

Statewide Health Care Insurance Plan Task Force

Review of Self-Insuring of Health Benefits

Arizona Health Care Cost Containment System

October 2001

Self-Insurance

Self-insuring is one of several ways employers can fund medical benefit plans. In order to understand self-insuring, it is helpful to understand the features and differences between fully insured funding arrangements and self-insured funding. We have also included minimum premium funding which is a combination of fully and self-insured.

Features of Each Funding Arrangement

Fully Insured	Self-Insured	Minimum Premium
<ul style="list-style-type: none"> the insurance company guarantees all benefits the insurance company retains the reserves (i.e., the estimate of claim dollars that have been incurred but not yet paid) premium paid includes “retention,” which includes premium taxes and profit after the end of the servicing year, if there is a surplus it belongs to the insurance company (e.g., when premiums exceed claims) the insurance company is liable for any claim deficits (e.g., when claims exceed premiums) claims incurred prior to termination of a contract, but paid after termination are the responsibility of the insurance company agreements are in the form of a contract 	<ul style="list-style-type: none"> there are no guarantees, except for those offered by stop loss protection the reserves would be held and maintained by the employer interest earned on the reserves is kept by the employer administrative fees charged would exclude premium taxes after the end of a servicing year, if there is a surplus it would be returned to the employer the employer or its stop loss provider would be liable for any claim deficits claims incurred prior to termination of a contract, but paid after termination would be the responsibility of the employer or its stop loss provider an agreement with a claims administrator or a network provider is an agreement only to perform administrative services or access to providers and discounts 	<ul style="list-style-type: none"> provides cash flow benefits to the employer, but limits overall liability the insurance company sets a predetermined amount per month for the employer to put in a bank account from which benefits are paid this amount is usually set as 110–120 percent of expected claims benefits paid up to this amount are the responsibility of the employer deficits or benefits paid beyond the amount are the responsibility of the insurance company the employer pays an additional fee or “risk charge” for the insurance company to pay the deficits annual deficits are typically carried forward to be recouped by the insurance company from future surpluses interest charges may accrue on deficits and can be passed on to the employer

Fully Insured	Self-Insured	Minimum Premium
<ul style="list-style-type: none"> when the contract is terminated, any surpluses or deficits are the responsibility of the insurance company 	<ul style="list-style-type: none"> when the contract is terminated, any claim surpluses or deficits are the responsibility of the employer 	<ul style="list-style-type: none"> the insurance company may mandate the stop loss coverage levels premium taxes are paid on any employer payments made directly to the insurance company when the contract is terminated, any claim deficits (beyond the pre-determined liability amount) are the responsibility of the insurance company, but surpluses would be returned the employer after a final accounting of claims and expenses is completed

Advantages and Disadvantages

It is important to consider the advantages and disadvantages for each of the types of funding.

Fully Insured	Self-Insured	Minimum Premium
Advantages <ul style="list-style-type: none"> easy to determine monthly amounts due and payable all risk is assumed by the insurance company any deficits are the responsibility of the insurance company; however, they are generally reflected in renewals the assets of the employer are protected from legal action against the 	Advantages <ul style="list-style-type: none"> elimination of premium tax lower cost of operation (i.e., fees charged by claims administrators are generally lower than those of an insurance company) insurance company profit margin and risk charges are eliminated the employer can determine the reserve levels 	Advantages <ul style="list-style-type: none"> easy to determine monthly amounts due and payable risk is shared between the insurance company and the employer employer is only responsible for claims cost up to the predetermined trigger point the majority of premium taxes eliminated

Fully Insured	Self-Insured	Minimum Premium
<p>insurance company</p> <ul style="list-style-type: none"> all claim costs are the responsibility of the insurance company 	<ul style="list-style-type: none"> return on investment for reserves (i.e., interest earned belongs to the employer) any surpluses are kept by the employer control and flexibility of plan design reporting on cost and utilization readily available mandatory benefits can be avoided stop loss levels and associated risk tolerance are determined by the employer 	
<p>Disadvantages</p> <ul style="list-style-type: none"> any surpluses between premiums and claims are kept by the insurance company the insurance company controls the plan design insurance companies must comply with state regulations regarding mandatory benefits the insurance company determines the types of utilization and disease management programs to be utilized (if any) premium tax and retention are included in the employer paid premiums the insurance company determines and controls the reserves 	<p>Disadvantages</p> <ul style="list-style-type: none"> employer assumes the responsibility for claim costs up to the stop loss coverage level monthly cash flow fluctuates due to claim cost fluctuations assets may be exposed to any liability created by legal action against the self-funded plan 	<p>Disadvantages</p> <ul style="list-style-type: none"> employer pays additional fees to offset “risk” passed to the insurance company stop loss coverage levels may be mandated by the insurance company deficits are carried forward to be recouped by insurance company in future years interest on the deficits can be accrued and passed on to the employer typically, employer assumes liability created by legal action against the plan

Who Selects Self-Insurance?

Self-insurance generally appeals to large employers that can tolerate the fluctuations in monthly claims paid, can spread the risk of large claims amongst a larger group of employees without adverse effects, and are looking for a way to exert some control on their claims cost. Minimum premium funding generally appeals to medium size employers who are willing to take some claims risk and are interested in the cash flow control this type of funding allows. In addition, large employers who are less risk tolerant may choose minimum premium funding.

Legislation and Regulation of Self-Insured Plans

The Employee Retirement Income Security Act (ERISA) governs self-insured health care plans. Under ERISA, a self-insured health plan is exempt from state regulation and mandated benefits. However, they are not exempt from federal mandates. The Department of Labor has enacted new regulations affecting ERISA plans regarding the claims and appeals process. These new regulations give private-sector employees the right to have their claims resolved more quickly and provide more time to appeal decisions when the health plan refuses coverage. In addition, there are requirements regarding the disclosure of certain items in the summary plan documents (SPDs). These include, but are not limited to, cost-sharing provisions, annual or lifetime limits on benefits, and any provisions requiring pre-authorization or utilization review as a condition to obtaining a benefit or service under the plan. At this time, the new regulations are scheduled to be effective January 1, 2002.

Successes of Self-funded Plans

There are a variety of success stories regarding self-funded medical plans. The success stories generally have some commonalities. They are:

- constant monitoring and assessment of costs and utilization,
- willingness to make changes when needed (e.g., implementation of disease management programs, plan design modifications, etc.),
- strong utilization and case management programs are in place,
- selection of “best of breed” providers (i.e., when the relative value of quality and cost are optimized), and
- targeted contracting with networks or providers for deep discounts.

