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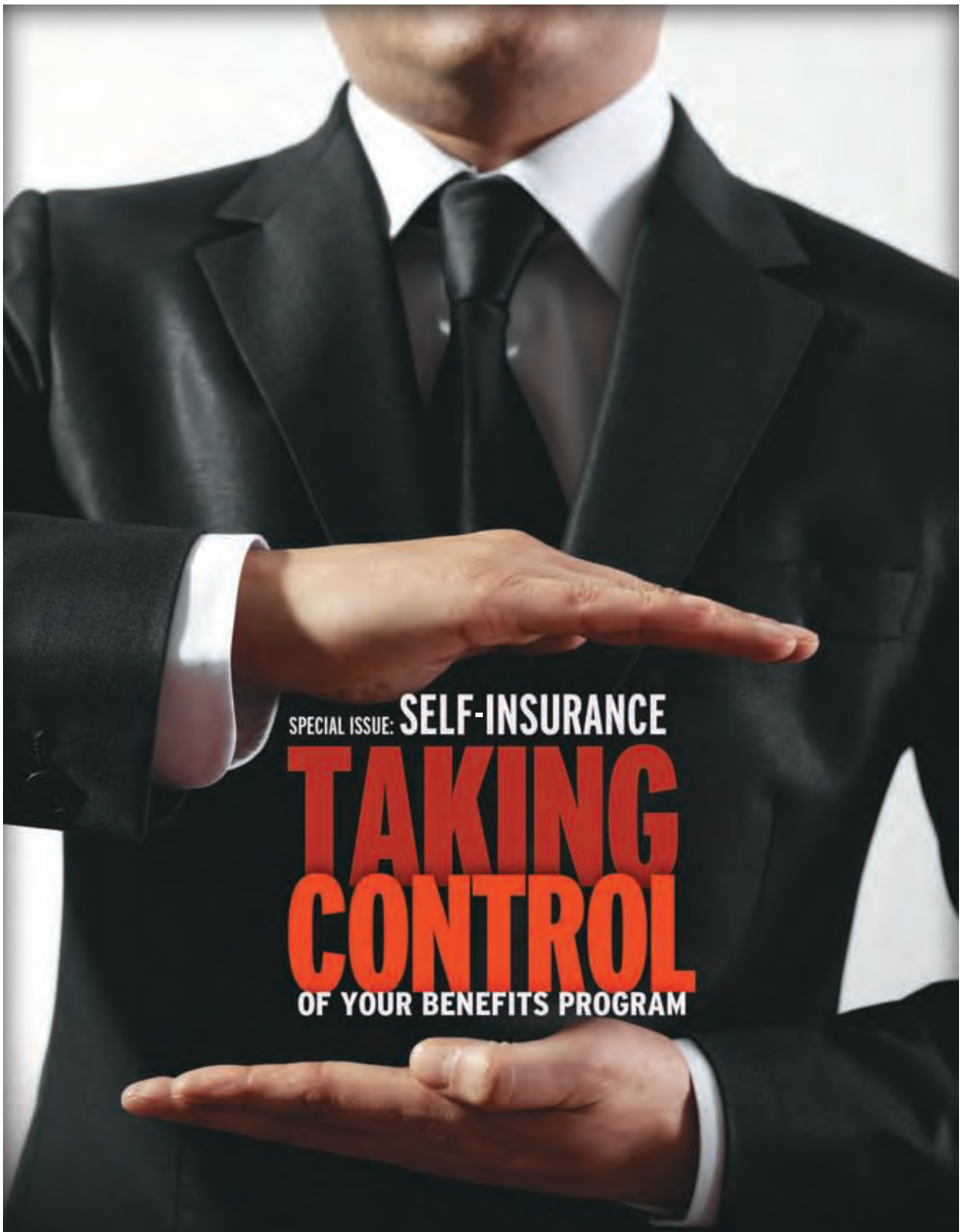

Rising costs, health care reform law create more interest in self-funding

By JOANNE WOJCIK

As health care costs continue to climb, many midsize employers are turning to self-funding as a cost-effective way to provide health benefits to their employees.

Fifty-eight percent of employers with 200 to 999 employees self-funded their health care programs in 2010, up from 44% in 1999, according to the annual Kaiser Family Foundation/Health Research & Education Trust Survey of Employer-Sponsored Health Benefits.

Even though middle-market self-funding lost some ground in 2011, dropping to 50% of midsize employer plans, it is expected to regain its upward momentum as the economy picks up, and in response to the federal health care reform law.

Although self-funded benefit plans are subject to many of the coverage requirements imposed by the Patient Protection and Affordable Care Act, such as unlimited annual and lifetime benefits, the cost of self-funded benefit plans will remain lower than fully insured plans because they are not subject to state benefit mandates or premium taxes that add to plan costs, experts say.

New minimum medical loss ratio requirements for insurers under PPACA also are expected to prompt more employers to switch to self-funding. Under the law, insurers must spend 85% of premium dollars collected from groups of 100 or more on medical care, leaving only 15% for overhead costs, including broker commissions.

Before PPACA, commissions generally were included in premiums. But beginning in 2012, these intermediaries will be forced to seek compensation directly from insurance buyers, which some experts say could add to the cost of fully insured health benefit programs.

See **SELF-INSURE** next page

SPECIAL ISSUE

SELF-INSURANCE FOR MID-MARKET FIRMS

Self-insuring benefits plans has long been seen as an attractive option for large employers. The cost savings and flexible plan designs that can be achieved are a big draw for organizations struggling to offer meaningful benefits in an era of escalating health care costs.

Increasingly, self-insurance is also becoming a serious option for midsize and smaller firms. The ready availability of stop-loss coverage to cap liabilities and the proliferation of service providers with the expertise to advise on and administer self-insurance programs has broadened the range of companies that self-fund health care benefits. And as the mandates of the health care reform law kicks in, more organizations are expected to opt for self-insurance.

In this special edition of *Business Insurance*, we examine the pros and cons of self-insurance, and offer practical advice from industry experts on what midsize employers, and other organizations considering self-insurance, should do as they examine their benefits options.

In addition, our fold-out data poster provides insights into scope of self-insurance and how the self-funding trend is developing among midsize employers.

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Moreover, because self-insured plans are governed by the Employee Retirement Income Security Act, self-funded employers will continue to be able to design benefit programs that are exempt from state benefit mandates and premium taxes.

While stop-loss coverage—which 90% of midsize self-funded employers purchase, according to the KFF/HRET survey—is subject to premium taxes, the total paid is considerably less because the premiums are far less than fully insured benefits, experts note.

Self-funded employers also will retain the flexibility to make value-based plan design changes that deter employees from using expensive providers or nonessential services or to encourage healthy behaviors. By contrast, insured programs still must meet state insurance regulations, which do not permit such modifications.

Self-funding also will continue to make claims and health care utilization data transparent, allowing employers to identify what drives their health costs and direct their programs to prevent disease and better manage employees already suffering from chronic conditions.

Because insured products often are community-rated, in which all employers in an area or industry pay the same regardless of their group's health status, an individual employer rarely benefits from wellness initiatives because pricing is applied almost universally across the group.

Until recently, using self-funding as a cost-containment strategy was out of reach for many smaller and midsize companies because many third-party administrators and insurers that administer self-funded benefits programs were reluctant to contract with employers with fewer than 1,000 employees.

Many midsize employers also shied away from self-funding because insurers were unwilling to share claims data, making it difficult to gauge the risk employers would assume or obtain reasonably priced stop-loss coverage.

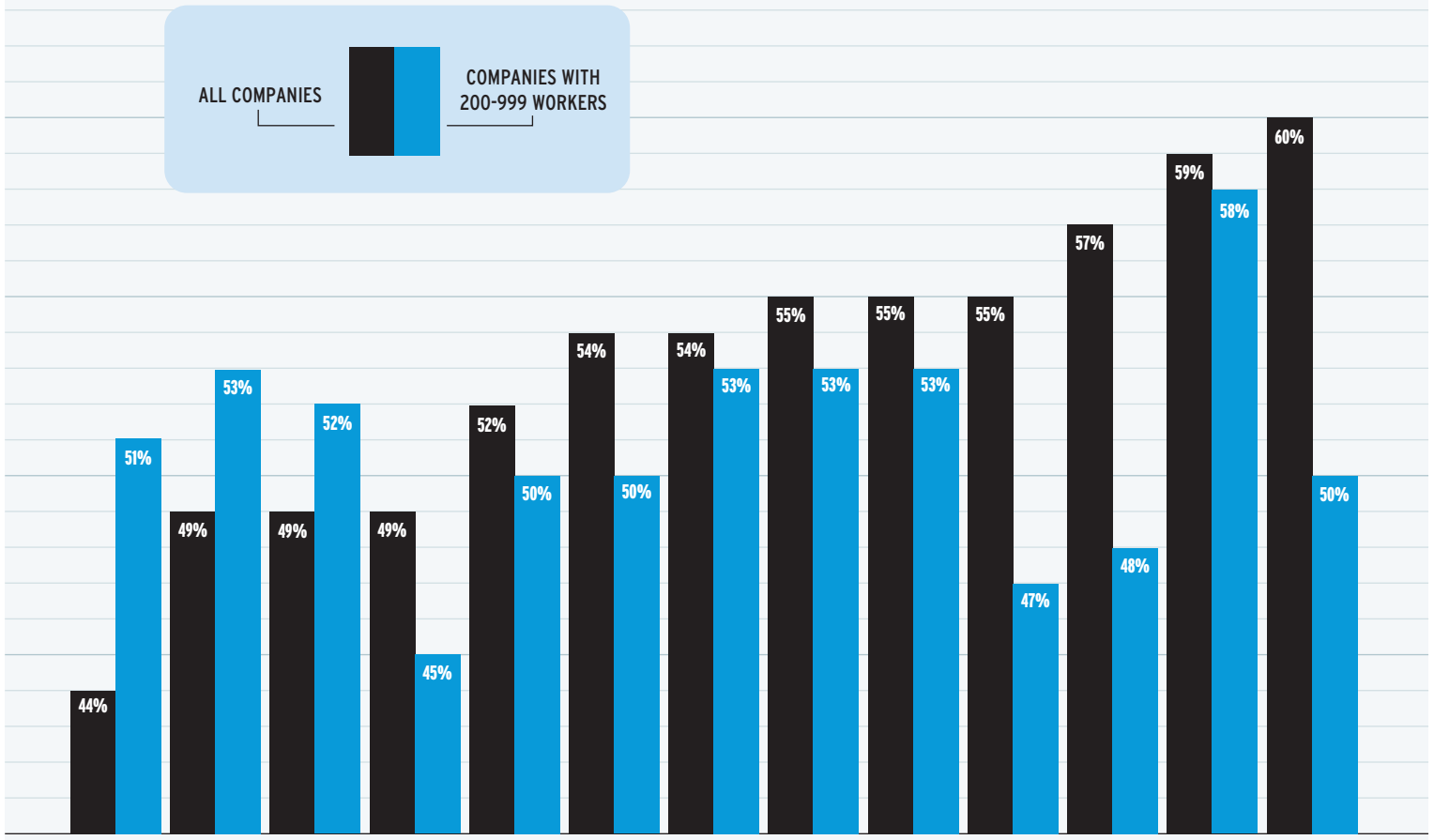
However, predictive modeling enhancements and the availability of reasonably priced stop-loss coverage with lower specific deductibles have made self-funding a feasible alternative for many smaller and midsize employers faced with escalating health benefit costs.

