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Benefits Perspectives

Current Issues in Employee Benefits

SUMMER 2003

• Will Employers Transform Healthcare?

• Self-Insured Healthcare Risk—Take It or Leave It?

Health Benefits by Association

by James T. O'Connor

As a small employer, do you wish you could offer your employees health insurance coverage or reduce the cost of your current plan? The “Small Business Health Fairness Act of 2003” currently under consideration in Congress aims to provide a new, federally certified outlet to lower healthcare costs for and expand healthcare coverage among small employers. Proponents of “association health plans” (AHPs) claim that health insurance would be more accessible and affordable by giving small employers some of the same advantages enjoyed by larger employers that self-insure their healthcare coverage under the Employee Retirement Income Security Act (ERISA), including an exemption from states’ mandated benefits laws and other state requirements. Critics assert that AHPs would worsen access to and affordability of healthcare, especially for those individuals most in need. In addition, AHPs might not be subject to state solvency requirements.

This article presents an overview of the small-employer healthcare market and discusses some of the advantages and disadvantages of AHPs.

Small Businesses and Healthcare

Once again the number of uninsured in the US is increasing, after a slight decrease during the business boom of the late 1990s, renewing public policymakers’ emphasis on the need to address this important issue. Most of the uninsured are employed by small employers (with fewer than 50 employees) or dependents of workers in the small-employer group sector. And when offered a plan, many employees of small businesses go without coverage due to affordability; others obtain coverage through their spouse’s plan or pur-

chase individual insurance. The latest Medical Expenditure Panel Survey conducted by the Agency for Healthcare Research and Quality shows the statistics for health insurance coverage by employer size (see Table 1).

The Bills Before Congress

The bills pending in Congress are H.R.660 and S.545. The House approved H.R.660 on June 19; no action has occurred on S.545, the Senate’s companion measure. The bills, which amend ERISA, have the support of the White House. Under the bills, AHPs:

- must be certified by the federal government, entailing sponsorship by a bona fide trade, industry, business, or professional association that exists “for substantial purposes other than that of obtaining or providing medical care.” An AHP must be established as a permanent entity actively supported by dues-paying members, must not condition membership, dues, and benefit coverage on the basis of health status-related factors, and must not condition membership and dues on participation in a sponsored health plan.

TABLE 1

CENSUS CATEGORY	EMPLOYER GROUP SIZE			
	Under 10	10-24	25-49	50+
Total Groups	3,635	783	318	1,520
% Offering a Health Plan	39.6%	69.3%	79.6%	96.8%
Percentage with No Plan	60.4%	30.7%	20.4%	3.2%
Total Employees	14,472	9,963	7,896	79,690
% Offered Health Plan by Employer	53.2%	75.2%	85.2%	98.1%

Source: 2000 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

- may offer fully insured coverage through health insurance carriers, self-insure benefits, or offer a combination of both.
- are exempt from the benefit mandates that many states require of group insurance plans.
- are subject to the insurance laws of only the state in which the group AHP is legally issued. AHPs that sell in multiple states have to adhere to the laws of only one state.
- must pay premium taxes and other assessments to the states in which they do business.
- are subject to specific reserve and surplus requirements to be established by law and regulation. Fully insured AHPs have no additional reserve and surplus requirements, but their health insurance carriers are subject to the requirements of the states in which they do business. AHPs that self-insure some or all health benefits would be subject to federal reserve and surplus requirements, some of which are spelled out in the bills.
- are subject to the Health Insurance Portability and Accountability Act (HIPAA) and its various provisions regarding guaranteed issue for association members, guaranteed renewability of plan coverage, portability of coverage, and prohibition against treating some employees or dependents in a group differently due to their health status.
- are regulated primarily by the Department of Labor (DOL), with states, primarily the state of plan domicile, retaining jurisdiction over certain aspects of the program.

Advantages of AHPs

The DOL, in support of the bills, maintains that ERISA preemption of the 50 state insurance regulatory systems has resulted in large employers and unions providing health benefits and that a similar structure could also help small employers. The DOL emphasizes that AHPs offer greater bargaining power, economies of scale, and administrative efficiencies, all of which can lead to lower premium rates. In addition, the bills include important safeguards, including federal certification; prohibitions on “cherry picking” by AHPs; “rigorous and nationally uniform” financial solvency standards; and consumer protections required by HIPAA.

