BENEFITS TOOLKIT

Self-insured Health Plans

Provided by Troy Benefits Consulting

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Introduction

As health care costs continue to climb, employers are actively looking for ways to mitigate these costs. Some turn to cost-sharing methods, like offering high deductible health plans. Other U.S. employers are making the switch to self-insuring as a way to reduce costs and improve service. Self-insuring is not right for every organization. Employers considering a switch from to a self-insured health plan should analyze the advantages and disadvantages before making the switch.

This toolkit serves as an introductory guide to self-insurance. It provides a general overview of what self-insurance is, how it differs from fully funded health plans and its market trends. It is not intended as legal advice. You should consult a legal professional or plan administrator before making the change to a self-insured health plan.

Background

What Is a Self-insured Health Plan?

A self-insured health plan is one in which the employer assumes the financial risk associated with providing health care benefits to its employees. Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk of paying claims—the employer pays for medical claims out-of-pocket as they are incurred.

A **self-insured plan** is a funding arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims.

How Do Self-insured Health Plans Differ From Fully Funded Plans?

A **fully insured health plan** is the traditional way to structure an employer-sponsored health plan. With a fully insured health plan:

- The company pays a premium to the insurance carrier.
- The premium rates are typically fixed for a year, based on the number of employees enrolled in the plan each month.
- The monthly premium normally only changes during the year if the number of enrolled employees in the plan changes.
- The insurance carrier collects the premiums and pays the health care claims based on the coverage benefits outlined in the policy purchased.
- The covered persons (that is, employees and dependents) are responsible to pay any deductible amounts or co-payments required for covered services under the policy.

With a self-insured health plan, employers operate their own health plan as opposed to purchasing a fully insured plan from an insurance carrier. One reason that employers choose to self-insure is that it allows them to save the profit margin that an insurance company adds to its premium for a fully insured plan. However, self-insuring can expose the company to much larger risk in the event that more claims than expected must be paid. With a self-insured health plan:

- There are two main costs to consider: fixed costs and variable costs.

- The fixed costs include administrative fees, any stop-loss premiums and any other set fees charged per employee. These costs are generally billed monthly by the third-party administrator (TPA), or carrier handling plan administration, and are charged based on plan enrollment.

- The variable costs include payment of health care claims. These costs vary from month to month based on health care use by covered persons (that is, employees and dependents).

- To limit risk, some employers use stop-loss or excess-loss insurance which reimburses the employer for claims that exceed a predetermined level. This coverage can be purchased to cover catastrophic claims on one covered person (specific coverage) or to cover claims that significantly exceed the expected level for the group of covered persons (aggregate coverage).

Self-insured Health Plans and Stop-loss Insurance

One component that many self-insured plans use is an extra feature called stop-loss insurance. The purpose of stop-loss insurance is to provide financial protection to a self-insured plan sponsor by capping and further defining the plan's financial exposure. A stop-loss contract operates differently from general insurance because it is actually insuring the employer and not the individual employee. It is important to grasp this concept. When a plan is self-insured, the stop-loss contract insures the employer against catastrophic losses under the plan. The medical plan established by the employer accepts the responsibility for paying providers' claims for individuals but limits its risk with stop-loss coverage.

Stop-loss insurance is neither health insurance nor reinsurance. It is more closely comparable to a catastrophic coverage plan that indemnifies a plan sponsor from abnormal claim frequency and severity. Stop-loss claim reimbursements can be made for a variety of benefits, including medical, prescription drug, dental and others. Severe, high-dollar claims such as cancer, organ transplants and dialysis are considered "shock loss" claims, which can give plans the most concern when they consider self-insuring. The protection afforded by a comprehensive stop-loss coverage shows its value in helping to financially manage these catastrophic events.

Stop-loss insurance provides protections in two forms:

1. Specific stop-loss—Also referred to as individual stop-loss, it protects a plan against individual catastrophic claim occurrences. This type of stop-loss coverage shifts responsibility for a claim to the insurer once it exceeds a certain dollar amount for a specific claim.
    - Example: An employer with a specific stop-loss attachment point of $25,000 would be responsible for the first $25,000 in claims for each individual plan participant each year. The stop-loss carrier would pay any claims exceeding $25,000 in a calendar year for a particular participant.
2. Aggregate stop-loss—Limits a self-insured plan's financial exposure for the entire plan year (or policy year) and protects against abnormal claim frequency across the entire group of individuals. This type of stop-loss coverage protects the employer against high total-health-plan claims.