"Stop-loss insurance is more readily available now than it has been in the past," said Aron Minken, a director at PricewaterhouseCoopers L.L.P. in New York. "Carriers are offering greater protection for smaller companies. We've seen companies with rather

See SELF-INSURE page 6

GAINING POPULARITY

Percentage of covered workers in partially or completely self-insured plans



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2011

Midsize employers drawn to flexibility of self-funding

By JOANNE WOJCIK

Though most health benefits experts agree that self-funding generally costs employers less than fully insured plans, the greater flexibility it provides often is the key selling point with middle-market employers, they say.

Because self-funded benefit plans are governed by the federal Employee Retirement Income Security Act, they are exempt from state benefit mandates that often drive up the cost of coverage. Moreover, employers can make benefit plan changes as needed without having to wait for their annual insured plan's renewal, experts say.

And though there is always the risk of claims volatility, self-funding can provide cash-flow advantages for employers during times when claims experience is good, the experts say.

According to Mark Meade, a self-funding expert in Chester, Md., who is updating "Self-Funding of Health Care Benefits," a guidebook published by the International Foundation of Employee Benefits Plans, there are five primary areas in which a self-funded plan will be measurably and significantly less costly than a fully insured plan: premium taxes, cash flow, mandated benefits, administrative overhead and profits (see box, page 6).

"If you do well, you hold your own reserves and the profit comes to you, not the carrier. And, in the good years, you can build up reserves" that can be tapped in years when claims costs are high, Mr. Meade said.

Self-funded employers also are exempt from "risk charges" that insurers levy on plans they think might have poor claims experience, according to Robert J. Melillo, national vp of risk financing solutions at USI Insurance Services L.L.C. based in Meriden, Conn.

"The insurer is in the business of taking risk. They will look at an employer's demographics and claims experience and come up with an estimate of future claims. But there's always a risk that the claims will be in excess of that estimate. So they charge a fee that takes this into consideration," he said.

Besides cost savings, self-funding gives employers greater flexibility in determining plan design, in some cases enabling them to make changes in the middle of a plan year, according to James Rivetts, president of JLR & Associates L.L.C., a benefit consultant in North Bend, Wash.

"We have quarterly meetings with employers to review claims and tweak plan design based on claims experience. That's the nice thing about being self-funded. You can change the plan every month, if you want," he said.

Employers that self-fund also have greater access to claims data, enabling them to direct wellness and health risk management programs at problem areas, according to Andrew Bloom, executive vp of operations at Corporate Synergies Group L.L.C., a middle-market insurance broker in Mount Laurel, N.J.

Because products that employers buy from insurers are often community-rated, with all employers in a given geographic area or industry paying the same premiums regardless of their group's health status, the employers rarely benefit from such wellness initiatives. Even when one group's experience improves, it still is pooled with other employers to come up with a manual premium rate that is applied almost universally across an insurer's book of business.

However, "when a company goes self-funded, they're more interested in wellness, disease management and value-based benefit design. They're controlling their own destiny. Alternative funding lends itself to these types of creative solutions that enable you to control costs," Mr. Bloom said.

"If you feel that you've got a healthy population, and the demographic is good, and you want to have better control over your costs and more flexibility in plan design, that's when you look at self-funding," said Martin Watson, CEO of SeeChange Health Insurance Co., a San Francisco-based provider of value-based insurance design programs for small and midsize employers.

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SELF-FUNDED SAVINGS

Five primary areas in which a self-funded plan will be measurably and significantly less costly than a fully insured plan

- **PREMIUM TAXES:** Savings range from **1.5% TO 3.5%**
- **CASH FLOW:** Savings range from **1.5% TO 3%**
- **MANDATED BENEFITS:** Savings range from **5% TO 7%**
- **ADMINISTRATIVE OVERHEAD:** Savings range from **15% TO 20%**
- **PROFITS:** Savings range from **2% TO 4%** of premiums.

Source: International Foundation of Employee Benefits Plans

Reform law could fuel self-funding

By JOANNE WOJCIK

The passage of health care reform is likely to further accelerate the growth of middle-market self-funding.

Starting in 2014 under the Patient Protection and Affordable Care Act, companies with 50 or more employees either must offer health care coverage or pay a per-employee fee to the government. While smaller companies will be able to purchase health care benefits via state insurance exchanges created in response to such legislation, health care benefits experts expect many employers with 100 or more employees will opt to self-fund rather than buy commercial coverage.

Although self-funded benefits will be subject to many of the same coverage requirements imposed on insured plans, such as providing coverage for what the Department of Health and Human Services deems are "essential benefits," the cost of self-funded benefit plans will continue to remain lower than that of insured plans because self-funded plans are not subject to state benefit mandates or premium taxes that add to plan costs, experts say.

And while stop-loss coverage—purchased by 90% of midsize employers that self-fund—is still subject to premium taxes, those levies are considerably less because premiums paid for this excess cover are significantly lower than premiums for fully insured benefits, experts say.

"The savings are greatest in states with a lot of mandates, such as Washington, which has 40 coverage requirements for insured benefit plans," said James Rivetts, president of insurance consultant JLR & Associates L.L.C. in North Bend, Wash. "If you go self-insured, you don't have to capitulate to those mandates."

Another provision in PPACA that sets new minimum medical loss ratio requirements for insurers also is likely to drive more middle-market employers to self-funding, experts say, because it will shed light on how much brokers' commissions have been contributing to premium costs.

Beginning this year, insurers must spend at least 85% of every premium dollar collected from groups of 100 or more on medical care, leaving only 15% to cover their overhead costs, including broker commissions. In response, some insurers have ceased paying brokers commissions, forcing these intermediaries to seek compensation directly from insurance buyers. In some cases, brokers are offering to help employers transition to self-funding after their clients learn their brokers' compensation has been growing commensurate with their increasing premium charges.

85%

Beginning this year, insurers must spend at least 85% of every premium dollar collected from groups of 100 or more on medical care, leaving only 15% to cover their overhead costs.

Because self-insured plans are governed by the federal Employee Retirement Income Security Act, self-funded employers also will continue to have the flexibility to make value-based plan design changes that deter employees from using expensive health care providers or nonessential services, or to encourage healthy behaviors, experts say. By contrast, insured programs will continue to be standardized to meet state insurance regulations, which do not permit such modifications, they say.

"Moving into 2014, there's one more reason to move to self-funding," said Mark Whiting, a principal with consultant Mercer L.L.C. in Kansas City, Mo. "PPACA may be enough to push a client that's been teetering on the edge to move to self-funding."

"It's the last straw on a camel's back," said Robert J. Melillo, national vp of risk financing solutions at USI Insurance Services L.L.C. based in Meriden, Conn. Cost increases had been the primary driver to self-funding before the passage of health care reform, and "there's little in PPACA that speaks to managing costs," he said.

"Brokers and consultants agree that if you're going to manage the spend, break it apart and micromanage it," Mr. Melillo said. "The only way to do that is to work the data, and self-funding is the only way to get the data and manage the spend. Even if you have access to the data, if you don't self-fund you can't manage the spend. Employers have to hold the purse strings if they want to manage how their money is being spent."

"With the passage of heath care reform and increasing upward pressures on price, (self-funding) is a topic we're talking about more and more with middle-market employers," said Andrew Bloom, executive vp of operations at Corporate Synergies Group L.L.C., a middle-market broker based in Mount Laurel, N.J. "We're talking about all the different funding alternatives with almost every one of our clients. Many of them have either read about or heard about self-funding and say they want to go self-funded, too."

Self-insure: Take control of benefits

CONTINUED FROM PAGE 4

low individual stop-loss deductibles. If they can manage the risk with affordable stop-loss, that's another reason to go self-insured."

PwC has more middle-market clients that are self-funded today than it did five or six years ago, he said.

Ironically, health insurers recently stepped up efforts to attract middle-market self-funded business, primarily because it is more profitable for them because they are not taking on any risk, industry analysts say.

"If you isolate WellPoint (Inc.) and see how their mix of business has evolved over time, they have a lot more (administrative services-only) business than they did five years ago as a percentage of the total," said Joe Marinucci, a primary credit analyst at Standard & Poor's Corp. in New York who tracks the industry. In addition, "the needle has been moving down on the average group size," he said.

A spokeswoman for WellPoint verified that the Indianapolis-based insurer does have a higher percentage of self-funded business today than it did five years ago.

Appetite for growth

Most of Bloomfield, Conn.-based Cigna Corp.'s income also is derived from being an administrator of self-funded benefit plans. Since its 2007 acquisition of Great-West Healthcare in Denver, it has been making significant strides to capture more middle-market business, he added.

Cigna also verified that it has been seeking more business in the lower end of the middle market since its acquisition of Great-West. Cigna's Select Segments product caters specifically to employers with 51 to 250 employees.

Mr. Marinucci also noted that Hartford, Conn.-based Aetna Inc. and Minnetonka, Minn.-based UnitedHealth Group Inc. recently acquired middle-market third-party administrators, indicating an appetite for growth of this business.

Most independent TPAs and insurers that provide administrative services-only contracts to self-funded employers are courting middle-market business, according to Mike Ferguson, chief operating offer of the Self Insurance Institute of America Inc., whose membership comprises about 800 TPAs, insurers and midsize self-funded employers. "This is the biggest growth area," he said. "Middle-market employers can now easily access specialty health plan management expertise either on an a la carte or bundled arrangement."

"Self-funding proposals are being included in the renewals of many more of the fully insured employers we work with," said Michael Reid, director of operations and client services at twentytwenty Insurance Services in Lakewood, Calif.

For example, "select insurers have begun offering quotes for turnkey self-insured products designed to transition fully insured employers to self-funding, in addition to their fully insured product offerings, as a form of creating market awareness, even if the employer has not specifically sought such a comparison," he said.

"Given that health care costs keep getting more expensive and there's more focus on how it affects an organization's profitability, more employers have been willing to take the risk" and self-fund their employees' health care benefits, said Rick Wald, national practice leader for employer health care consulting and health care reform solutions at Deloitte Consulting L.L.P. in Minneapolis.

Benefit funding strategies examined in webinar

To learn more about the heath care self-insurance strategies discussed in this issue, view our on-demand webinar, "Exploring Alternative Risk Financing Options for Employee Benefits."

The webinar, part of *Business Insurance*'s Middle-Market Challenges series, offers information for mid-market firms and their broker partners on how firms can make use of alternative risk financing options, including captives and self-insured arrangements, for health care employee benefit programs. Webinar viewers will learn about traditional self-funding of health benefits as well as the use of blended programs that combine large-deductible plans with a self-funded health reimbursement arrangement.

The presentation also explores using a captive to fund stop-loss coverage for a self-funded benefits program as a way to avoid the risk of "lasering," in which stop-loss carriers laser in on an individual plan member whose health history or diagnosis indicates that he or she likely will be a high-cost claimant (see story, page 18).

Presenting on the webinar are Robert J. Melillo, national vp of risk financing solutions, USI Insurance Services; and Rick Stasi, executive vp of alternative risk, Avizent. The webinar is moderated by *Business Insurance* Senior Editor Joanne Wojcik.

The cost to view the webinar is $30, which includes one voucher for free online courses from *Business Insurance*'s CE Center. To register to watch the webinar immediately, visit *www.businessinsurance.com/webinars*.

More control, but more risk for self-insured employers

Feasibility studies can help companies decide best route

By RUSS BANHAM

Midsize organizations can gain more control over their employee benefit plan costs by self-funding their plans, effectively handling the underwriting, claims payments and other functions typically provided by an insurance carrier.

The potential downside, of course, is that the company now has full responsibility for paying claims.

"You reap rewards in a good claims year, and you reap losses in a bad one," said Brock Squire, national practice leader, reporting and analytics, in the Phoenix office of broker Willis Group Holdings P.L.C.'s human capital practice.

To get a firmer grasp on which route is best, organizations should consider undertaking a feasibility study comparing an insured benefits plan with one that is self-funded. The idea is to unbundle the insured plan into its various components, such as administrative fees, claims processing expenses and insurance premiums, and then contrast them against respective costs in a self-funded plan.