Other proponents assert that AHPs introduce competition into the market, expand accessibility of coverage, lower premiums, increase the number of groups offering coverage, and reduce the number of uninsureds, while remaining subject to the rat-

ing and underwriting regulations of the plan’s issuing state. A Congressional Budget Office study last year estimated that enrollees in AHPs would have premium rate reductions averaging 9% to 25%, while those remaining in the traditional state-regulated market would experience rate increases averaging only up to 2%. People already covered would have extra discretionary income available and employers with lower health plan costs might be able to invest more in their businesses and in their employees through increased wages. A more recent CBO study projected that 7.5 million people from small employers and 1.0 million self-employed people would enroll in AHPs by 2008, with net new coverage of 630,000.

AHP Drawbacks

Those voicing opposition contend that AHPs will create serious problems for the current state-based small employer insurance system and ultimately result in a two-tiered health insurance system. Opponents’ chief fear is that AHPs will attract healthier and younger groups on average, leaving state-regulated plans with less healthy and older groups to cover, requiring premium rate increases. In turn, more healthy groups would then flock to the less costly AHP market, further causing adverse selection against state-regulated plans. Some believe that the anti-selection spiral could result in the death of the state-regulated health insurance market as we know it today. Furthermore, opponents argue that by allowing AHPs to pick the issuing state of their plans (a process referred to as “forum shopping”), the bills will result in undoing the consumer protections that states have carefully introduced into the small-employer insurance market. There are also concerns about the adequacy of the solvency requirements, lack of state controls over market conduct and fair marketing, and potential confusion regarding AHP oversight responsibilities.

Impact on States

Some states are more likely to be affected by the proposed federal AHP requirements than others. States that require pure community rating (i.e., charging the same premium for each employee based on his or her family composition) and tight rate banding (i.e., setting health insurance rates within a specific range from highest to lowest risk) for their small employer group carriers, as well as those with costly benefit mandates, are more exposed to adverse selection than states with relatively wide rating bands and few mandates.

For example, the state of New York requires use of pure community rating by small-employer group insurance carriers. Premium rates cannot vary by age or gender, unlike in most other states.

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Thus, an AHP domiciled in a state that allows age/gender rating could set its premiums for New York groups based upon the actual age/gender distribution of the group, while the state-regulated plan must charge the community rate. For large groups with distributions similar to the community, the two rates might not vary much (all other things being equal). But small groups rarely have distributions similar to the community. Therefore, the AHP rate is likely to be higher or lower than the state-regulated group (all other things being equal).

Younger groups with more male participation would have a lower premium rate under the AHP, while an older group would have lower rates with the state-regulated plan's community rate. The result could be younger groups moving to the AHP, leaving the state-regulated plan with an older average age of insured remaining. In turn, this would force the state-regulated plan to increase its community rate, making it less attractive to the younger, healthier groups that persisted the year with it. If healthy, they become more likely to switch to the AHP at the time of their next renewal. The fact that the AHP can also lower its rate by excluding coverage for state-mandated benefits and may be able to vary its rates based upon health status intensifies the disparity in rates that could occur in community-rated states, particularly for mini-sized groups.

To illustrate this through example, consider two different groups in the Syracuse area, each with four single employees. Table 2 shows the sample group censuses and the resulting premium rates offered by the unbridled AHP and by the state-regulated community-rated plan. Benefits are identical (e.g., \$250 deductible, 80%/20% coinsurance to \$1,250 out-of-pocket including the deductible), except that the AHP chooses not to cover mental health and substance abuse services.

TABLE 2

SAMPLE PREMIUM RATE COMPARISON		
	GROUP 1	GROUP 2
Employee 1	Male Age 25	Female Age 27
Employee 2	Male Age 32	Female Age 35
Employee 3	Male Age 37	Male Age 45
Employee 4	Male Age 46	Male Age 57
AHP Premium Rate*	\$738.17	\$1,431.64
State-Regulated Rate*	\$1,288.85	\$1,288.85
Ratio of AHP to Regulated	57.3%	111.1%

* Based upon the Milliman USA *Health Cost Guidelines* (7/1/2002 edition) and an 80% target loss ratio.

As the example shows, Group 1 subsidizes Group 2 under the state-regulated community rating market, but each group is rated on its own characteristics in the AHP market. The temptation to move to an AHP would be great for Group 1, but for this year would make no sense for Group 2. While this example is extreme, more skewed examples could be illustrated. States that allow age and gender rating but limit other rating characteristics will experience less rating variance from AHPs, but will still be affected, albeit to a lesser degree.

The example illustrates that the AHP proposal will make health insurance more affordable to younger people who comprise the majority of the uninsured, provided that they are in a younger and healthier group than average. The proposal is also likely to result in increased rates for those groups that stay in the state-regulated market.