- **Example:** Aggregate stop-loss insurance with an attachment point of $500,000 would begin paying for claims after the plan's overall claims exceeded $500,000. Any amounts paid by a specific stop-loss policy for the same plan would not count toward the aggregate attachment point.

Advantages of Self-insurance

The primary reasons employers cite for self-insuring are:

- **Reduced insurance overhead costs**—Carriers assess a risk charge for insured policies (approximately 2 percent annually), but self-insurance removes this charge.
- **Reduced state premium taxes—**Self-insured programs, unlike insured policies, are not subject to state premium taxes. The premium tax savings is about 2-3 percent of the premium dollar value.
- **Avoidance of state-mandated benefits—**Although both insured and self-insured plans are governed by federal law (predominantly ERISA), self-insured plans are exempt from state insurance laws. State benefit mandates can add to the cost of insured employer benefit programs. For multi-state employers, self-funding can help create national consistency by elimination of the need for state-by-state compliance.
- **Employer control—**Employers who want to revise covered benefits and the levels of coverage are free from state regulations that mandate coverage and the carrier negotiation typically required with changes in insured coverage. By self-funding, employers are able to design their own customized health benefit packages.
- **Employers see improved cash flow since they do not have to prepay for coverage—**Claims are paid as they become due. There is also a cash flow advantage in the year of adoption when "run-out" claims are being covered by the prior insurance policy. Employers pay for claims rather than premiums and earn interest income on any unclaimed reserves.
- **Choice of claim administrator—**An insured policy can be administered only by the insurance carrier. A self-insured plan can be administered by the company, an insurance company or independent TPA, which gives the employer greater choice and flexibility. When selecting a TPA, employers should consider whether the TPA efficiently handles claims, has contacts with stop-loss carriers, has a strong reputation, cost management skills and negotiating clout, has medical expertise on staff, and provides excellent customer service and claims administration.

Note: Talk to an attorney for self-insured health plan specifics related to your state. This guide is intended for informational use only and uses general statements.

Disadvantages of Self-funding

While self-funding can have its advantages, it can be a lengthy process for employers, and it can sometimes be a long time before they see results. This section outlines other potential disadvantages to self-funding.

- **Greater risk**—The main risks of self-insuring involve situations where claims are higher than anticipated. While stop-loss coverage will protect employers from paying excessive claims in a given year, the cost of that coverage will likely increase, and it may be more difficult to get rates from other stop-loss providers. Claims that are higher than expected in a self-insured plan may also make it more difficult for employers to go back to a fully insured plan in the future. And, an employer's assets may be exposed to liability as a result of any legal action taken against the plan. Legal matters in regards to self-insured plans can be complex.
- **Higher administrative costs**—For organizations that choose to run their self-insured plans internally, the administrative costs involved can be significant. However, using TPAs to operate the plans will still likely involve lower administrative costs than those associated with fully insured plans.

Self-insurance: A Rising Trend

According to the Kaiser Family Foundation and the Health Research and Educational Trust's Employer Health Benefits 2018 Annual Survey, 61 percent of covered workers are in a self-insured health plan. Of these covered workers, 13 percent are workers in small firms and 81 percent are in large firms. Generally speaking, as the number of workers in a firm increases, the percentage of covered workers in a self-insured plan increases. Experts believe this is because large firms can spread the risk of costly, large claims or unexpectedly high expenses over a larger pool of workers and dependents. These trends are on par with what the market has seen in the past few years.

What Types of Self-insured Plans Are Workers Enrolled in?

When it comes to the different types of self-insured health plans workers are enrolled in, the trends are fairly stable between 2008 and 2018 for health maintenance organizations (HMOs) and preferred provider organizations (PPOs). However, the trend significantly increased for high deductible health plans with a savings option (HDHP/SO).

- Percentage of covered workers enrolled in a PPO:
    - 2008: 64 percent
    - 2018: 67 percent
- Percentage of covered workers enrolled in a HDHP/SP:
    - 2008: 35 percent
    - 2018: 65 percent
- Percentage of covered workers enrolled in an HMO:
    - 2008: 40 percent
    - 2018: 39 percent

Do the Average Premium Contributions Differ Between Self-insured and Fully Funded Plans?