Savings can be realized. For instance, the premium for stop-loss insurance in the self-funded plan will be much less than the premium charged by an insurer for an entirely insured plan. Premium taxes similarly will be lower.

"You're not paying premium tax on the full premium, just on the stop-loss, and in Virginia, where this is 2.5%, it can represent a significant savings," said Robert Sullivan, vp and senior health care benefits consultant at Hampton Roads, Va.-based Rutherfoord, a unit of Marsh & McLennan Agency L.L.C., a subsidiary of Marsh Inc.

Midsize enterprises need not undertake the feasibility study on their own—insurance brokers, benefits advisers and even insurance providers can help.

"What we try to do is help companies understand their risk tolerance—are they willing to trade the very predictable nature of a fully insured plan for one in which every week or so they must hit their bank account for a certain amount of money?" said Sandy Ageloff, Southwest health and group benefits leader in the Los Angeles office of benefits adviser Towers Watson & Co.

Key factors in determining feasibility are the size of the employee group and its demographics. "The smaller the pool of employees, the more potential for volatility and thus more stop-loss insurance," he said. "The younger the population, the less volatility, as younger people tend to be stereotypically healthier."

Additionally, male employees in their 20s tend to be healthier than women at this age, but the ratio switches as workers enter their 40s, according to Mr. Squire.

But it's the fixed costs like administrative fees, premiums, taxes and an insurer's profit and overhead costs that best guide the decision. "Whether you're fully insured or self-funded, employees will go to the doctor at exactly the same rate—thus, the real savings comes from reductions in the fixed costs," Mr. Ageloff said.

UNDER EVALUATION

Data needed to evaluate self-insurance:

- At least 12 months of claims experience
- Employee demographic data, such as age and gender
- Specific information on catastrophic claims exceeding $25,000 each

If the feasibility study points to self-funding, the first step in how to structure the plan is finding who to go to for help. A midsize company may decide to partner with a provider like Cigna Corp. or Blue Cross Blue Shield, which can handle many of the administrative tasks normally associated with full insurance and may also provide stop-loss insurance, which addresses per-claim losses and aggregate losses above a certain financial threshold.

Helen Darling, president and CEO of the National Business Group on Health, a Washington-based nonprofit organization, advised companies to obtain quotes from at least three competing carriers.

"It's also sensible to ask for separate quotes on the different services provided, such as second surgical opinions or high-risk pregnancy screenings, and then comparison shop," said Ms. Darling, who prior to her current job was manager of health benefits at Xerox Corp., which self-funded its employee benefits plan.

Alternatively, a company can reach out to a third-party administrator that has relationships with preferred provider organizations to provide health care, claims and other services. "Go through a (request for proposal) process, and then analyze the discounts, figure out what claims might look like, compare different stop-loss carriers and so forth," Mr. Sullivan said. "That's how best to arrive at who to partner with."

These various partners will want data in hand to formulate their proposals. Typically, this includes at least 12 months of claims experience; employee demographic data, such as age and gender; and specific information on catastrophic claims exceeding $25,000 each.

The latter is the toughest data to access, Mr. Sullivan said. "Some carriers on a fully insured program may to some extent hide behind (the Health Insurance Portability and Accountability Act) privacy rules and be reluctant to share this information," he said (see related story).

Perhaps the most challenging part of establishing a self-funded plan is determining the point at which the stop-loss insurance should attach.

"A good starting point always is one's current insurance provider, which should be able to provide at least two to three years of carrier renewals—the volume of claims incurred by the employee population," Mr. Ageloff said. "This will tell you at which point the carrier was pooling your claims and reinsuring them. This would then influence when you should take the stop-loss."

Making the decision between full insurance and self-funding can be Solomon-like in its complexity and risk, despite perceived savings. "All you need the minute you open your doors with a self-funded plan is one employee who gives birth prematurely to a baby," Ms. Darling said. "Depending on where you put the stop-loss insurance, the idea of savings will soon fade."

As Anne Lennan, president of the Society of Professional Benefit Administrators, a Chevy Chase, Md.-based association representing third-party administrators, sums up: "The important thing for employers to remember is that they are the 'self' in self-funded."

'The important thing for employers to remember is that they are the "self" in self-funded.'

Anne Lennan, Society of Professional Benefit Administrators

Gathering claims data challenging but vital

To self-fund or not to self-fund? In making this often challenging determination, companies must gather an array of data to discern the level of risk they will be taking on by self-funding their employee benefit plans.

Unfortunately, not all data may be easily accessible.

A startup company, for instance, won't have claims data on the employee population to extrapolate potential claim severity and frequency. Even companies that have long insured their benefit plans may not be able to acquire claims data from the insurer.

"It depends on the state you're in, the size of your organization, and the carrier's willingness to hand it over, among other factors," said John C. McDonough, a benefits consultant with RJF Agencies, a Marsh & McLennan Agency L.L.C. company based in Minneapolis. "Most often you can get it, but even then it may not tell all you want it to tell."

Fortunately, there are other ways to analyze the risks of the employee population bringing a claim. One is asking them to complete a health risk assessment—a series of questions designed to unearth previous, ongoing and future medical conditions.

The drawback is that employees cannot be forced to take an HRA because of privacy and Health Insurance Portability and Accountability Act rules, but they can be offered an incentive to take it, such as a discount on their out-of-pocket pharmaceutical costs or a year's free dues at the company's fitness facility, according to Brock Squire, national practice leader, reporting and analytics, in the Phoenix office of broker Willis Group Holdings P.L.C.'s human capital practice.

Information on the types of drugs an employee takes also can be instructive, according to Helen Darling, president and CEO of the National Business Group on Health, a Washington-based nonprofit organization. "Pharmacy data tells you quite a bit about a person's health status and risk," she said. "Someone may not have had a hospital claim for several years, but the drugs the person takes may indicate a heart transplant five years ago."

Another assessment tool is to peruse the organization's policy renewals with its insurance provider.

"Did the company get a large increase, moderate increase or potentially a decrease in rates? That gives you some indication what's going on in the employee population," said Julie McCarter, vp, product development, in the Denver office of provider Cigna Corp.

Mr. Squire offers another piece of advice.

"Biometric screenings of the employee population can tell you their glucose levels, whether or not they have nicotine in their system, and how much cholesterol they have, among other things," he said. "From that you can extrapolate where they are in terms of diabetes and hypertension, two big chronic conditions."

—By Russ Banham

Opinions

EDITORIAL

Self-insurance an essential tool

SELF-INSURED HEALTH PLANS have become a viable option for employers of various sizes. It is no longer just large employers that can take advantage of the flexibility and cost savings of self-funding their health care risks.

The ready availability of stop-loss coverage to cap employers' liabilities and the numerous firms offering expertise to set up and administer self-funded programs means midsize and smaller employers no longer have to turn to insurers to offer health coverage to employees.

In addition, self-funding allows employers to craft health care plans that address the unique needs of their employee populations.

Despite the advantages self-insurance can bring, insurance regulators are trying to curb the ability of smaller organizations to use the option.

They argue that if small businesses buy stop-loss coverage with low attachment points, they are simply looking for ways to avoid requirements of the Patient Protection and Affordable Care Act and state benefit mandates. As a result, the regulators want to raise the minimum attachment point for stop-loss to a level that would effectively price smaller organizations out of the market (see story, page 17).

In addition, critics argue that small employers with good claims experience would self-insure rather than join state exchanges created by the health care reform law, but then jump into the exchanges after they suffer a catastrophic claim. Plus, they say the exchanges need broad participation to be viable, and that midsize and smaller employers should not be able to easily opt out of the exchange system.

Such arguments are unconvincing. The attachment points they cite as being too low, in some cases as much as $30,000, still keep significant risks with employers. While employers conceivably could jump in and out of the exchanges, the administrative burden of doing so likely would be too great.

Finally, smaller and midsize employers should not be forced into health insurance exchanges for public policy reasons when their larger rivals face no such requirement.

Organizations entering the self-insurance arena often are better able to take control of their health costs, a goal that all should be allowed to try to attain.

LETTERS

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SCHILLERSTROM

COMMENTARY

Self-funding pain worth ultimate gain

The longstanding exercise motto "no pain, no gain" easily could apply to what a middle-market employer might experience when transitioning employee benefits to a self-funded plan.

Like trying to shed the pounds gained from a holiday eating binge, it will be painful for that employer to delve through its historical claims data to uncover what health risks lurk within their employee populations. There are sure to be some unsightly bulges camouflaged by oversized clothing, much like community-rated insurance premiums have a tendency to obfuscate an individual employer's actual claims experience.

JOANNE WOJCIK
SENIOR EDITOR

A lot of midsize employers use the privacy provisions of the Health Insurance Portability and Accountability Act as a convenient excuse to overlook their employees' health risks. But HIPAA doesn't preclude employers from analyzing their aggregated health data to determine which conditions are the most prevalent. It merely bars them from using that information to discriminate against employees with health conditions.

Perhaps even more agonizing for employers that transition to self-funding is acknowledging just how much those risks have contributed to their health insurance costs. Experts say 20% of an employer's population is responsible for 80% of its health care costs. In a group with just 200 people, that's 40 people weighing down the other 160 who are either lucky enough to be naturally fit or who are making an effort to either become or stay healthy.

While the health care reform law does little to help employers address the rising cost of health care due to increasing health risks, it does give employers at least one new exercise that researchers have found can be effective in mitigating those risks. Under PPACA, employers can offer financial incentives worth up to 30% of the cost of single coverage.

Under HIPAA, such incentives were limited to 20% of single coverage costs.

If just half of those 40 high-risk individuals in that 200-employee group were to change unhealthy habits, it would substantially affect benefit costs.

Finally, because self-funded benefit plans are governed by the Employee Retirement Income Security Act, employers have the ability to tailor them to facilitate cost-effective utilization, unlike fully insured programs that often include costly, but not always applicable, state-mandated benefits.

Some employers may be too timid for self-funding, especially if their employee populations are rife with health risks. Others may be impatient, expecting an immediate return on their investment. But as television reality shows such as "The Biggest Loser" consistently demonstrate, hard work and perseverance almost always lead to success.

Only after employers have endured the pain of identifying and addressing their employees' health risks will they be able to realize the gain that comes from lowering their health care costs by self-funding.

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Self-funding key aspect of employer's strategy

Ski resort emphasizes need for employees to use services wisely

By LOUISE KERTESZ

To motivate its workforce to engage in their new consumer-driven health plan, Vail Resorts Management Co., a mountain resort company based in Denver, highlighted its self-funded status in a robust communications campaign.

For the new plan to be successful, it was essential that employees understand self-funding and that becoming good consumers of health care would benefit them and the company, said Rebecca Shipley, director of total rewards at Vail Resorts.

"We were self-funded before, but employees didn't know what it meant," she said.

The company's benefits website features videos of company executives explaining what it means that their company is self-funded.

While an employee population may want to be "good stewards" of a company's resources, "90% of them may not know what self-funding is," said Bart Halling, vp of customer solutions at UMR in Minneapolis, a subsidiary of UnitedHealth Group Inc. that administers self-funded benefit plans.

Vail Resorts spent a lot of time helping employees realize that if fewer assets of the company are used to pay an employee's claims, "not only do I get the benefit, but I'm also creating dollars to reinvest in the business," Mr. Halling said.

"The key difference (between a self-funded and an insured plan) is who accrues the benefit. In a self-funded environment, if I can encourage my employee base to adopt healthier behaviors, the benefit goes not only to the employee" but to the entire organization, he said. "In an insured environment, the benefit goes to whoever is taking the risk: the insurer."

Ms. Shipley and David Ganick, Vail Resorts' benefits manager, worked with UMR to design and roll out the new, full-replacement CDHP with a health reimbursement arrangement, which covers 4,000 employees and 2,000 to 3,000 dependents.