Conclusion

As with most legislation, there are likely to be winners and losers. Healthy groups that today subsidize less healthy groups could benefit from passage of the bill, while the less healthy groups could end up paying more for coverage (receiving less subsidy). Of course, today's healthy group could tomorrow become unhealthy. Uninsured groups could be beneficiaries of the bill if enacted into law since it could make health plans more accessible and affordable to many. Certain health providers, particularly those that specialize in the types of mandated services that may be excluded in AHPs, could also be losers if Congress approves the bill.

If the bill becomes law, states will need to assess the extent to which their small-employer insurance laws and regulations will expose state-regulated health plans to adverse selection and possibly revise some of the current rules to minimize the impact on the plans and groups insured by the plans. Health insurers will need to decide whether to align themselves with associations to create AHPs and how their current small-employer group business will be managed alongside any AHPs they may insure. And small employers will have to decide whether to obtain health-care coverage through an AHP based on premium rates in addition to considering the reputation of the health plans, the benefits offered, and the provider networks available.

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Will Employers Transform Healthcare?

by Steve Cigich

The healthcare marketplace is undergoing sweeping changes driven in part by innovations adopted by employer-sponsored health plans. In many respects, the transformation is similar to the successful business model that Amazon.com adopted in the retail market. First, Amazon.com created a strong consumer base by allowing its customers to conveniently find and purchase books. To further compete in the ever-changing world of web retailing, Amazon.com expanded its offerings and vendors, giving its customers a centralized location from which they could navigate and purchase a myriad of products.

But Amazon.com does more than simply provide a meeting place for buyers and sellers. It also creates standards by providing product comparisons and consumer feedback. By imposing standards and measurements that give consumers

the ability to intelligently comparison shop for price and quality, Amazon.com has generated strong customer affinity and in turn is creating new behaviors in the retail business.

Amazon.com's consumer-driven transformation may be a model for solving rising healthcare costs, improving care, and educating healthcare customers. This article explores how some employers are working to change healthcare consumer behavior and are similarly transforming the healthcare marketplace.

Healthcare—An Uncontrollable Labor Cost?

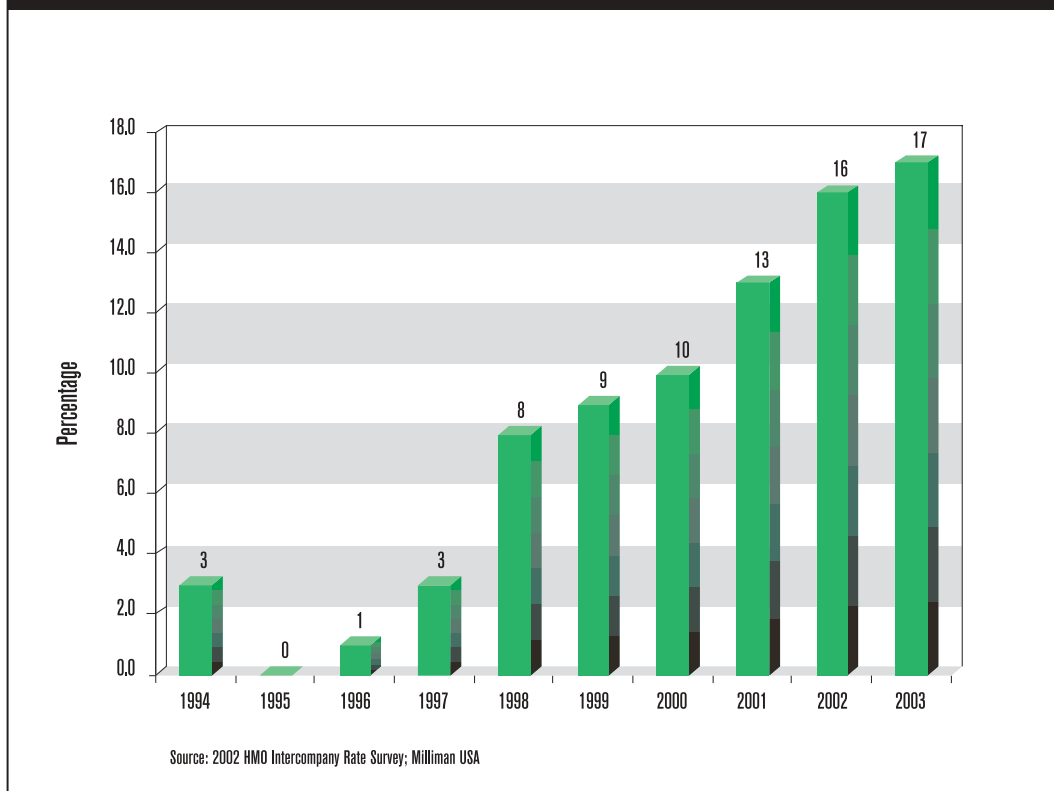
Of all the major healthcare players (e.g., healthcare systems, hospitals, physicians, health maintenance organizations (HMOs), insurers), employers have the closest affiliation to the consumers of healthcare: their employees. Employers

provide work places, incomes, and funding for healthcare benefits as part of a vested and shared interest with their employees. After all, healthy workers are productive workers.

