Self-Insuring Group Health Plan Benefits: Key Considerations for Employers

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Calculated risk. A chance of exposure to loss or injury that might be undertaken after its advantages and disadvantages have been carefully weighed and considered. Many business operators need to take a calculated risk to expand their business activities into a new competitive arena.¹

It’s what a CEO, President, CFO, finance, risk or HR professional, and in fact any business decision-maker, grapples with every day in a number of contexts. And for some employers who sponsor group health plans, it may be worth considering (and calculating) the potential risks and benefits of self-insuring. Plan sponsors in this position need to consider how to best leverage known attributes while mitigating risk. This article discusses the fundamental concepts behind self-insuring, and provides several key considerations for employers to contemplate.

**Introduction**

Whether to self-insure or fully insure an employer’s benefit programs, in particular the medical coverage offered to employees, constitutes a long-term major decision. The decision is one whose full spectrum must be analyzed completely and the known calculated risk understood. Some organizations steer away from the risk while others innately embrace it.

Internal Revenue Code Section 105(h) and accompanying regulations define a self-insured health plan as coverage which is not provided through an accident or health insurance policy that shifts sufficient economic risk to a third party. As such, risk-shifting is a defining characteristic that differentiates an insured plan from a self-insured plan.

Since self-insuring at its simplest is no more than a funding strategy, it is the risk tolerance aspect associated with self-insuring that needs be examined. Arthur J. Gallagher & Co. is in a unique position to provide guidance on this topic. In the 1960s, Gallagher facilitated the creation of self-insuring in commercial insurance. Many of the same methodologies and algorithms apply to self-insuring group health plan benefits.

Gallagher’s 2015 Benefits Strategy & Benchmarking Survey, which included over 3,000 respondents, reflects that 43% of organizations with more than 100 employees self-insure their medical programs while a significant percentage, roughly 32%, are contemplating self-insuring their medical programs in the next few years. More and more organizations are realizing the effectiveness, flexibility, and consistency achieved by self-insuring their medical programs.

To assess your organization’s DNA, and to define the variables associated with this funding choice, four distinct yet connected considerations require attention. These are:

- Financial
- Plan design
- Administration
- Compliance

Each of these variables is discussed in greater detail below.

¹ Source: http://www.businessdictionary.com/definition/calculated-risk.html
Financial Considerations

Assessing the feasibility of self-insuring typically begins with a financial analysis. Each organization will determine the main concerns and its own unique risk tolerance. However, this article addresses the primary concerns in the same way that many employers commonly analyze the issue. Based upon an employer's receptiveness, it may or may not make sense to analyze all of the criteria immediately rather than tackle the most essential items such as financial implications, and if plausible to continue to vet the other considerations after conducting an initial analysis. In other words, don't get bogged down in the details until you have at least tackled the weighty part of the subject matter.

Risk tolerance, or lack thereof, is often the driving force of the decision to self-insure versus remain fully insured. With a self-insured plan, an employer has the ability to limit its liability to the claims experience of its own participants. If an employer has a relatively healthy workforce, including dependents, then choosing to self-insure may save the employer on the total cost of coverage. Conversely, if an employer's employees or dependents are not generally healthy and have a negative claim history, then placing those participants in a larger risk pool via a fully insured plan may be more advantageous for the employer. With a self-insured plan, the employer bears the risk of any claims exceeding expectation, although this risk can be mitigated with the purchase of stop loss coverage.

Stop loss coverage is a critical consideration for employers who may decide to self-insure their medical plan benefits. It enables employers, even employers with a higher risk aversion, to enjoy the benefits of self-insuring while limiting the associated risk. Stop loss coverage is designed to limit an employer's liability to a pre-determined amount for each covered individual on the plan, per policy year. It can also be used to limit overall claim liability per policy year, if desired. There are two common types of stop loss coverage.