"We started the year before to make moves" toward the new plan. "In 2010 we took away the copays and went to coinsurance, to make people pay attention to the true cost of health care," Ms. Shipley said.

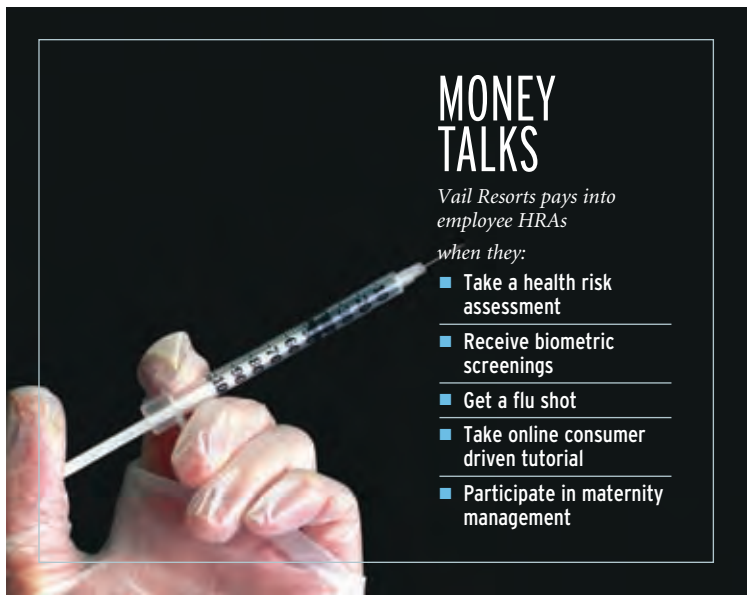
Self-funding allowed Vail flexibility as it designed and rolled out its plan, making changes along the way. It would have been more difficult to make any changes if a carrier bore the risk, Ms. Shipley said.

"When we saw components of the plan that did not mesh with what we were driving for (e.g., ER and urgent care coverage being similar), we could easily tweak that component without having to worry about finding (a carrier's plan) with those provisions," Ms. Shipley said.

As the company introduced the plan, employees asked questions "that we were able to address on the fly without having to run them by a carrier to understand the financial impact," she said.

Pricing the plan also was much easier as a self-insured company, Ms. Shipley said. "The number of assumptions (about pricing) we had to make when changing to a dual-option CDH plan with an

See **DESIGN** next page



Be familiar with stop-loss options before purchasing

Coverage can limit costs, premiums for self-insured firms

By MATT DUNNING

Medical stop-loss insurance is one way employers can limit their costs and premiums and still provide health coverage for their employees who need very expensive procedures and care.

Though not as inherently complex as health insurance itself, employers should familiarize themselves with the intricacies of medical stop-loss insurance before adopting the coverage, experts said.

At their core, specific and aggregate stop-loss insurance programs are forms of excess liability protection designed to reimburse self-insured health care claims above predetermined dollar amounts.

"It's really more like a traditional casualty product than it is an employee benefits product," said John Snyder, CEO of Medical Excess L.L.C. in Costa Mesa, Calif., a unit of Chartis Inc.

Specific stop-loss insurance is designed to cover unforeseen and costly individual medical claims. Buyers select a deductible amount, below which they agree to cover claims incurred in a given year for the individual. In turn, the insurer agrees to pay costs above the deductible. The deductible should reflect the risk an employer can reasonably finance on its own, experts said.

Without specific stop-loss coverage, a single claim could wipe out an employer's funding reserves for the entire health plan.

For example, an employer may be able to set aside only enough money to cover annual claims of less than $50,000, but complications resulting from costly conditions such as a premature birth, can generate claims north of $600,000, experts said.

Over time, adverse claims experience could prompt an underwriter to single out individual plan members likely to generate high claim costs and force the employer to purchase a higher attachment point for that member or refuse to cover them, a practice known as "lasering" (see story, page 18).

Alongside specific stop loss coverage, many brokers and insurers encourage employers to consider stand-alone carve-out coverage of for certain treatments and procedures, such as organ and tissue transplants (see story, page 19).

Aggregate stop-loss coverage responds when the total cost of claims reaches a certain threshold. For employers buying stop-loss insurance for the first time, that threshold—or attachment point—typically is a dollar amount near or slightly above the employer's most recent fully insured health plan premium.

Employers that already have a claims history with a specific stop-loss policy usually calculate their aggregate attachment point at around 125% of expected claim costs, depending on the policy underwriter.

"In our world, it's called 'sleep-easy' insurance for the (chief financial officer)," Mr. Snyder said. "The probability of having an aggregate claim scenario is very low; but if it did happen, it could be catastrophic to an employer without the coverage."

Much like other insurance, the higher the deductible and attachment points an employer is willing to take on, the less they are likely to pay in premiums. However, pricing can vary wildly depending on an employer's workforce size and demographics, industry, geography, past claim experience, contract type and risk tolerance. That sort of fluctuation

See **STOP-LOSS** page 12

TRANSPLANT COSTS

Estimated total U.S. transplant patients under age 65 and averaged billed costs for single-organ and tissue transplants in 2011

TYPE	TRANSPLANTS MADE	COST/PATIENT
Bone marrow (donor cells)	6,894	$805,400
Bone Marrow (patient cells)	13,263	$363,800
Heart	2,161	$997,700
Intestine	74	$1,206,800
Liver	5,898	$577,100
Lung (single)	734	$561,200
Lung (double)	1,050	$797,300
Pancreas	286	$289,400

Source: Milliman Inc.

Design: Self-funding key aspect of ski resort's benefits strategy

CONTINUED FROM PREVIOUS PAGE

HRA, with incentives, was large," she said. "In a fully insured environment, we would have had to spend so much effort" getting the insurer to agree to assumptions about pricing prior to the plan year beginning, she said.

Vail is "unique from our standpoint and book of business," said Minneapolis-based Stephanie Elliott, UMR's account manager, who worked with the Vail team to implement the plan. Only 9% of Vail's population has one or more of the costly chronic conditions identified by the Centers for Disease Control, vs. about half of the U.S. population.

Vail tied the goals of its new health plan to the company's service model of "Own, Personalize, Elevate." Translated to the new health plan, the mantra became "Own Your Choices, Personalize Your Care, Elevate Your Health."

Although the prevalence of chronic conditions among Vail employees is low, "we have other health issues. We see more musculoskeletal issues—with knees and shoulders—and we have a higher pregnancy rate. And with so many of our employees working at higher altitudes, we have a higher rate of premature babies," said Ms. Shipley.

"We were really trying to focus on how to design a plan that supports our culture of health and wellness," she said. Tying the concepts of "health and wealth," the company provides first-dollar coverage of employee medical expenses through funds deposited in their HRAs. In addition, cash incentives are deposited into their HRAs when employees engage in wellness activities, including taking a health risk assessment, receiving biometric screenings, getting a flu shot, taking an online consumer-driven health tutorial and quiz, and participating in a maternity management program.

In the maternity management program, once employees sign up, "they are given certain dollars as they go through each trimester, and as they're learning and engaging, additional dollars go into their HRA to offset the cost of their pregnancy," Ms. Shipley said. An employee can earn up to $400 for participating in the program, according to the benefits website.

From August through December 2011, 54% of employees received biometric screenings and earned a cash incentive, and Vail contributed more than $360,000 in incentives to employees' HRAs, which can roll over year to year, Ms. Shipley said.

"For healthy people who are paying attention (to their health and available incentives), the great thing is that, in Year 3 or 4, there is a very good chance they would actually pay zero out of pocket" for their health care, she said.

"Although it's really early, in the first seven months of this plan we're seeing some really encouraging behaviors. For example, we're seeing per-employee per-month costs staying flat or even lower than in the last couple of years," Ms. Shipley said.

"The savings we are seeing are helping to build support for the plan and helping us build momentum with senior leadership. Under a fully insured plan, those savings would only really show up at renewal time," she said.

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SPECIFIC STOP-LOSS PRICING

The average premium per month per employee, by contract type, for specific stop-loss medical insurance deductibles during 2011

DEDUCTIBLE	PAID[1]	12/15[2]	15/12[3]	12/12[4]
$100,000	$79.32	$77.76	$76.27	$62.95
$200,000	$31.67	$31.05	$30.45	$25.13
$300,000	$18.51	$18.15	$17.80	$14.69
$400,000	$12.64	$12.39	$12.15	$10.03
$500,000	$9.41	$9.23	$9.05	$7.47

1 For claims incurred after the policy effective date and paid during the policy term. 2 For claims during the 12-month policy term and paid within 15 months of the effective policy date. 3 For claims within the 12-month policy term plus three months prior to the effective date that are paid in the 12-month policy term. 4 For claims incurred and paid within the 12-month policy term.

Source: Aegis Risk L.L.C., International Society of Certified Employee Benefits Specialists survey of 106 plan sponsors with some 310,000 employees.

Stop-loss: Buyers at mid-market firms should become familiar with options

CONTINUED FROM PAGE 10

can make identifying conclusive premium rate trends extremely difficult, experts said.

"You can take the same risk to four or five carriers, and the rate could vary by 20% depending on the underwriters' experience in that specific industry or geography" or preferred provider organization, Mr. Snyder said.

In its annual survey of medical stop-loss premiums, Alexandria, Va.-based Aegis Risk L.L.C. said average monthly premiums for specific attachment points up to $100,000 were between around $63 and $79 per employee in 2011 depending on contract type (see chart), though some premiums were above $150 per employee.

Aegis' survey predicted specific stop-loss renewal rates will increase an average of 17% in 2012. Experts said a significant factor in how premium trends behave in the coming years could be the elimination of individual lifetime and annual coverage limits mandated under the federal health care reform law.

Experts say buying adequate specific stop-loss insurance—if not specific and aggregate—often is essential to a successful self-funded group health plan.

"There's generally no reason not to buy this coverage, and specifically not for mid-market companies," said Ken Olson, CEO of Orland Park, Ill.-based stop-loss broker Horton Group Inc. Mr. Olson noted that many employers may purchase higher deductibles or eliminate aggregate cover as they grow and build claims experience.

"You will see some employers start to operate without the aggregate coverage, because they've become comfortable with their own internal reserves' ability to fund whatever aggregate costs they had been covering with stop-loss insurance," he said.

But he also advised caution in taking on too much risk.

"One out of every four or five years, an employer is going to have a bad year in terms of claim experience," Mr. Olson said. "Even if an employer gets through a few years and hasn't had a bad year, we still caution them to keep their coverage level with their expected claim costs."

> 'Even if an employer gets through a few years and hasn't had a bad year, we still caution them to keep their coverage level with their expected claim costs.'
>
> Ken Olson, Horton Group Inc.

In most cases, middle-market employers should be able to rely on the advice of an employee benefits broker or risk consultant for guidance on implementing and monitoring of stop-loss coverage, experts said.

Cheri Cuchna, human resources manager for Chicago-based All Truck Transportation Co. Inc., said it is even better if an employer can turn to existing relationships for that guidance, as familiarity with the company's medical claims history, finances and employee population likely will lead to more consistently appropriate coverage.

"You've got to make sure that your broker is very knowledgeable about your claims history," Ms. Cuchna said.

"If they're not, let's say they lower your stop-loss attachment point to $50,000 and you blow that up. The next year your stop-loss renewal is going to be astronomical."

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Stop-loss: Buyers at mid-market firms should become familiar with options

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Choosing a TPA pits independents against insurers

Both show gains in expertise, services; price range narrows

By LOUISE KERTESZ

When deciding to self-fund, an employer needs to consider the advantages and disadvantages of using an insurer vs. an independent third-party administrator to manage its benefit plan.