The well-documented rise in healthcare costs increasingly strains employers' ability to fund healthcare benefits. In the HMO area alone, premiums have steadily increased over the past six years, and are now more than double the amount they were in 1998 (see Table 1). Employers cannot eliminate their employee's healthcare benefits without suffering significant repercussions, yet they cannot continue to fund a benefit doubling in cost every four to five years.

TABLE 1

HMO REPORTED ANNUAL RPREMIUM CHANGES



Managed Care Yields to Consumer-Driven Care

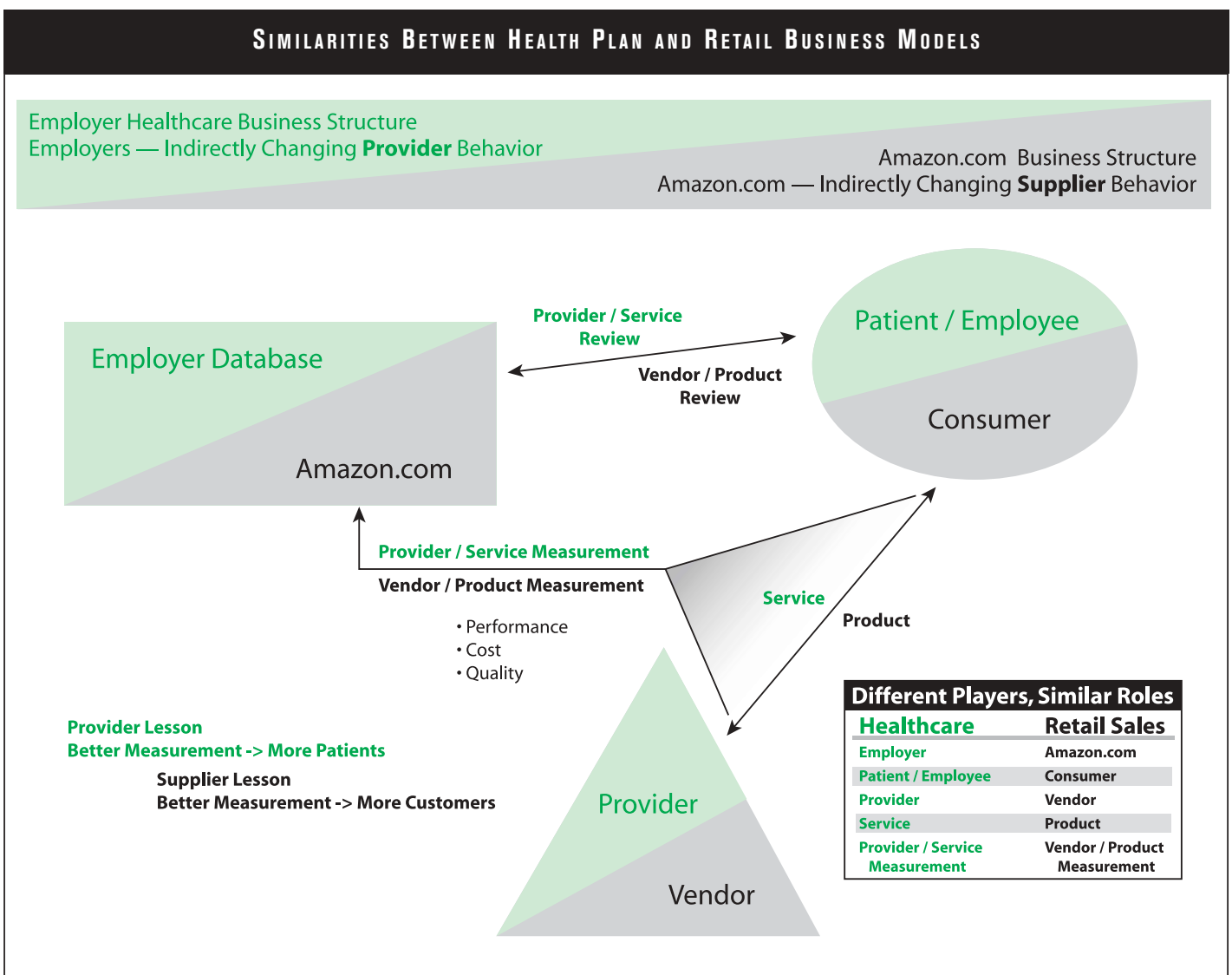
The managed care industry's approach to healthcare has attacked provider prices for more than a decade. While still an approach for lowering costs, it is becoming a strategy with limited returns. Also, managed care's attempt to address healthcare usage by "managing" the interaction between patients and providers resulted in backlash from both parties, limiting its effectiveness.