- **Individual stop loss ("ISL") coverage** limits an employer's liability to a set dollar figure per individual, per policy year. For example, an employer may elect a deductible of $100,000 per policy year. That means the maximum liability per person on their benefit plan for that policy year will be $100,000. The stop loss policy will reimburse the employer for claims in excess of that amount.

- **Aggregate stop loss coverage** limits an employer's liability to overall claim fluctuation. The employer's maximum liability is expressed in terms of a percentage of total expected claims, typically 125 percent. If paid claims exceed expected claims by more than 25 percent, the stop loss coverage will reimburse the employer for the difference. Claims reimbursed under individual stop loss coverage do not apply to the aggregate stop loss threshold. However, claims that satisfy the individual stop loss limit will also apply to the aggregate stop loss limit.

It is often the case, based on the size of an employer relative to employee count, that the ISL level increases and the need for aggregate coverage becomes immaterial. Individual stop loss can be obtained without securing
an aggregate policy. Concurrent with the purchase of ISL coverage is the need to have consistency and to connect the dots between the plan document and the coverage that is obtained. Stop loss contractual provisions, eligibility rules, or definitions that differ from those contained in the underlying plan can end up costing the employer.

Another consideration is cash flow, which is a close second in deciding whether to self-insure or fully insure the medical program. Most employers are happy to learn that the health insurer fee under the Patient Protection and Affordable Care Act (“PPACA”), estimated at the aggregate level of $11.3 billion for all insurance carriers in 2016, is not assessed against self-insured plans. Further, additional state premium taxes (2% on average) apply to the total premium on a fully insured plan, but only to the stop loss premium on a self-insured plan, a significantly lower amount.

Nonetheless, employers with self-insured plans will generally fund the benefits when claims are submitted and approved. This allows a self-insured employer to retain the use of its money until each claim is approved and paid from the company’s general assets. However, paying claims as submitted is much less predictable than paying a fixed monthly premium, as payments could vary significantly from month to month. Over time it can be expected that claims will normalize, particularly for employers with more than 1,000 employees.

This element of the equation may encourage an organization that is stringent in the profit and loss budgeting of its divisions to maintain a fully insured plan rather than self-insure. However, this element is often dismissed or diminished when the distribution of financial liability and impact is appreciated.

Related to cash flow and funding is the reserve amount, or Incurred But Not Reported (IBNR) liability. This amount represents the claims that have been incurred but have not yet been reported to the plan administrator on a particular date—for example, a hospital stay that is billed to the plan in the following month by the provider. An employer needs to know the plan’s total liability, and for that reason a lag study is conducted which assists in the calculation of the IBNR and supports the reserve amount (or “true up”) that the employer will be responsible for if the plan were terminated. An IBNR liability should be booked on the employer’s balance sheet to account for this ongoing liability.

In short, there are a variety of expected costs associated with managing the plan on a self-insured basis—such as expected claims and administrative expenses, including stop loss premiums, and expert guidance including actuarial assistance. As a result, a financial picture emerges which can help gauge the employer’s risk tolerance along with the total cost of self-insuring. If financial indications conclude that self-insuring is viable, the employer moves on to the second phase of the feasibility study.
Plan Design Considerations

Flexibility in plan design is achieved from a self-insured ERISA plan’s freedom from the numerous state benefit laws. This flexibility may be particularly important for multi-state employers, as freedom from state insurance laws will help the plan sponsor achieve consistency in its benefit design across geographic boundaries. This allows increased ease in administration and communication. Nevertheless, plan design in the self-insured context is not the “Wild West.” An array of benefit mandates still apply to the plan regardless of whether it is self-insured or fully insured, including a number of mandates under PPACA, the Mental Health Parity and Addiction Equity Act, and various other benefit laws that affect plan design. And further, non-ERISA plans (in particular, governmental plans) may remain subject to an array of state law mandates even if they are self-insured.