In some cases, the decision may involve weighing a smaller, independent local or regional TPA vs. one owned by an insurer.

However, said Fred Hunt, active past president of the Society of Professional Benefit Administrators in Chevy Chase, Md., "ownership is not an issue anymore. It's more an attitude. It's what you do" in services provided to a self-funded employer.

In general, large self-insured employers choose administrative-services-only contracts with insurers, which offer integrated services that include claims payment; discounted networks; medical case, disease and pharmacy management; wellness programs and stop-loss insurance.

Unless they have "a unique situation or plan," large employers generally want more integrated services provided under an ASO contract, said Helmut Braun, Lexington, Ky.-based chief operating officer of UMR, a Wausau, Wis.-based TPA formed by Minnetonka, Minn.-based insurer UnitedHealth Group Inc. from its acquisition of United Medical Resources Inc. and two other TPAs.

"In our case, we have a true integration with our larger trading partners" in sharing data, Mr. Braun said, noting that most UMR clients have 100 to 3,000 employees.

TPAs' niche has been midsize and small employers that want the flexibility of choosing services a la carte, he said.

Large insurers have acquired or developed their own TPAs to market more customized services for midsize employers. For example, Hartford, Conn.-based Aetna Inc. acquired Meritain Health to offer a "flexible, customized, unbundled option" to companies with 100 to 5,000 employees, said David Parker, Meritain senior vp of sales in Tampa, Fla.

On the other hand, insurers that offer ASO contracts "have become much more agile, and the big ones have done a good job of adapting their business model and platforms" to provide more customization, such as carving out services from the insurer's ASO bundle to use best-in-class vendors, said Eileen Quenell, health and group benefits practice leader at Towers Watson & Co. in Washington.

Asked whether insurers or independent TPAs can better administer value-based benefit designs that include wellness incentives, Cyndy Nayer, president and CEO of the Center for Health Value Innovation, said, "A year and a half ago, I would have said you probably need to work with a TPA, because they're more agile. But the industry has come a long way," and some of the larger health plans now have the required technology, she said.

"ASOs is a legacy term and not taken literally," since they function like TPAs, said John Lapinski, principal at Buck Consultants L.L.C. in Southfield, Mich. "It all got rather muddled," he said.

TPAs provide less discount on their leased provider networks compared with insurer-owned networks, but TPAs often make up for that in lower administrative costs, he said.

"For the more sophisticated TPAs, the pricing difference is not as wide as it used to be," said Donna Cowden, senior vp at Aon Hewitt in Winston-Salem, N.C., due in part to competition.

Mark Watson, personnel director for Union County in Monroe, N.C., works with Integra Administrative Group Inc., a regional TPA that offers its MedCost L.L.C. regional provider network. He evaluated major insurer networks and said "the savings would have been negligible."

"We were the first local government to implement a full-replacement self-funded consumer-driven health plan in 1993," Mr. Watson said. Early on, the plan offered free generics and varying deductibles linked to a health reimbursement arrangement administered by a TPA.

"Evaluate both (insurer ASO and TPA contracts) for the components you need," Ms. Cowden said. Compare an insurer's charges for ASO services vs. TPA charges for services that include claims processing, a customer service center, network fee, identification cards and standardized reporting. An ASO contract "bundles" many services, including medical management, for one fee.

Insurers and TPAs charge extra for specialty services and stop-loss insurance, sources said. One difference is that TPAs may charge on a per-case basis to manage large cases, whereas an insurer may incorporate that into the bundled fee, Ms. Cowden said.

"Integration is the key piece I get from my Humana ASO," which also "integrates the ASO piece with stop-loss" coverage, said Connie Goss, risk and purchasing manager for Chippewa County in Chippewa Falls, Wis.

Ms. Goss also values how Humana Inc. handles subrogation. "They're watching our dollars as if they were their own," she said.

Last year, Youthville Inc., a nonprofit child welfare agency in Wichita, Kan., became self-funded and adopted a value-based design with an HRA, said Stephanie Glazier, human resources benefit manager. It chose Benefit Management Inc. in Great Bend, Kan., based on employer references, competitive pricing, flexibility and customer service.

The independent TPA's primary role is paying claims. Youthville works closely with their "very hands-on broker," Willis of Greater Kansas, whose wellness consultant "plays a big role in our plan design," Ms. Glazier said. With the TPA at the table, it was Willis who found Chicago-based MCM Solutions for Better Health to do the plan's medical management, Ms. Glazier said.

"We work with our broker to provide detailed reports on our high-claim areas" to target employees for wellness initiatives and medical cost management, said Misa Daily, Youthville's human resources director.

Willis also provides reports comparing employees who participate in Youthville's wellness program with those who do not, Ms. Glazier said. The program offers $150 for completing biometric screenings and maintaining or improving their health levels, Ms. Glazier said.

TOP TPAs

Largest third-party administrators for benefit plans based on 2010 gross revenues from claim services provided to self-insureds*

Company	2010 total revenue from claim services to self-insured clients	2010 percentage from health care claims
UMR Inc.	$393,949,776	99.0%
Meritain Health	$193,000,000	83.2%
CoreSource Inc.	$86,619,141	85.0%
HealthSCOPE Benefits	$65,142,906	90.0%
POMCO Group	$41,800,000	90.0%
HealthPlan Holdings Inc.	$28,950,240	95.0%
Health Plans Inc.	$24,110,000	98.0%
Professional Benefit Administrators Inc.	$11,788,060	92.0%
Southeastern Indiana Health Operations Inc. (dba SIHO Insurance Services)	$7,800,700	97.0%
Group Administrators Inc.	$7,400,000	95.0%

**50% or more of claims come from providing health plan claim services to self-insured clients.*

Source: BI survey

Smaller third-party administrators rely on personalized service

By LOUISE KERTESZ

With large insurers acquiring third-party administrators and other consolidations in the TPA industry, some sources say they believe smaller TPAs' days are numbered.

Others say the talk about small TPAs' demise have been greatly exaggerated.

"I think smaller TPAs are struggling" because insurer-owned TPAs are taking their business, said Helmut Braun, chief operating officer of UMR, a Wausau, Wis.-based TPA formed by Minnetonka, Minn.-based insurer UnitedHealth Group Inc. in 2008 after it acquired Cincinnati-based United Medical Resources and two other TPAs.

"One reason we got hooked up with United is so we now have access to a national network," said Mr. Braun, who previously was senior vp of operations with Fiserv Inc., a Brookfield, Wis.-based TPA also acquired by UnitedHealth in 2008.

Some insurers will lease only their second-tier networks, which have fewer providers, to smaller TPAs, sources said.

"There definitely is an advantage in size and the resources and services we can provide our clients," said David Parker, senior vp of sales and marketing for Meritain Health Inc. in Tampa, Fla., a TPA and business unit of Hartford, Conn.-based Aetna Inc. "There's a greater opportunity for administrators that are large like us in the long term," he said.

However, small TPAs are "still very predominant in certain areas," said Donna Cowden, Winston-Salem, N.C.-based senior vp and national stop-loss practice leader in Aon Hewitt's health and benefits practice. "In the Charlotte (N.C.) area, there are probably 30 of them serving the midmarket."

Stephanie Glazier, human resources benefits manager at Youthville Inc., a nonprofit child welfare agency in Wichita, Kan., said one of the reasons the agency chose Benefit Management Inc. in Great Bend, Kan., is "when you call BMI customer service, you actually talk to someone in Great Bend."

"At least half of our members—150—are truly independent TPAs," said Fred Hunt, active past president of the Society of Professional Benefit Administrators in Chevy Chase, Md. "They won't go away," he said. The hallmark of smaller TPAs is "personalization, personalization, personalization," he said. "The CEO gets his hands dirty when there's a claim problem," he said.

Mark Watson, personnel director for Union County in Monroe, N.C., said consolidation led to his small TPA being absorbed by a "conglomerate" of TPAs that were later bought by an insurance company. "Different time zones, major differences in the cultures of different business units" meant poor service, he said. The county's TPA now is Integra Administrative Group Inc., a regional TPA.

"I think there will always be a market for TPA services, but I'm not convinced there will be a growing market, and they will have to evolve their model," said Eileen Quenell, health and group benefits practice leader at Towers Watson & Co. in Washington.

Evolution happened at San Francisco-based SeeChange Health Insurance Cos., which bought Triveris Inc.—"an old-school, traditional TPA"—and now offers employers "a software platform like a TPA" that can administer an employer's various services and multiple plan designs, including value-based health plan designs, said Martin Watson, SeeChange's CEO.

Medical stop-loss captives help firms pool risk

Midsize companies can protect against significant losses

By MATT DUNNING

In the past several years, group-funded captives programs for medical stop-loss insurance have emerged as a mechanism by which midsize employers can reduce the financial volatility and, in many cases, administrative complexities that can undermine the benefits of self-insuring a group health care plan.

Similar to captive programs in the property/casualty insurance industry, stop-loss insurance captives allow midsize employers self-funding their group health plan to pool their risk of excess medical claims costs with other "like-minded" companies. By banding together, the employers are able to take on a greater level of excess claim liability before having to pay premiums to an underwriter or reinsurer.

Aside from the potential to deliver greater stability in an employer's year-to-year fixed costs, captives provide employers with the opportunity to earn some of their premium dollars back through favorable claims experience, experts said.

The captive concept also can significantly reduce the chance of a stop-loss employer applying a sudden premium increase or coverage limit—called a "laser"—to a high-risk individual or medical condition.

"It's proving to be a great tool for those midsize employers to participate in the benefits of self-funding by mitigating a bit of the volatility that exists in that space," said Burt Wilson, a Sacramento, Calif.-based senior vp of Chartis Inc.'s accident and health corporate benefits practice.

Typically, a stop-loss captive program is divided into three layers of risk. Individual employers assume responsibility for the lowest layer of claim costs, the cap for which often is determined by the attachment point the company would have purchased in a traditional stop-loss model.

Most of the actual premiums paid by employers will be applied to the middle layer of risk, which is assumed by the captive and is designed to encompass most, if not all, of the "laser" costs employers would expect to incur if they purchased stop-loss coverage on their own.

"You give up something for that comfort, and that's usually more money on the fixed cost side," said Ken Olson, CEO of the Chicago-based benefits broker Horton Group Inc. "That initial captive layer is more expensive than if you had just purchased it on (your) own, but what you find is that any profit coming back out of that layer comes back to you as opposed to the underwriter."

Since joining a captive stop-loss program in 2009, Salinas, Calif.-based farm equipment supplier Coastal Tractor has saved an estimated $180,000 in medical expenses compared with the cost of its fully insured health care plan. The bulk of those savings were realized in the form of comparably stable renewal rates, which Coastal Tractor general manager Al Parolini said have been held in check by the captive group's collective loss experience.

"If we were a stand-alone entity, and we had one $200,000 medical exposure, that could drive us through the roof in terms of potential rate increases for the following year, and probably several years after that," Mr. Parolini said. "With a group of more than 3,000 insured individuals, that one incident doesn't skew the entire medical costs of our small company."

Though the underwriting market for medical stop-loss captive programs is still fairly limited—Chartis and Stamford, Conn.-based W.R. Berkley Corp. remain the two major domestic insurers with developed medical stop-loss captive products—new captive groups and program managers continue to emerge.

> **'Before you enter a captive, you have to realize that as an employer you're actually getting involved in understanding how to manage your risk dollars.'**
>
> Don Gasparro, W.R. Berkley Corp.

Last year, Schaumburg, Ill.-based Captive Resources L.L.C. introduced its medical stop-loss captive, Well Health Insurance Ltd. Hamilton, Bermuda-based captive manager Roundstone Management Ltd. also unveiled its Mid-Market Med program last year. Orland Park, Ill.-based insurance broker the Horton Group Inc. plans to release its own medical excess captive in early 2013.