With the managed care health model sputtering, there is a rise in "consumer-driven" benefit designs. Such designs typically involve more employee cost sharing, education, and personal accounts, either using the traditional flexible spending account

(FSA) or the emerging health reimbursement arrangement (HRA). Some employers are also working harder to educate employees on health matters and interacting with providers in ways that promote quality and efficient care. The roles become similar to the Amazon.com business model (see Figure 1).

While consumer-driven approaches vary, all provide employees a financial incentive to use healthcare more responsibly. But consumers may become frustrated when seeking care if they lack the ability to determine the best healthcare for their money. Something else is required if consumers are to make intelligent healthcare choices. Employers are finding themselves in a unique situation to fulfill this need.

FIGURE 1



Employers Find Strength in Numbers

Employers can play a key role in promoting performance measures and standards for healthcare. Acting in informal groups or formally through coalitions, some employers are using their position in the healthcare “demand chain” to leverage their affinity with their employees, aggregate data, develop measurement standards, use those standards to hold community healthcare providers accountable, and communicate information to their employees.

Using aggregated information and standards, some employers are judging providers, creating differentiated provider networks, redesigning employee benefit plans, or negotiating provider payments. Employees who are armed with summary information may better navigate the healthcare system to find the right provider at the right price for them. Providers may also find summary information beneficial to aid in their improvement relative to the standards.

Though individual employers may lack sufficient data and community influence, when bound together their actions become stronger. For these employer groups, the time has come to use their employee affiliation, technology, and community power to improve healthcare delivery in their communities. Each organization addresses the problem differently based on their local community assets. Each is implementing programs to create and impose measurement standards on providers, to disseminate this information to employees, and to help employees navigate the healthcare system.

Employers Taking Charge

Examples are found across the country of employers banding together and using their influence to improve healthcare. Like Amazon.com, these employer groups are evolving. Employer groups, most of which started out as “purchasing” coalitions, used their size to negotiate better unit price contracts from providers or to select “preferred” vendors. Today, some of these groups are using their size to create broader solutions based on creating and using measurement standards.

- In Orlando, Florida, the Central Florida Health Care Coalition is creating a “Pay for Performance” model, which will align incentives throughout the healthcare system to promote quality and effective patient care for coalition members. The Pay for Performance program uses Milliman USA to help in analyzing data mostly from the area’s largest

employers’ combined health plan experience, developing provider measures, placing providers into performance-based tiers, and designing employee benefits to encourage use of “platinum” providers (those providers with proven, highly successful healthcare outcomes).

The coalition’s CEO Becky Cherney, states, “The power of the program is to contract with providers in a way that drives improvement using actionable experienced-based data.” Pay for Performance goes beyond the coalition’s previous efforts, which improved local care and reduced some costs, but not for all parties involved. She sees the value of working with other employers through the coalition as a critical component to its success. “Even the largest single-site employer in the world realizes that, when acting alone, it doesn’t have sufficient clout in the provider community. But acting alongside other area employers, they cannot be ignored,” Cherney emphasizes.

- HealthCare21, an employer- and provider-based coalition in Knoxville, Tennessee, is using data obtained through the Leapfrog Group on hospital safety measures. Other groups are also using data from the Leapfrog Group, which is a coalition of 115 public and private organizations that provide healthcare benefits to more than 32 million Americans and was formed to promote patient safety and quality measures.

HealthCare21’s goal is to provide consumers information that will enable them to choose safe and effective hospitals. This process puts a spotlight on what hospitals need to do to improve care, specifically: using a computerized physician order entry system, achieving volume levels for certain procedures, and properly staffing intensive care units. Each of these three measures has been shown to reduce clinical errors and enhance clinical outcomes.

By working with innovative employers that are willing to leverage their affinity with their employees, “we are moving the market to better healthcare for all people in our region,” states Healthcare21’s CEO Jerry Burgess, who notes that early reports indicate a significant improvement occurring at many local hospitals.