Adding to the attractiveness of becoming self-insured, self-insured plan sponsors have access to comprehensive claim data, which allows them to make informed decisions to redesign their plan consistent with their institutional DNA. Having this heightened level of knowledge allows for an in-depth review of plan management opportunities such as enhanced disease management, employee engagement, carving out the prescription program, etc. Further, self-insured plan sponsors may also be able to engage more specialized resources for disease management, technology solutions and the like that are not available to fully insured plan sponsors. However, greater access to claims data may also include additional obligations and responsibilities under HIPAA privacy and security regulations, as well as a greater possibility of potential HIPAA violations and data breaches.

Employers that are self-insured may be more nimble in making desired plan design changes. A self-insured employer can redesign its plan without the restrictions, delays, and costs involved in obtaining the approval of an insurer carrier. However, a self-insured employer’s flexibility can be limited by the stop loss coverage and/or contract, as well as the third-party administrator’s limitations.

Administration Considerations

To manage the administrative tasks that are typically handled by the insurance carrier in the fully insured environment, a third-party administrator (TPA) is usually engaged to handle a number of tasks associated with the management of the plan, including: enrollment; access to provider network; pharmacy benefit management, unless carved out to a different pharmacy benefits manager; claim appeals; preparing specific communications, including the Summary Plan Description and Summary of Benefits and Coverage (“SBC”); COBRA administration, unless sourced elsewhere; certain HIPAA privacy and security tasks; and, assisting with plan sponsor reporting requirements. Given the breadth of functions that a TPA may provide, and the significance and cost of those functions, selecting a TPA calls for a careful analysis of potential vendors. “BUCA” carriers (otherwise known as BlueCross and BlueShield, UnitedHealthcare, Cigna and Aetna) often operate as TPAs for self-insured clients. Other established,
high-quality TPAs outside of the BUCA carriers are worth considering as well. And an employer can choose to place the stop loss with a carrier facilitated by the TPA or with a separate stop loss carrier. A different analysis attaches to this process and is not addressed within the confines of this article. It “takes a village” to properly administer a self-insured group health plan. If the analysis to self-insure rather than fully insure the medical program continues to reflect that self-insuring is appropriate, then additional items worthy of consideration include banking arrangements, possible addition to staff or engagement of outside consultants or counsel, and general compliance considerations. However, none of these issues should serve as a roadblock to an employer that is prepared and financially able to self-insure.

Compliance Considerations

Self-insured plans face a number of compliance requirements that are not in play for fully insured plans. Some of these requirements have been alluded to already. A few of the more significant differences between fully insured plans and self-insured plans are detailed below.

- **Transitional Reinsurance Fee.** This fee was established by PPACA to offset risk incurred for certain high-risk individuals by insurance carriers in the Marketplace. While the fee is only in effect for the 2014, 2015, and 2016 calendar years, the fee is significant — at a rate of $63, $44, and $27 per covered life for those years, respectively. While the insurance carrier reports and pays this fee for fully insured plans, the plan sponsor (i.e., the employer) is responsible for doing so for self-insured plans. However, self-insured plan sponsors that also choose to be self-administered are exempt from the fee for 2015 and 2016.

- **Patient Centered Outcomes Research Institute (PCORI) Fee.** This fee was also established by PPACA, to fund research into making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings. Like the Transitional Reinsurance fee, the PCORI fee is borne by plan sponsors of self-insured plans. The PCORI fee extends for seven plan years (ending after September 30, 2012 and before October 1, 2019), and is a much lower overall fee (with the most recently paid fee amount being $2.00 or $2.08 per covered life, depending on the plan year, though this amount will continue to be adjusted for inflation in future years).

- **Health Insurance Industry Fee.** Not all of the fees created by PPACA fall on self-insured plans. An annual tax is assessed on fully insured premiums intended to fund premium tax credit subsidies through the public exchanges and Medicaid expansion. While fully insured plans must pay this fee, self-insured plans do not pay it.