Stop-loss captive products tend to be marketed to midsize employers, particularly those in need of additional guidance regarding wellness initiatives, health risk assessments and other loss control programs, as many captive groups establish such programs as a requisite for participation. Broker/consultants and program managers also often have base criteria for captive placement, including the number of insured lives in a program and years of available loss experience data.

"A captive is established by developing and requiring certain elements that each participant needs to adopt in the areas of PPO networks, third-party administration, utilization review, large case management and wellness programs," Mr. Wilson said. "These are the things/elements that are determined to best impact their health care spend."

Additionally, employers should make an honest assessment of their own ability to drive behavioral changes among their employees, experts said. If an employer's senior executives aren't able to increase adherence to wellness initiatives and other risk management activities, the switch to a captive-funded program will have accomplished little beyond an increase in fixed costs.

"Before you enter a captive, you have to realize that as an employer you're actually getting involved in understanding how to manage your risk dollars," said Don Gasparro, COO of W.R. Berkley's accident and health practice in Hamilton Square, N.J.

IS SELF-INSURING RIGHT FOR YOUR COMPANY?

The pros and cons of self-insuring

BENEFITS OF SELF-FUNDING

- Not subject to state, federal premium taxes.
- Not subject to state benefit mandates.
- No insurer profit margin built into rates.
- No broker commissions.
- Pay only for desired services.
- Greater control over plan design.
- Employer maintains claims reserves.
- Access to claims data.
- Ability to conduct periodic claims audits.
- Full credit for wellness, disease management.

DOWNSIDES OF SELF-FUNDING

- Increases financial risk.
- Requires long-term commitment.
- More internal administration.
- More employer involvement in plan design decisions.
- Must contract for actuarial, claims, other services.
- Must arrange benefit communications, enrollment.
- PPO discounts may be less than those of insurers.
- Increased fiduciary liability.
- May need to buy medical stop-loss insurance.
- Risk of stop-loss price volatility and "lasering."

Source: BI research

Perspectives

Every company wants to save money and get the best possible insurance coverage at a competitive price. But is your broker's bonus structure clouding his judgment? Jim Edholm, president of Business Benefits Insurance, an employee benefits planning firm, reveals the brokerage industry's best-kept secret and gives you tips to make sure your insurer and the price you're paying are appropriate.

Your best interests in mind

By Jim Edholm

Mr. Edholm

A benefits broker is an independent consultant who should share your interests and understand that what's good for you is good for him.

Middle-market employers probably would save money by partially or fully self-insuring their benefits or moving to a different insurer, but a broker may not divulge that information because it could cut his or her bonus.

You want the best possible coverage at a competitive price. If your insurer won't provide it, your broker should get a better deal. But the way bonuses are structured could affect the broker's judgment.

A benefits broker is an independent consultant who should share your interests and understand that what's good for you is good for him. The broker should know which insurers are best for all lines of coverage, get quotes from multiple insurers, and provide plan design options and risk-sharing ideas.

He should know each insurer's contractual language and how seemingly small changes will affect your plan provisions and costs. He should lay out all the options and assist in making the best possible choice.

Many states require that the same price be charged whether an employer buys benefits coverage directly or via a broker. So do-it-yourself efforts save nothing. Because commissions from insurer to insurer don't vary much, the broker can send you where you are best served.

But while it may seem a perfect solution, brokers are subject to crosscurrents.

Here's why: The insurer that has your business doesn't care if you have the best possible deal; they want to keep your profitable business, so they give the broker a bonus.

Unlike commissions, which reward the broker for servicing your account, resolving questions and expediting claims, bonus programs have nothing to do with your interests and everything to do with the insurer's and broker's interests. Bonus incentive programs reward the broker for:

- Placing new business with the insurer. The more products and the more accounts sold in a given year, the bigger the broker's bonus.
- Total business with the insurer. The more business, the bigger the bonus in amount and as a percentage of total premiums.
- Percentage of last year's business renewing with the insurer. The greater the share of an insurer's business the broker renews, the greater the bonus.

So the broker is torn, and here's where the conflict comes in. Let's say the broker has lots of business with Insurer A. If he moves business from Insurer A to Insurer B, his commissions will remain about the same. But he reduces his total business and lowers his renewal percentage with Insurer A.

The reduction applies to all of his clients with Insurer A, not just the one he moves. There's no way he can make up that loss with Insurer B because he's not in a bonus position with them. He has a strong incentive to keep your account with Insurer A, even though Insurer B offers a better rate.

That said, not every broker will act in a completely self-beneficial way. Brokers take care of their clients, and many, perhaps most, will gladly sacrifice their income to serve the interests of the client. However, at some point, the bonus can be large enough to greatly strain a broker's sense of fairness.

Here's another scenario where bonuses can warp a broker's advice. Let's say you're a mid-market employer with about 200 predominantly young, healthy employees. This is a perfect group for self-insuring (see box), but why hasn't the broker mentioned that possibility?

Steps to keep brokers straight

Insurers furnish every employer who employs more than 100 employees with a Form 5500, which shows commissions and bonuses the insurer paid to the broker on your account. That report will give you the input you need to gauge your broker's bonus "temptation." This information is publicly available.

Whatever your organization's size, there are five steps to make sure your organization is not being steered inappropriately to an insurer or coverage that's more expensive than necessary:

ONE: Ask your broker, "What percent of your total income do bonuses, as opposed to commissions, represent for your business?"

What should that number reasonably be? My company's bonuses, for example, account for less than 5% of total revenue. That's because we encourage our clients to shop every year and change insurers frequently.

However, it can be disadvantageous for accounts to switch insurers too often. So if you're a larger employer and your broker mainly serves larger clients, expect bonuses to be a larger percentage simply because of the rate penalties for frequently changing carriers.

TWO: Look back at how long you've been with your insurers. If it seems like you almost never switch, perhaps the bonus—even if seemingly small—is inappropriately influencing the broker's advice.

THREE: Periodically have another broker compete for the business. It's probably unwise to have multiple brokers quoting every year because that limits a broker's ability to get price concessions from an insurer. But every fifth year or so, it's probably worth annoying your broker by bringing in competition.

FOUR: For companies with more than 100 employees, examine the Form 5500s from the past several years. Look at the absolute bonus amount and its growth trend. With fewer than 100 lives insured, ask your broker what his commissions and overall bonuses were. He won't be able to tell you what the bonuses were on your specific case because the insurer bonus arrives as a lump sum, but he'll know them for his entire book of business.

FIVE: At a certain size, you can compensate your broker directly via a fee and request that he quote the plan commission-free. Most insurers don't pay bonuses when no commissions are paid.

This may not always be a money-saver, however. Some insurers quote exactly the same rate with or without commissions. So despite paying your broker/consultant a fee, you won't get any plan price reductions to compensate you for your troubles. And you'll shortchange your broker without saving any money.

Now that you know the brokerage industry's best-kept secret, you have the tools you need to assure that the insurer you're using and the price you're paying are appropriate.

Jim Edholm is president of Business Benefits Insurance, an employee benefits planning firm based in Andover, Mass. The firm specializes in serving employers with up to 250 employees. He can be reached at 978-474-4730, at www.group-insurance-guide.com or via email at jedholm@bbibenefits.com.

CONFLICT OF INTEREST?

Here's an actual example illustrating just how much impact a bonus program can have on an insurance broker. The employer in question is a high-tech firm with 185 to 195 employees in the year reported. The group is very young and all lines were fully insured.

LINE	INSURER	COMMISSION	BONUS	PREMIUM
Dental	A	$5,330	$6,787	$123,648
Health	A	$18,589	$6,953	$1,016,853
Life, AD&D	R	$4,769	$1,002	$47,693
Vision	X	$887	N/A	N/A
Total		$29,575	$14,742	$1,188,194
% of premium		2.5%	1.2%	

LOOK CAREFULLY at the numbers. The overall bonuses equaled 46% of the commissions. A specific example is the dental coverage with Insurer A. The bonus was a staggering 124% of the commission. It's doubtful that client will ever hear their broker say, "You know, those dental rates seem a bit high. Why don't we shop that?" Even the health insurance bonus is 57% of the commissions. That's a perfect age for self-insuring with lots of maternities and few, if any, cancer cases. It's a win-win deal for the employer, yet the group is fully insured. It turns out that Insurer A doesn't pay a bonus on self-insured plans. Did that fact affect the broker's recommendation? I don't know, but I can guess.

Regulators wary of self-funding for smaller firms

NAIC considers raising attachments for stop-loss coverage

By KAREN PALLARITO

Midmarket employers looking to self-fund their health benefit plans could encounter a new regulatory hurdle in the months ahead.

With state health insurance exchanges coming online in 2014 as part of the federal Patient Protection and Affordable Care Act, many insurance regulators and consumer advocates are worried about adverse selection. The concern is that more employers with healthy populations will opt to self-insure, abandoning the state exchanges or shifting back when their risk profiles deteriorate.

To create some stability in the marketplace, state insurance regulators are looking to raise the bar for purchasing stop-loss coverage by having employers bear more risk. One option that's been proposed is to raise the attachment point, the dollar amount a self-insured plan must pay in claims before stop-loss insurance coverage kicks in.

Timothy S. Jost, professor of law at the Washington and Lee University School of Law in Lexington, Va., and a consumer representative to the National Assn. of Insurance Commissioners, argues that "writing stop-loss coverage with very low attachment points that begin to look like conventional high-deductible plans is a sham, and I think it's a way to evade the requirements of the Affordable Care Act."

Under current market conditions, "You could have a small business that buys a stop-loss plan with a $10,000 or $20,000 or $30,000 attachment point. As long as everybody's healthy, it just rolls along," he said. But if an employee were to get cancer or have a serious car accident, the employer might decide, "That's it, I'm into the exchange," Mr. Jost said.

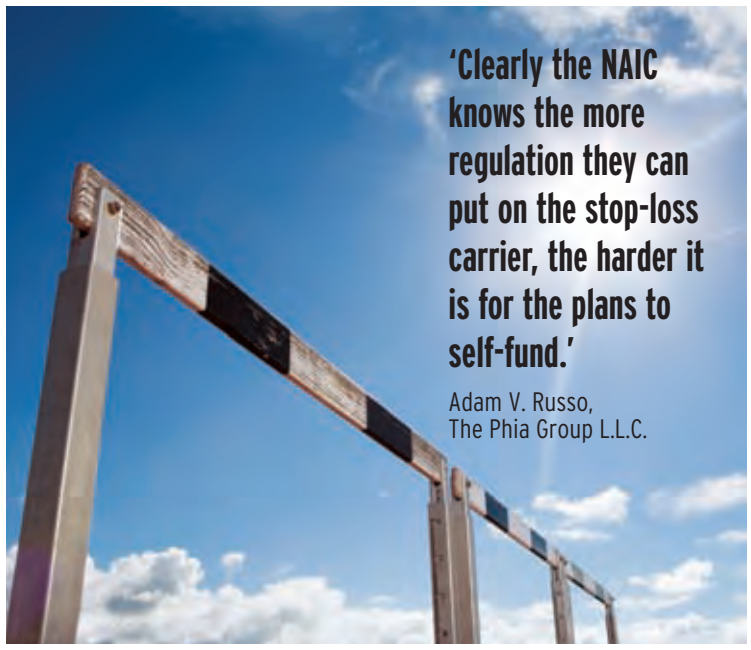
"If this isn't stopped in some way, it will basically destroy health care reform in the small group market," he added.

In a white paper published in October, the Self-Insurance Institute of America Inc. insists that any assertion that employers that choose to self-fund would have a negative impact on state health insurance exchanges starting in 2014 "is highly speculative and inconsistent with 25 years of empirical experience under (the Employee Retirement Income Security Act)."