In 2018, covered workers in firms that were partially or completely self-funded contributed about 25 percent of their total premium cost, while covered workers enrolled in fully insured plans contributed about 36 percent of the cost. For single coverage in 2018, there was no difference in average premium contribution between workers enrolled in self-insured plans and workers enrolled in fully insured plans.

Making the Decision: Considerations

When deciding if self-funding is right for your organization, make sure that you consider the following best practices to ensure that your self-funding strategy is appropriate and effective.

1. **Evaluate Stop-loss Coverage.** Most self-insured employers purchase stop-loss insurance on their self-insured health care benefit plans to reduce the risk of large individual claims or high claims for the entire plan. The employer self-insures claims up to the stop-loss attachment point, which is the dollar amount above which claims will be reimbursed by the stop-loss carrier. Obtain stop-loss quotes at several different levels.
2. **Understand the volume and nature of your employee health claims for the past five years.** Knowing facts such as whether your workforce is mostly young or old, whether the majority of claims were due to chronic illnesses or one-time incidents, and the total dollar amount of claims will help you budget for claims in the future. Self-funding should be viewed as a long-term strategy in which good and bad years average out in the employer's favor.
3. **Analyze cash flow.** Self-insured plans work best for companies that have a strong cash flow or reserves. Understand what your cash needs are so you have money available to make timely claim payments.
4. **Decide whether it makes sense to administer the plan internally or through a TPA**. If you decide that it is best for your organization to use a TPA, make sure you factor TPA fees into your decision to self-insure. Obtain several different TPA quotes. Your TPA should offer a strong plan for monitoring the plan.
5. **Make coverage goals.** Decide on such things as eligibility, benefit coverage, exclusions, cost-sharing, policy limits and retiree benefits. Weigh the self-insured plan advantages of flexibility and lower average cost versus the increased risk and administrative responsibilities.

Summary

Self-insuring health benefits can provide many advantages for employers. However, it is important for employers to do their due diligence before deciding if self-insurance may be the right choice.

There are certain attributes that an employer must have in order to successfully manage their health benefits, including the following:

- Risk tolerance
- A steady employee population
- Stable claims experience
- Employee involvement in cost-savings strategies

Because the employer assumes the financial risk of providing health care benefits, a company can either save or lose money depending on the level of claims incurred by its employees. The most important step you can take to assure that you make the best decision is to have an experienced professional assist you. Your Troy Benefits Consulting representative has experience with self-insurance programs, and can answer your questions and assist you with your decision to self-insure your company health plan.

Troy Benefits Consulting welcomes the opportunity to help your organization examine its plan designs and make recommendations for improvement.

Appendix

Self-insured vs. Fully Insured Infographic

This infographic illustrates the differences between a self-insured health plan and a fully insured health plan. Please contact Troy Benefits Consulting for access to the stand-alone version of this infographic.

Self-insurance Scorecard

Use this scorecard to determine whether your organization is a good candidate for self-insurance. Please contact Troy Benefits Consulting for access to the stand-alone version of this infographic.

TPA Carrier Questionnaire

This questionnaire is fully customizable, and can help you in your search for a TPA.

Group Health Insurance: Self-insured Health Plans

This employee-facing flyer explains what self-insurance is in an easy-to-understand way.

Self-insured vs. Fully Insured

Self-insured		Fully-insured
The employer does not pay premiums; instead, it pays fixed costs (administrative fees and stop-loss premiums) and variable costs (employee health care claims).	PAYMENTS	The employer pays monthly premiums to an insurance carrier.
The employer assumes the risk.	ASSUMPTION OF RISK	The insurance company assumes the risk.
Employers have more control and freedom in their plan designs.	PLAN DESIGN	Employers are more limited by insurers' plan design options.
The Employee Retirement Income Security Act of 1974 (ERISA) pre-empts state regulations.	COMPLIANCE PAYMENTS	The plan must comply with state regulations.

SELF-INSURANCE EVALUATION

A self-insured health plan is one in which the employer assumes the financial risk associated with providing health care benefits to its employees. Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk—the employer pays for medical claims out of pocket as they are incurred.