- In Boston, Cincinnati, and Louisville, some of the nation’s largest employers and health plans have joined forces to cre-

ate “Bridges to Excellence,” which is designed to provide a positive return to both the business purchasers of healthcare and the providers of care while yielding higher quality care. While firmly convinced that Bridges to Excellence is fundamentally good for the communities served, the program’s founders also believe a business case can be made for their efforts, that is, businesses can receive a positive return on investing in systems designed to create quality healthcare. Bridges to Excellence gives a voice in the program’s development to all stakeholders and ensures business gains are attainable by all stakeholders.

The program has identified three critical clinical processes for measurement: care management; patient education and support; and evidenced-based clinical information and decision-support systems. Incentives are paid to providers meeting performance targets from a pool of money set aside by the purchasers and derived from savings from preventing the misuse, overuse, and underuse of care. The incentives currently reward diabetes care and patient management systems, with cardiovascular care to be launched later this year.

Conclusion

Aggregating data and applying measures for safety, efficiency, and effectiveness are designed to lead to lower costs and high-

er quality care, results that will be welcomed by employers and employees alike. As managed care yields to consumer-driven care, employers may need to look beyond “simply” implementing consumer-driven healthcare benefit designs and consider the extra effort required to affordably create healthy employees and families.

The early stages of healthcare’s consumer-driven transformation look similar to the Amazon.com Internet retail model. Some of the more innovative employer-sponsored healthcare plans are applying that model’s successful approach by aggregating the purchasing data between their employees/consumers and the providers/vendors. They are determining product/service standards and measures, assessing quality and cost, and enabling employees to comparison-shop for their healthcare intelligently and responsibly. These employers are creating an environment for improving the quality and cost of healthcare. They are driving change, and they are transforming health care.

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Self-Insured Healthcare Risk—Take It or Leave It?

by Nickolas J. Ortner

With healthcare costs skyrocketing, employers that provide health benefits to their employees by purchasing coverage from an insurer or a health maintenance organization (HMO) should evaluate whether they are leaving money on the table. When making this evaluation, fully insured employers should review a broad range of factors, including current administration costs, medical cost trends, benefit plan designs, and healthcare provider networks to determine whether financial savings and greater flexibility and choice might be available elsewhere.

This article examines key components that employers should consider when evaluating whether to cover their employee healthcare risk on their own (i.e., be self-insured) or to purchase healthcare coverage (i.e., be fully insured).

Self-Insured Versus Fully Insured Plans

Self-insurance, also known as self-funding, is a financing arrangement under which the employer directly pays for employees' health benefits and assumes the risk to pay the medical claims. Self-insured employers typically contract with a third-party administrator (TPA) to provide enrollment, eligibility, claim, and other administrative services. The TPA could be an insurer or HMO that offers stand-alone administration services to self-insured employers. Only some of the very largest employers have the resources and the desire to administer the benefits themselves. By contrast, a fully insured employer pays a fixed premium to an insurer or HMO, which in turn assumes the risk to pay the healthcare claims.

Advantages of Self-Insuring

Self-insuring a health plan offers several advantages over a fully insured plan:

- **Annual cost savings:** Self-insured employers that contract with a TPA for administrative services might save costs in three areas:

1. **Baseline administration:** The TPA's baseline administration charge might be lower than the administration costs underlying the fully insured premium rates. Overall,

administration fees for self-insured plans usually range from 5% to 7% of total costs (medical claim costs plus administration fees), compared with fully insured loads of 10% of premium or more. Competitive self-insured administration fees and fees the employer pays for its employees to access the TPA's preferred provider organization (PPO) networks typically fall in the following ranges:

- *Claim administration:* \$15 to \$25 per employee per month (PEPM)
- *Utilization review:* \$1.50 to \$3.50 PEPM
- *Pharmacy administration:* \$0.15 to \$0.50 per retail claim, excluding any rebates that TPAs receive and sometimes share with the employer, as specified by contract
- *PPO access:* \$2 to \$5 PEPM for access to the primary PPO network and, for access to a secondary PPO network composed of healthcare providers not in the primary network, a fee of 15% to 25% of savings the employer realizes from discounts on claims that otherwise would have been paid in full

2. **Insurer profit and risk charge:** A fully insured employer's premium includes a load to reflect the insurer's profit goals and to cover the risk that the employer's claim experience will be worse than projected. On the other hand, self-insured employers pay no profit and risk charge. Savings could range from 1% to 5% of the employer's fully insured premium rate, depending on the insurer and the size of the employer.