Says SIAA Chief Operating Officer Michael Ferguson: "Self-insurance really is for companies that want to take ownership of their plan management and be able to get their hands around it and be able to manage that plan for the longer term."

Even before the 2010 passage of the health care reform law, NAIC was concerned about the growth of self-funded benefit plans. Unlike fully insured health plans, which are regulated by the states, self-funded plans are governed by ERISA, a federal law that preempts them from various state benefit mandates and premium taxes that can serve as additional sources of income to the states.

NAIC adopted model legislation in 1995 that establishes criteria for issuing stop-loss policies, and amended the criteria in 1999 to clarify that the law applies to stop-loss insurance carriers. Under the model law, an insurer may not issue a policy with an attachment point for claims incurred of less than $20,000 per person per year.



As part its review of the treatment of self-funded plans under the PPACA, the NAIC's ERISA (B) Working Group agreed to review and revise the Stop-Loss Insurance Model Act "to account for medical inflation" that has occurred since 1995. It referred the issue to the NAIC's Health Actuarial (B) Task Force for further review.

Mr. Jost proposed that NAIC consider prohibiting the sale of stop-loss coverage to small groups, or least doubling minimum attachment points to $40,000 per individual to account for inflation.

In a memo dated Oct. 27, 2011, the working group lays out the central issue: "whether the ability of employers to self-fund and move in and out of the insured marketplace depending on the relative health of their employees will place the stability of the fully insured marketplace materially at risk after Jan. 1, 2014, when all plans will be guarantee issue, community rated with no medical underwriting or pre-existing condition exclusions."

The NAIC is examining the need to modify the stop-loss model act, as well as how that modification would occur, a spokesman said. With no official position or timetable from the standards-setting organization, self-funding experts say they can only speculate on the significance of any forthcoming policy.

"I don't view it as a threat," said Craig Kelbel, president in the Atlanta office of HCC Life Insurance Co., a provider of stop-loss coverage. "Even if the NAIC comes out with some regulation where they suggest some (new) limitations, I'm not sure the states have ever really followed it entirely, anyway," he said.

To date, only three states—Minnesota, New Hampshire and Vermont—have adopted the NAIC model law. Another 18 states have undertaken related legislation or regulation that is not similar to the model law.

In 2011, after several years of 15% to 20% increases in health plan premiums, Adam V. Russo, an attorney and CEO of The Phia Group L.L.C., a Braintree, Mass.-based health care cost containment and consulting company, decided to self-fund his company's health benefits. Eighty of the company's roughly 100 employees participate in the plan. The move from fully insured health benefits to a self-funded plan reduced plan expenses by 50% in the first year, Mr. Russo said.

"If I could not purchase stop-loss at $25,000 and instead I had to purchase it at $100,000, I could not be self-funded because it's too much risk for my company," he said. And although he doesn't see the NAIC's actions as an immediate threat to self-funding, he said that higher attachment points could impede employers seeking to enter the self-funding marketplace.

"Clearly the NAIC knows the more regulation they can put on the stop-loss carrier, the harder it is for the plans to self-fund. It's a way for them to get more control," he said.

Selective marketing by insurers slammed

Insurance regulators in New Jersey continue to work on drafting regulations aimed at cracking down on stop-loss insurers that selectively market coverage to small employers based on the health history of their workers.

A spokesman for the New Jersey Department of Banking and Insurance said a stakeholder meeting on the draft regulations is tentatively scheduled for late this month.

In a bulletin issued in October, the department said some insurers have been selectively marketing to small employers based on health history and denying coverage to employers based on employee health status.

"The result of this selective underwriting is to 'cherry-pick' groups less likely to incur claims, leaving the groups more likely to incur claims to the state's guaranteed issue insured market," the bulletin said.

The department warned stop-loss insurers that such selective marketing and underwriting constitute unfair trade practices subject to unspecified sanctions.

The Self-Insurance Institute of America Inc. immediately blasted the action, saying the assertion of unfair trade practices is "misguided." SIIA subsequently filed an Open Public Records Act request to review the documents that the New Jersey department relied on in concluding that such unfair trade practices exist.

"They seem to be confusing the issue of plans being prohibited from considering individual health status for coverage eligibility with stop-loss carriers utilizing health plan data for underwriting (pricing) purposes," said Michael Ferguson, the SIIA's chief operating officer.

The department's spokesman said the bulletin issued by the department supports employers who want to self-insure "by ensuring their stop-loss carrier doesn't turn them down because they have sick employees."

He added that the bulletin is not part of an attack on self-funding.

"ERISA prohibits employers from discriminating on the basis of employee health status. This just says their stop-loss insurer can't either."

—By Karen Pallarito

Employers have options to address 'lasering' risk

Stop-loss insurers target costly cases to curb exposure

By JOANNE WOJCIK

Many mid-market employers that opt to self-fund their employees' health care benefits face a situation that is becoming increasingly common. At renewal, the stop-loss insurer decides to "laser" one of the company's employees because of a costly medical condition, such as cancer.

Lasering is a common stop-loss industry practice of setting higher specific deductibles for individual plan members based on the likelihood that they will become high-cost claimants, said Jon Rauser, president of the Milwaukee-based Rauser Agency, a mid-market insurance broker.

Mr. Rauser estimates that 25% to 30% of self-insured employers with fewer than 500 employees will have a laser in any given plan year.

"That's a fear that every employer has," said Mark Whiting, a principal with employee benefit consulting firm Mercer L.L.C. based in Kansas City, Mo.

To alleviate that fear, Mr. Whiting said he typically asks stop-loss insurers to provide his clients with a quote on coverage with a "no-laser option," which means it will promise not to laser, regardless of claims experience. But that will cost an employer more for the coverage, he said.

"There's no question that will influence the rates," he said.

Historically, stop-loss carriers have been more likely to impose lasers at the beginning of a contract if they can identify potentially high-cost claimants by analyzing an employer's past claims experience. More recently, however, "we are seeing more incidences of lasering at renewal," said Donna Cowden, Winston-Salem, N.C.-based senior vp and national stop-loss practice leader in Aon Hewitt's health and benefits practice. "A lot has to do with the cost of specialty drugs" in stop-loss contracts that combine prescription drugs costs with medical care, she said.

She said that 10 to 15 years ago, most stop-loss insurance covered only medical care, not prescription drugs. But as the cost of pharmaceuticals continued to grow, often rivaling that of hospitalizations, employers began purchasing stop-loss coverage for that expense as well, she said.

Today's stop-loss contracts typically cover medical and pharmaceutical costs, and it is possible to purchase stop-loss coverage solely for prescription drugs.

Mike Sullivan, Pittsburgh-based president and chief operating officer of HM Insurance Group, a stop-loss carrier owned by Highmark Blue Cross & Blue Shield, said his company may laser at either the beginning of the contract or at renewal, depending on the circumstance.

When an employer comes to HM Insurance seeking a stop-loss quote, the insurer will ask for disclosure of any large claimants in the group and will place a laser on those individuals in the first year, depending on the condition and how high of a specific deductible the employer purchases, he said.

"At that point, the employer has the choice of taking the laser, staying fully insured or staying with their current carrier for stop-loss" if they already are self-funded, Mr. Sullivan said.

But if a self-funded employer already is an HM Insurance customer and is going through the renewal process, "this is where the headaches around lasering exist," he said.

"It can put the employer in a tough spot. They have been self-funded, but now their carrier is asking them to take more risk," Mr. Sullivan said.

While the threat of having a laser placed on any individual plan member may seem scary for some self-funded employers, there are ways to mitigate the financial impact, experts say.

In some cases, employers can elect to pay a higher premium for the entire group to offset the additional costs the lasered claimant is likely to incur. But that's not always feasible.

"If it's a $100,000 deductible, and the underwriter says we have a $1 million liability on one employee, some carriers will put $900,000 into the premium," said Mr. Sullivan.

In most cases, though, the increased premium should be less than the laser.

"It should not be a dollar-for-dollar switch. If you have a long-term relationship with a carrier, they may try to recoup the expense over three years vs. one year to spread out the risk and look for alternatives that might mitigate some of the cost increase," said Ms. Cowden.

In lieu of lasering a specific individual, some stop-loss carriers might offer to spread the risk across the entire group by "aggregating the specifics," according to Robert J. Melillo, national vp, risk financing solutions at broker USI Insurance Services L.L.C. based in Meriden, Conn.

"In cases where there is a concern, but not a high probability, that a claimant will exceed the deductible, the carrier may choose to 'aggregate the specifics,' which can be satisfied by adding together all of the claim costs above the specific deductibles on any individuals and then applying them to an additional risk corridor," he said.

For example, say an employer has a $100,000 specific deductible, and four individuals incur claims averaging $150,000 apiece, totaling $200,000. The employer would be responsible for paying an additional risk corridor of only $75,000 rather than the entire $200,000, Mr. Melillo said.

A third option is "tiered coinsurance," where the employer and the insurer share various layers of liability above the specific deductible.

"Say the specific deductible is $100,000. The carrier might take responsibility for 25% of any claims over that amount, the employer might take the next 50%, and then the carrier would pay the remainder," said Ms. Cowden.

EASING THE PAIN

Experts recommend ways to mitigate the financial impact of lasering

- Pay a higher premium for the entire group to offset the additional costs the lasered claimant is likely to incur
- Spread the risk across the entire group by "aggregating the specifics," or adding together all the claim costs above the specific deductibles on any individuals and applying them to an additional risk corridor
- Opt for "tiered coinsurance," where the employer and the insurer share various layers of liability above the specific deductible

Stop-loss insurers, TPAs seek cost-effective care

Regardless of how an employer chooses to address lasering, most stop-loss insurers will work with third-party administrators and disease management companies to ensure that affected claimants receive the most cost-effective care.

In fact, nearly all stop-loss insurers insist that lasered individuals seek treatment at "Centers of Excellence," medical centers that have reputations for providing optimal care for certain conditions at a more reasonable cost, experts say.

"Say a plan member is getting close to reaching the specific deductible. We may be able to reach out with medical management. We as a stop-loss carrier will work with cost-containment vendors to work with a group that may become subject to lasering," said Karin James, assistant vp of stop-loss and strategic operations, at Wellesley Hills, Mass.-based Sun Life Financial Inc., the U.S. business group of Sun Life Assurance Co. of Canada in Toronto.

Because the stop-loss underwriter will be on the hook for claims that exceed the higher attachment point created by the laser, "there is a vested interest on the part of the carrier to keep those costs in check," said Maria Harshbarger, a senior vp at Aon Hewitt in Chicago.

—By Joanne Wojcik

Transplant claims can jeopardize self-funded plans

Critical care coverage helps reduce impact of expensive claims

By MATT DUNNING

While stop-loss insurance can protect a self-insured employer from the majority of unexpected medical claims, even well-protected health plans are prone to the potentially catastrophic impact of organ and tissue transplant procedures.

Claims stemming from an organ or bone marrow transplant can range anywhere from $100,000 to $1.2 million and often span multiple policy years.

For small and midsize self-insured employers, a single transplant claim could deplete reserve funds and lead to stop-loss renewal rate increases as high as 45%-50%, depending on the length of the claim, experts say.

'Transplants are one of the most common conditions that can blow up a stop-loss renewal.'

Fred Garfield, Horton Group Inc.

"Transplants are one of the most common conditions that can blow up a stop-loss renewal," said Fred Garfield, senior vp and principal of the Orland Park, Ill.-based broker Horton Group Inc.

To mitigate that risk, several stop-loss underwriters in recent years have introduced critical care carve-out insurance policies, which provide first-dollar—no deductible or patient copay—coverage for organ and bone marrow transplants and related expenses, such as evaluations; organ search; registry and transportation, travel and lodging for patients, donors and companions; and post-operation expenses such as anti-rejection drug treatments and physician costs.