It's important to remember that self-insurance may not be the best solution for every organization. However, it is worth asking Troy Benefits Consulting about self-insured plan designs that may save your organization money.

Instructions: Answer the following questions to determine whether your organization is a good candidate for self-insurance.

QUESTIONS

1. How many employees does your organization employ?	
2. What is the average employee age at your organization?	
3. When is the last time your health care costs decreased?	

	YES	NO
4. Are you willing to assume additional liability and risk to potentially save on health care costs?	☐	☐
5. Have you ever wanted increased flexibility in plan design?	☐	☐
6. Do you anticipate growing in employee count?	☐	☐
7. Do you do business across state lines?	☐	☐
8. Do you desire the ability to have access to better benchmarking information?	☐	☐
9. Do you want better overall data on your health plan?	☐	☐
10. Do you have concerns about medical claim fraud or double-billing	☐	☐

If you answered "yes" to many of these questions, you may be a good candidate for plan design changes. Return this evaluation to Troy Benefits Consulting to start a conversation about implementing a self-insured health plan at your organization.

TPA Carrier Questionnaire

The following questionnaire is fully customizable, and can help employers in their search for a TPA.

GENERAL INFORMATION: Questions must be answered for each coverage you are quoting.

1. Describe the history, organization and ownership of your company.
2. Explain your ownership, listing all separate legal entities and their relationships.
3. Do you contemplate any agreements, or are agreements being negotiated between you and other parties, which may affect the plan's ownership, corporate structure or management during the next year?
4. Provide the name and address of your company and all outside vendors used in this RFP. Include local, toll-free telephone and fax numbers.
5. Supply an organizational chart identifying the functions and reporting relationships of key people directly responsible for administrative services to .
6. Give the name and title of the person(s) with overall responsibility for planning, supervising, and performing the day-to-day administrative services for .
7. Will you assign an underwriter or another group benefit professional with similar knowledge and experience to ?
8. Will Troy Benefits Consulting have direct contact and access to all of the above named person(s)?
9. Explain in detail the steps you anticipate will be needed to ensure a smooth implementation. Include a definition of specific activities and a timetable of events. The timetable should assume an award notification date and plan implementation schedule, which includes completion of all enrollment packets, enrollment meetings, system updates and ID card issuance by .
10. requires that you provide year-end financial information and renewal rates and fees 120 days prior to the policy anniversary date. Additionally, Troy Benefits Consulting will be provided all service agreements, contracts, amendments, reports and claims data. Will you agree to this?
11. Will you agree to performance-based administrative fee structures as outlined in this RFP?
12. Describe any previous or pending material lawsuits in the last 10 years.
13. Have any of the principals in your firm or any of your employees (former or current) ever been indicted or convicted of mishandling or misappropriating any insurance company or client funds? If yes, please explain.
14. Are you HIPAA – EDI compliant?

Please respond to the following questions, recognizing that your organization will be expected to underwrite and administer the program as stated in this RFP unless specifically noted here.

1.	Will your organization insure and/or administer the program exactly as shown in this RFP?
2.	Will your organization require any additional information or impose restrictions on benefit selections?
3.	Does your organization agree to the performance objectives outlined in this RFP?

REFERENCES

1.	Please provide three references of current clients and two references of clients you have lost in the past two years. Ideally, these references would be similar in size to .
2.	Please provide a reference from a similar product or service offering.

CLAIMS PROCESSING AND ADMINISTRATION

1.	Do you have an automated claim processing and payments system?
2.	How long has this system been operational?
3.	Who can add or change eligibility information?
4.	How does the system keep track of non-covered expenses? Are all denied claims tracked?
5.	How is hard copy stored? How long is it retained?
6.	How are providers identified (TIN, name/zip, phone number, other)?
7.	Does the system track carry over deductible amounts and adjust out-of-pocket sequence claims?
8.	Define “turnaround time” for claim processing purposes.
9.	Describe the procedures for administering COB in-network versus out-of-network, specifying whether COB is system-calculated or manually calculated.
10.	What is the current collection/return rate for COB (as a percent of paid claims)?
11.	Do you routinely capture, maintain, and access a spouse’s coverage and employment data for COB? What specific data elements do you store in these files? How do you update them?
12.	Describe the quality management program which is applied to the claims administration function (e.g., coding, processing, paying), specifying audit procedures and error categories.