3. **State premium tax:** Depending on the state, fully insured employers pay a load of up to 3% of premiums to cover state-imposed taxes that the insurer passes on to the employer. On the other hand, a self-insured employer pays no premium tax.

- **Savings realized by avoiding high medical cost trends in renewal projections:** Insurers might assume conservatively high medical cost trends in developing the employer's fully insured renewal premium rates to protect themselves against potential adverse experience for the upcoming renewal

period. An employer will likely only realize any savings from avoiding an insurer's use of high medical cost trends in the renewal premium projections in the first year an employer switches to a self-insured arrangement. In the long run, the self-insured employer's actual claim costs will approximately equal the claim costs underlying the employer's fully insured premium rate. Thus, an employer should not use claim experience as a compelling factor in deciding whether to fully insure or self-insure healthcare benefits.

- State mandated requirements:** The Employee Retirement Income Security Act (ERISA) considers self-insurance arrangements to be employee benefit plans rather than insurance contracts. Therefore, unlike fully insured plans, self-insured arrangements are not subject to certain state laws, such as requirements that mandate coverage of specific benefits or that prescribe remedies, access to care, and procedural rules. The estimated costs of mandated benefits and other state law requirements vary by state.
- Cash-flow gains:** Self-insured employers could realize cash-flow gains from holding their own claim reserves. Cash-flow gains could represent 1% to 2% of premium in higher interest rate environments. In a fully insured arrangement, the insurer is the party that usually keeps investment income earned on claim reserves.
- Benefit plan design flexibility:** In a fully insured arrangement, employers are locked into the benefit plans offered by the insurer. On the other hand, the self-insured employer has the flexibility to determine the covered benefits, employee cost-sharing levels, and other plan design elements.
- Greater PPO network choice and flexibility:** Employers with a fully insured PPO benefit plan are often bound to the insurer's healthcare provider network. In addition, the insurer's network might not include certain hospitals or physicians desired by employees. For a self-insured plan, TPAs might be able to offer and contract with a variety of PPO networks (subject to network access fees) to give the self-insured employer greater network choice and flexibility.

TABLE 1
ESTIMATED PROBABILITY OF CLAIMS
IN EXCESS OF PROJECTED ANNUAL BUDGET
TYPICAL SELF-INSURED MEDICAL PLAN

Group Size	Estimated Probability of Exceeding the Projected Annual Claim Budget by				
	# of Employees	0% to 5%	5% to 10%	10% to 15%	> 15%
200		14%	10%	8%	18%
500		19	14	9	8
1,000		26	14	7	3
2,500		35	13	2	< 1
5,000		43	7	< 1	< 1

Potential Disadvantages of Self-Insuring

The primary disadvantage of self-insurance is that employers are subject to annual fluctuations in claim costs that the insurer absorbs for a fully insured plan. Even if the self-funded employer purchases stop-loss insurance to pay claims exceeding a threshold per individual (i.e., specific stop-loss coverage), it could still experience overall claim fluctuations. Although an employer can purchase aggregate stop-loss coverage to protect itself against overall claim fluctuations, aggregate stop-loss insurance is often a poor value for larger employers. Of course, favorable claim fluctuations produce savings for the self-insured employer.

Table 1 summarizes Milliman's estimates of the probabilities that a self-insured plan will exceed a projected annual claim budget based on monthly medical claims of \$620 per employee and assuming a \$250,000 specific stop-loss deductible. For example, Table 1 shows that a 200-employee group has a 14% probability that actual medical claims will exceed the projected annual budget by 0% to 5%.

Overall, Table 1 shows that a self-insured employer of any size should expect annual claim experience fluctuations due to statistical variation, even with a \$250,000 specific stop-loss deductible. The statistical variation shown reflects random variation only and assumes accurate projection of the annual claim budget.

In addition, a smaller group experiences greater variation from the projected annual claim budget than a larger group. For example, a 200-employee group has a 26% probability of exceeding the projected annual claim budget by 10% or

more, compared with about a 2% probability for a 2,500-employee group.

Other disadvantages to self-insuring include:

- **More compliance responsibilities:** Under a fully insured arrangement, the insurer is solely responsible for ensuring that the health plan complies with various regulations, such as state insurance laws and the Health Insurance Portability and Accountability Act (HIPAA). Under a self-insured arrangement, the employer and TPA share compliance responsibilities.
- **Less competitive healthcare provider reimbursement arrangements:** Some insurers are able to negotiate more favorable reimbursement arrangements from hospitals, physicians, and other healthcare providers than the terms that a TPA obtains for a self-insured employer. Even if an insurer serves as the self-insured employer's TPA, there is no guarantee that the employer will receive the same healthcare

provider reimbursement arrangements as it would with a fully insured plan.

