)(2)(A). The savings clause excepts from preemption certain categories of state law, including state law that regulates insurance. A state law "regulates insurance" if (1) it is directed specifically toward the insurance industry and (2) it applies to the "business of insurance" within the meaning of the McCarran-Ferguson Act, 15 U.S.C.S. §§ 1011-1015, which gives the states the authority to regulate the business of insurance.

A law applies to the business of insurance under the McCarran-Ferguson Act if it (1) has the effect of transferring or spreading the policyholder's risk; (2) is an integral part of the policy relationship between the insurer and the insured; and (3) is limited to entities within the insurance industry." *Id.* This language clearly shows that, in the Eighth Circuit, the courts will be quick to determine that state law impacts a plan, and is thus preempted, and that a plan will be considered self-funded so long as it retains risk, per the McCarran-Ferguson Act.

In another Eight Circuit decision, *Malan F. Johnston v. Paul Revere Life Insurance Company*, now known as Provident Insurance Company, 241 F.3d 623, (8th Cir. 2001), the Court determined that ERISA preempted a plaintiff's state-law claim. "The Employee Retirement Income Security Act of 1974 seeks to comprehensively regulate certain employee welfare benefits and pension plans and to protect the interests of participants in these plans by establishing standards of conduct, responsibility, and obligations for fiduciaries, and contains a preemption clause." Id.

"The scope of the preemption provision in the Employee Retirement Income Security Act of 1974 (ERISA) is deliberately expansive. A state law may "relate to" an employee benefit plan and, therefore, be preempted, even if the state law was not designed to affect benefit plans and its effect on such plans is incidental. The United States Supreme Court applies a two-part test to determine if a state law "relates to" an employee benefit plan covered by ERISA. Pursuant to this inquiry, a state law relates to a covered employee benefit plan for purposes of ERISA § 514(a), 29 U.S.C.S. § 1144(a), if the plan (1) has a connection with or (2) reference to such a plan. Courts are to look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." Id.

"The United States Court of Appeals for the Eighth Circuit holds that a variety of tests are helpful when determining the effect of state law on an Employee Retirement Income Security Act of 1974 (ERISA) plan. Factors which are instructive in this regard include: (1) whether the state law negates a plan provision; (2) the effect on primary ERISA entities and impact on plan structure; (3) the impact on plan administration; (4) the economic impact on the plan; (5) whether preemption is consistent with other provisions of ERISA; and (6) whether the state law at issue is an exercise of traditional state power." Id. Once again, the court considered any state law influence on a self-funded plan to be pre-empted, and went to great lengths to honor the legislative intent of ERISA: that plans funded by employer contributions be regulated by one consistent set of provisions nationwide. The court also looks to the McCarran-Ferguson Act and defines a self-funded plan under the purview of ERISA to be one that retains risk of loss.

In Arkansas, the District Court held that a plan which obtained a stop-loss policy was nonetheless a self-funded plan under the purview of ERISA. *Capital Mercury Shirt Corp. v. Employers Reinsurance Corp. & US Able Insurance Co.* 749 F. Supp. 926, (W.D. Ark. 1990). Likewise, in Nebraska's sister state of Minnesota, the District Court there also determined that a self-funded plan remained self-funded despite the purchase of reinsurance. "... an employer and the plan sponsor of a self-funded employee welfare benefit plan governed by ERISA... entered into a separate contract... to secure stop-loss insurance coverage. Stop-loss insurance is often used by self-insured employers such as Workforce to protect against the risk that a high claim might wipe out the employer's medical insurance fund." *Workforce Development, Inc. v. Corporate Benefit Services of America, Inc.* 316 F. Supp. 2d 854, (Dist. Minn. 2004).