CLAIM ADMINISTRATION AND ADJUDICATION

1.	Where will you process medical claims? Where will drafts and EOBs be issued?
2.	Describe the organization, methods and procedures for responding to routine claim inquiries from employees.
3.	Is your software leased or owned? If owned, when was it purchased?
4.	Describe your procedures for auditing and/or negotiating provider bills.

AUDITING PRACTICES

1. What are your standard claim audit procedures for claims in process and those that are already paid?
2. How are overpayments handled, and to what extent does your company go to recover those overpayments?

UTILIZATION REVIEW SERVICES

1. To what extent do you involve the patient and/or family in the review process? Be specific.
2. What percent of all cases are reviewed by a physician and what determines whether a physician becomes involved?
3. What is your fee structure? Do you charge on a monthly or case rate?

NETWORKS

1. Provide a response for the following questions describing the capabilities for each PPO network that would be applicable to this RFP. a. PPO network b. Location(s) c. Date established d. Total enrollment e. Average hospital discount—breakdown inpatient/outpatient f. Average professional discount g. Percent PCPs Board Certified
2. What is your service area? Please describe by county and zip code.
3. Chiropractic a. Indicate the chiropractic services currently available. b. Describe the method used by subscribers to access such services.
4. Do you have the capability to coordinate a drug testing program for all locations? If yes, is there a separate cost? If not, would you be willing to develop a program? If yes, is there a separate cost?

5. Please indicate whether your physician application and credentialing process requires the following;
    a. Written verification of education and experience
    b. Verification of current license and DEA certificate
    c. Investigation for adverse action on license and/or hospital privileges
    d. Verification of letters of recommendation
    e. Regular recertification of participating physicians
    f. Verification that physicians complete continuing education requirements
    g. Documentation on malpractice claims, settlements, and judgments for the previous five years
6. Are physicians prevented from balance billing?
7. How are radiology services reimbursed?
8. How are laboratory services reimbursed?
9. How are anesthesiology services reimbursed?
10. What screens do you use to audit coding accuracy?
11. What physician services are not available through the network? How are they handled?

SELF-FUNDED QUOTATION ASSUMPTION/CONDITIONS

1. Are the fees quoted for firm and guaranteed for:
    a. Administrative services?
    b. Individual stop loss?
    c. Aggregate stop loss?
2. Do quoted rates and fees include all services described within this RFP? If not, please indicate which services are not included.
3. Will individual medical underwriting of self-funded members ever be required? Under what circumstances?
4. What is the maximum percentage the quoted fees will increase for:
    a. Administrative services?
    b. Individual stop loss?
    c. Aggregate stop loss?
5. Please outline the reimbursement process and banking arrangements for your self-funded quotes. Attach copies of any agreements related to this process.
6. Please describe the process and timing of reimbursements to when the stop loss threshold has been exceeded for:
    a. Individual stop loss
    b. Aggregate stop loss

7. Does individual and aggregate stop loss coverage include:
    a. COBRA participants?
    b. All other covered members as of the effective date?

KNOW YOUR BENEFITS.

Group Health Insurance: Self-insured Health Plans

The health plan that offers is called a self-insured health plan. You need to know how this type of health plan works, and what it means for the way you receive health care benefits.

What Is Self-insuring?
An employer has a self-insured (or self-insured) group health plan if the employer assumes the financial risk associated with providing health care benefits to its employees.

Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk— pays for medical claims out of pocket as they are incurred.

Why Do Employers Choose Self-insuring?
An employer may choose to offer a self-insured health plan for a number of reasons.

- Instead of trying to purchase a "one size fits all" health plan, self-insured plans can be customized to fit the needs of an employer's workforce.
- Employers with self-insured plans control the health plan cash reserves, allowing them to maximize interest income (insurance companies generate interest income for themselves by investing premium dollars).
- Self-insured coverage is not prepaid, as it is when the employer pays premiums to an insurance company. Therefore, companies that self-fund their health plans have improved cash flow.
- Self-insured plans are not subject to conflicting state health insurance regulations and benefits mandates. Instead, these plans are regulated by federal law.
- Employers with self-insured plans are not subject to state health insurance premium taxes.
- Employers can contract with the providers or a particular provider network that will best meet the needs of its employees.