- **HIPAA.** All covered entities, including health plans, are subject to HIPAA. But whereas fully insured plans that do not have access to protected health information (“PHI”) outside of summary health
information and enrollment information may consider themselves “hands off” plans with a more limited set of HIPAA obligations, self-insured plans do not have that option. Self-insured health plans must maintain detailed HIPAA privacy and security policies and procedures, and they must follow them carefully.

- **Nondiscrimination.** All plans that provide their benefits through a cafeteria plan (for example, if employee premium contributions are made on a pre-tax basis) are already subject to nondiscrimination rules under Section 125 of the Code. Self-insured health plans are also subject to another set of nondiscrimination rules under Section 105(h) of the Code. Like the Section 125 nondiscrimination rules, the Section 105(h) rules prevent discrimination by the plan in favor of highly compensated employees, though the definition of who is “highly compensated” is different between these two sets of rules.

Employers must remain mindful of other compliance considerations as well. Insurance carriers will complete and deliver an SBC to participants for a fully insured plan. Employers are responsible for completing this task for a self-insured plan. They can contract with a TPA to provide the SBC, as long as they monitor the TPA to ensure compliance. Further, self-insured plans are not required to offer essential health benefits (just as large group fully insured plans are not required to do so), but if they do offer any essential health benefits they cannot have an annual or lifetime dollar limit on the value of those benefits. Self-insured plans must choose a state “benchmark” plan for purposes of correctly defining which benefits are essential health benefits subject to the prohibition on annual and lifetime dollar limits.

The compliance issues noted above may cast another layer of doubt on some employers who are considering self-insuring their health plan. But they should not create that doubt. Rather, these items are relatively straightforward “to-do” list items that do not outweigh the overall benefits of self-insuring.

**Moving Forward and Other Considerations**

So let’s assume that self-insuring is an appropriate calculated risk for your organization. The transition process takes time and effort that most organizations will believe worthy of the outcome.

This change in funding also opens up the possibility to investigate a medical stop loss captive or a private exchange arrangement without losing autonomy. Both concepts are explored below.

**Medical Stop Loss**

As the costs of healthcare accelerate and regulations mount, self-insuring group medical benefits becomes increasingly attractive for a mid-size employer who has had good success with their program and therefore would be considered a good risk. Nevertheless, some employers remain wary of the costs, and potential rising costs, of obtaining an appropriate level of stop loss coverage. An employer has the opportunity to further control these costs by engaging in a captive program for medical stop loss coverage.
These programs typically provide protection against lasers, which is an underwriting practice allowing increases to the individual stop loss level for a known claimant, and allow mid-size employers who are highly engaged in the management of their programs with good success to band together with other like-minded employers leveraging their buying power to capture large employer pricing and risk management services.

Similar to deciding if self-insuring is an appropriate funding vehicle, an additional analysis specific to your organization is sensible when determining if engaging in a medical stop loss captive meets your organization’s business goals and objectives.

**Private Exchange**

A private exchange is a marketplace that empowers employees to take control of their health plan choices. If done strategically, a private exchange provides:

- More predictable benefit costs for the employer, if the employer provides a “defined contribution” approach to its benefit offerings.
- Greater employee choice among various plans, rather than limiting choice to two or three plans as selected solely by the plan sponsor.
- Increased employee engagement in the process of selecting their health plan and other benefits, with education for employees about their own levels of risk and an appropriate level of benefits to match that risk.
- No loss of autonomy because the organization can still:
  - Influence plan design
  - Impact contribution strategy
  - Self-insure the medical plan (and other coverage, e.g. dental, short-term disability)

While self-insuring can certainly be accomplished without using a private exchange arrangement, an increasing number of employers who self-insure are also considering a private exchange for the reasons noted above.

**Conclusion**

Deciding whether to self-insure your medical programs is complicated and a calculated risk. The evaluation process and analysis can be disciplined while logically revealing if self-insuring your medical program is fiscally prudent and warranted. Even if an organization is not yet sold on the concept of self-insuring, it may be worth “kicking the tires” with a feasibility study to see if the financial and other benefits of self-insuring make it an obvious choice.
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