- **Direct accountability and responsibility for benefit decisions:** While an employer has greater benefit design flexibility with self-insurance, a self-insured employer also assumes direct accountability and responsibility for benefit decisions and complaints.

Table 2 (below) summarizes the features associated with self-insured and fully insured health plans.

Other Considerations

In addition to considering the features associated with fully insuring or self-insuring healthcare coverage, employers should take into account:

- **Group size and financial asset sufficiency:** Employers must have a sufficient number of employees over which to spread the risk of high-cost claims to benefit from self-insur-

TABLE 2

FEATURES ASSOCIATED WITH SELF-INSURED AND FULLY INSURED HEALTH PLANS		
FEATURE	SELF-INSURED HEALTH PLANS	FULLY INSURED HEALTH PLANS
Costs and Other Financial Issues		
Baseline administration costs	Fees usually range from 5% to 7% of total costs	Administration loads of 10% of premium or more
Insurer profit and risk charge	None	1% to 5% of premium
State premium tax	None	Up to 3% of premium
Savings realized by avoiding high medical cost trends in renewal projections	Perhaps in the first year of self-insurance	None
State-mandated benefits	Employer option to cover	Required to cover
Cash-flow gains	1% to 2% of premium in higher interest rate environments	None
Risk and claim cost fluctuations	Employer is subject to annual fluctuations	Insurer absorbs annual fluctuations
Healthcare provider reimbursement levels	Might be higher (i.e., less competitive)	Might be lower (i.e., more competitive)
Benefit Plan Issues		
Benefit plan design flexibility	Employer determines covered benefits, employee cost-sharing levels, and other plan design elements	Employers locked into what the insurer offers
Benefit decision accountability and responsibility	Assumed by employer	Assumed by insurer
Other Issues		
PPO network choice and flexibility	TPAs might provide larger networks and greater network choice and flexibility	Employers bound to the insurer's healthcare provider network
Compliance responsibilities	Share with TPA	Insurer is the only party responsible

ance. As shown in Table 1, the smaller the group, the more likely actual medical claims will exceed the projected annual budget by greater than 15%. An employer with at least 500 employees might consider self-insuring, although there are employers that self-insure below that threshold. In general, a majority of employers with 500 or more employees self-insure some or all of their healthcare coverage. The percentage of employers that self-insure also tends to increase with group size (i.e., a larger number of employers with 1,000 to 2,500 workers self-insures than employers with 500 to 1,000 employees). In addition, self-insured employers should have sufficient financial assets to withstand potential year-to-year claim fluctuations.

- **Claim reserves:** In a fully insured arrangement, the insurer establishes a reserve for claims incurred but not paid. The premiums that the fully insured employer pays reflect the claim reserve (i.e., the insurer bases the fully insured employer's premiums on incurred claims). In a self-insured arrangement, the employer is responsible for establishing a reserve for claims incurred but not paid. The amount held in a self-insured employer's claim reserve is not tax deductible unless prefunded through a nonrevocable trust.
- **Insured arrangement variation by type of coverage:** Employers do not necessarily have to pick a single financing arrangement for all of their healthcare coverage. For example, employers commonly fully insure their HMO coverage because of the availability of low premium rates and favorable healthcare provider reimbursement arrangements. The same employers elect to self-insure their high-cost indemnity coverage because doing so offers significant potential savings.

In addition, TPAs might also offer large networks of healthcare providers with whom the TPAs have negotiating clout.

- **TPA selection criteria:** Administration fees and healthcare provider reimbursement levels are typically the key factors that self-insured employers consider when selecting a TPA. Beyond costs, self-insured employers also should assess a TPA's breadth, depth, and quality of the available healthcare provider networks and customer service, reporting, and analytical capabilities and guarantees.
- **Administration of coverage other than healthcare:** Coverage other than healthcare (e.g., life and disability) requires different expertise and knowledge than healthcare coverage. Therefore, an employer should evaluate the feasibility of self-funding and the resulting choice of an administrator separately by coverage. The feasibility of self-funding coverage other than healthcare will depend on the number of employees covered and total dollars involved.

Conclusion

Each employer must make its own decision to self-insure or fully insure by taking into account all of the factors discussed and issues raised. Employers also might consider using a hybrid of fully insured and self-insured arrangements (i.e., alternative funding arrangements) to realize some benefits of both fully insured and self-insured plans.

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