Because your employer assumes the financial risk of providing you with health care benefits, it's important to be a wise health care consumer.

How Self-insured Benefits Work
Imagine you make an appointment with your doctor because you are sick. When you arrive at your doctor's office, you are asked to provide your insurance card to your physician's office personnel. Your insurance card tells the doctor's office what type of health plan you have and how it is administered, including to whom your claim should be sent.

After you have seen your doctor, a claim for payment for the office visit is generated. Someone in your doctor's office prepares the claim and submits it to the administrator—the entity that will determine how your claim will be paid—listed on the insurance card you provided. Some employers administer employee health care claims in-house, while some use a third-party administrator (TPA).

The administrator then adjudicates your claim. Adjudication is the process of paying health care claims according to your health plan's contract. Your health plan's administrator will determine how your health benefits work and what payment is required for your doctor. Your plan may require you to pay coinsurance or a

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deductible before your health plan pays its portion of your bill. Or, your doctor may participate in a Preferred Provider Organization (PPO) or another type of managed care plan and therefore will charge discounted fees to your plan. These and other factors determine how much of the claim the plan will pay, how much you will pay, and how much the doctor will eventually receive.

Once all of the payment issues are cleared up and it is determined that your expense will be covered by the plan, your plan administrator contacts your employer for approval of your claim's payment (and any other current claims). Your employer approves payment of the claim.

After receiving payment approval from your employer, the administrator requests payment from your employer's bank. The bank will wire the appropriate funds to the administrator, who will then send payment to your physician. Your claim is paid.

This payment process generally takes two to four weeks.

The Explanation of Benefits
After your visit with your physician, you will receive an informational statement from your health plan administrator. This is the explanation of benefits, or EOB. An EOB summarizes your claim, the payments you must make, the payments your health plan (employer) must make, and any other payment information regarding your claim. This statement is not a bill or request for payment, it is simply informational.

Your Rights Under a Self-insured Plan
Self-insured health plans are regulated under the federal Employee Retirement Income Security Act (ERISA), rather than state law as insured health plans are. They fall under the jurisdiction of the U.S. Department of Labor.

Federal regulations require your employer to provide you with a summary description of your health plan and certain other documents related to the plan. You can also request to see a copy of the plan document that determines what benefits are available and how they get paid.

Self-insured group health plans are also regulated by other applicable federal laws including the:

- Health Insurance Portability and Accountability Act (HIPAA)
- Consolidated Omnibus Budget Reconciliation Act (COBRA)
- Americans with Disabilities Act (ADA)
- Pregnancy Discrimination Act
- Age Discrimination Employment Act
- Civil Rights Act

The Impact of Health Care Reform
Many health care reform regulations apply to all group health plans, regardless of whether they are fully insured or self-insured, but self-insured plans are exempt from certain provisions of health care reform. The following are examples of reforms that do and do not apply to self-insured plans.

Reforms that do apply:

- Dependent coverage until age 26
- Preventive health coverage without cost-sharing (grandfathered plans are exempt)
- No rescissions of coverage, except in the case of fraud or intentional misrepresentation of material fact

Group Health Insurance: Self-insured Health Plans

- Improved internal claims and appeals process and minimum requirements for external review (grandfathered plans are exempt)

Reforms that do not apply:

- Essential health benefits package
- Premium rating restrictions
- Review of premium increases

Do Your Part
Because assumes the financial risk of providing you with health care benefits, we can either save or lose money depending on the level of claims incurred by our employees.

We want to be able to provide you with high quality health benefits, but as the cost of providing health care rises, you too must do your part to keep benefits high and costs low.

Some ways that you can help save money for yourself and our company are:

- Eliminate unnecessary visits to your doctor.
- Discuss healthy living and preventive care with your doctor.
- Follow prescription drug directions precisely, and be sure to take all of your medication, even if you feel better.
- Use in-network providers if you have a Preferred Provider Organization (PPO) or Point-of-Service (POS) plan.

To help keep your health care costs down, do your best to be a wise health care consumer and always ask questions if you do not understand the benefits available to you. Contact HR if you would like more information on our self-insured health plan.