"With one of these kinds of products in place, not only does the member not incur any out-of-pocket costs, the plan doesn't incur any costs," usually for a period of time from the date of the transplant through up to one year of post-operation treatment, Mr. Garfield said.

Experts say pricing for transplant carve-out insurance averages about $7 per member, per month for single plan members and about $14 for families.

The limited number of insurers that underwrite transplant carve-out policies—including Chartis Inc.; United HealthCare Services Inc., a unit of Minnetonka, Minn.-based health insurer UnitedHealth Group Inc.; Arch Insurance Group Inc.; and Zurich North America, a unit of Zurich Financial Services Ltd.—typically market the products to employers insuring between 50 and 1,000 lives. Larger employers, experts say, likely would not need the coverage, as their self-funded retentions would be sufficient to cover claims costs without affecting stop-loss renewals.

When a transplant carve-out is purchased, its terms and conditions typically are attached to an employer's specific stop-loss policy as an exclusion to that coverage.

However, transplant carve-out policies do not relieve a stop-loss policy from its liability for claim costs above a certain deductible level, nor do they relieve the underlying self-insured health plans from their obligation to provide care. Instead, the transplant carve-out is viewed as separate mechanism by which the self-funded health care plan and the stop-loss policy meet those respective obligations.

Employers often are advised not to exclude transplant coverage from their stop-loss plan until after their transplant carve-out's first renewal.

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Perspectives

Small and midsize companies are looking at self-insurance as a cost-effective health care benefits solution as Patient Protection and Affordable Care Act deadlines approach. Michael W. Ferguson, who serves as chief operating officer for the Self-Insurance Institute of America Inc., looks at facts and myths surrounding the decision to self-insure.

Myths, facts about self-insuring

By Michael W. Ferguson

As more smaller and midsize companies look to self-insurance solutions to control escalating group health care costs in the wake of passage of the Patient Protection and Affordable Care Act, this proactive risk management approach has attracted increased negative attention from traditional health insurance industry and state regulators who warn of various calamities.

Of course, this criticism is largely predictable, as health insurance carriers are worried about market-share erosion, and state regulators don't like the fact they cannot directly regulate self-insured group health plans because of Employee Retirement Income Security Act pre-emption. Nonetheless, it's worth pointing out some of the more frequently repeated canards in order to help clear up any confusion this may cause for employers considering self-insurance.

Mr. Ferguson

It's worth pointing out some of the more frequently repeated canards in order to help clear up any confusion this may cause for employers considering self-insurance.

But first the disclaimer: Self-insurance is not the best option for every employer, regardless of size. In fact, it could be a very bad option based on a variety of considerations. In this regard, it is highly recommended that employers engage in the same type of thorough due diligence they would rely on for any other major financial decision.

That said, let's jump in and separate some important myths from realities.

Perhaps the most unfortunate allegation is that a primary motive for many employers to self-insure is that they can escape regulation, raising consumer protection concerns. While it is true that self-insured plans are not subject to state benefit mandates, there is no evidence to suggest that self-insured employers scrimp on covered benefits. In fact, it is widely acknowledged that self-insured plans incorporate more robust coverage terms for key health services because they have the ability to customize their plans to meet the specific needs of their employees.

And for employers switching to self-insurance since the passage of PPACA, they don't evade any new substantive federal regulations—except those specifically geared toward commercial health insurance carriers—because, by definition, they would establish "nongrandfathered" plans.

The reality is that self-insured employers actually subject themselves to more regulatory requirements because they are governed by ERISA, which prescribes strict federal rules for plan fiduciaries, among other requirements designed to protect the interests of plan participants.

Some critics also claim that self-insured health plans are more cost-effective because they deny claims at a higher rate than fully insured plans. But in a report issued by the U.S. Department of Health & Human Services last year, HHS-contracted researchers from RAND Corp. concluded that there is no evidence of such disparity.

Then there's the belief that self-insured plan participants pay higher premiums than their fully insured counterparts. The available data does not support this conclusion, either.

As part of a U.S. Department of Labor report on self-insured health plans released last year, Deloitte Financial Advisory Services L.L.P. and Advanced Analytical Consulting Group Inc. found that from 2009 to 2010 for employers with more than 200 covered lives, the average per employee premium contribution to be covered by fully insured plans increased by $808 compared with an average increase of $248 for self-insured premiums.

Most recently, influential academics and public policymakers predicted that such self-insured plans would contribute to adverse selection when insurance market reforms are fully implemented, suggesting that employers would switch back and forth between self-insured and exchange-offered plans based on their claims experience on a yearly basis.

That's a nice conspiracy theory for sure, but it does not match up with marketplace realities. The fact is that due to ongoing administrative and compliance requirements, employers cannot simply switch their self-insured plans on and off.

Moreover, once an employer transitions to a fully insured health plan, it loses possession of claims data, which makes it more difficult to re-establish a self-insured plan in the future regardless of other considerations.

Claims data is arguably the most important health plan asset, as it can help employers control future health plan costs and can be used to customized plan design details. Giving up this asset over one bad claim year is not a decision to be taken lightly by plan sponsors.

The health care marketplace certainly is evolving, creating shifting roles for self-insurers, commercial health insurance companies and public sector payers. All three industry segments contribute in different ways to ensure that coverage is as available and affordable for the widest population possible.

Those who disseminate misleading information about any of these segments do a disservice to the ongoing public dialogue on how to improve the country's health care system.

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inBrief

Baljit Dail resigns from Aon Hewitt

Baljit Dail, co-CEO of Aon Hewitt, will leave the benefit consultant and outsourcing unit of Aon Corp. at the end of March, Aon disclosed last week. In a filing with the Securities & Exchange Commission, Aon said Mr. Dail is "leaving the company to focus on his health and work-life balance." He entered into a separation agreement that entitles him to a cash payment of $1 million and vesting of various stock options and rewards available under the "termination without cause" provisions of Aon's stock plans. Kristi Savacool, who has run Aon Hewitt with Mr. Dail, will become the sole CEO.

Willis again to take benefit contingents

Willis Group Holdings P.L.C. said it again will accept traditional contingent commissions and bonus payments for its employee benefits business as of April 1, but not on its retail business. The brokerage stopped accepting all contingent commissions in 2004 amid then-New York Attorney General Eliot Spitzer's probe of the insurance industry. However, Willis has taken such commissions on the business it gained with its 2008 purchase of Hilb Rogal & Hobbs Co., though it has been phasing out such pay.

Zurich proposes name change

Zurich Financial Services Ltd. said its board of directors has proposed changing its name to reflect the company's strategic focus on insurance. The new name, Zurich Insurance Group Ltd., will be brought to the March 29 annual shareholder meeting.

Obama targets tax break for offshore reinsurance

The Obama administration is reviving its call to disallow the deduction for excess nontaxed reinsurance premiums paid to affiliates. The proposal was part of the administration's 2013 budget plan and casts the change as an issue of fairness. It says that reinsurance transactions with affiliates that aren't subject to U.S. income tax on insurance income "can result in substantial U.S. tax advantages over similar transactions with entities that are subject" to U.S. tax, according to the Treasury Department. The proposal says the excise tax on reinsurance policies issued by foreign reinsurers is not always sufficient to offset this tax advantage.

Mexican insurance market continues to grow

The Mexican insurance market is growing despite the industry's low penetration level, according to a report by A.M. Best Co. Inc., which noted that Mexico is the second-largest insurance market in Latin America behind Brazil. But the insurance industry has a relatively low penetration level, amounting to only 1.8% of the country's gross domestic product. Nevertheless, Best's report found that direct premiums written across all lines of insurance grew 7.9% to 204.3 billion Mexican pesos ($15.96 billion) during the first three quarters of 2011 compared with the same period a year earlier.

DOL, California to address employee misclassification

The U.S. Department of Labor has entered into a memorandum of understanding under which it will work with the state of California to address the issue of misclassification of employees. Wage-and-hour lawsuits are becoming a major concern for employers as more suits are filed. The Labor Department and California "will embark on new efforts" to protect employees rights "and level the playing field for responsible employers by reducing the practice conducted by some businesses of misclassifying employees."

Mo. Senate passes work comp law revisions

The Missouri Senate passed a bill that would make workers compensation the exclusive remedy for occupational illnesses, among other revisions to the state's workers comp law. The bill would require occupational diseases to be covered solely by workers comp, except in cases of toxic exposure to chemicals, radiation and other substances caused by a third party. A separate clause says an employee's co-workers can't be sued for workplace injuries or deaths that would be covered by workers comp, excluding cases of negligence.

AP PHOTO

Penn State sues PMA over abuse case coverage

Pennsylvania State University last week countersued its commercial general liability insurer of 60 years for its refusal to provide coverage in the case involving child sexual abuse allegations against former assistant football coach Gerald A. Sandusky (above, second from right).

The suit alleges that Pennsylvania Manufacturers' Assn. Insurance Co. refused to honor obligations under CGL policies in connection with a November suit filed against Penn State alleging negligence related to Mr. Sandusky's alleged sexual misconduct.

In late January, Blue Bell, Pa.-based PMA sought a declaratory judgment that Penn State is not entitled to coverage and defense under certain policies.

PMA said only the policy in effect for the period during which the alleged abuse by Mr. Sandusky first occurred in 1992 was triggered by the November suit. But Penn State may not be covered due to exclusions for "abuse and molestation," "intentional acts" and "known loss," PMA said in its suit.

In its countersuit, Penn State said because the alleged molestation was ongoing, PMA owes it a defense and indemnification under each CGL policy during the period of alleged injury. Penn State has had CGL coverage with PMA since the 1950s.

PBGC to offer employers temporary penalty waiver

Under a new temporary voluntary compliance program, the Pension Benefit Guaranty Corp. will waive penalties on employers who have never paid federally required pension insurance premiums. To qualify for the relief, employers will have to contact the PBGC by July 31 to discuss how they can comply and then pay the required amount by Aug. 31. In announcing the program, the PBGC said that once plan administrators realized they should have been paying premiums, one reason they didn't pay them is because the penalties for late premiums can be substantial—up to 100% of the unpaid premium. In fairness to "compliant" plan sponsors, the PBGC warned that after the relief program ends, it will step up its efforts to enforce premium requirements for covered plans that have not paid required premiums.

Automatic enrollment delayed to 2014

A provision in the health care reform law that requires employers with more than 200 employees to automatically enroll new employees in one of their health care plans will not go into effect until 2014, federal regulators say. In guidance released last week by the departments of Labor, Health and Human Services and the Internal Revenue Service, the agencies said the requirement will not go into effect until regulations are issued.

Ore. bill would allow formation of captives

A measure that would allow the formation of captive insurance companies in Oregon is advancing through the state's Senate. It would allow the formation of single-parent captives, association captives, branch captives and captive reinsurers in Oregon. If passed, the Oregon captive law would take effect July 1.

Noted

Tony Melia has been named by **Willis Group Holdings P.L.C.**'s Willis Re unit as CEO of Willis Re International, effective immediately....Richard Houghton will leave his post as chief financial officer at **Aspen Insurance Holdings Ltd.**, effective Feb. 29. Chief risk officer, Julian Cusack, will assume his responsibilities until a replacement can be found.

CONTRIBUTING: Roberto Ceniceros, Matt Dunning, Mike Tsikoudakis

End Page

Lawmakers ice plan to release sled liability

Municipal risk managers in Iowa hoping for new protections against the litigious parents of sledding youngsters were rebuked last week, as a measure releasing cities of liability for injuries sustained on public property failed in the state Legislature.

The Iowa House Judiciary Committee returned a tie vote on the measure Tuesday morning, according to a Radiolowa.com report. Members of the committee raised concerns that the new law would place an undue legal or financial burden on families who allow their children to sled on city-owned property, Radiolowa reported.

"I don't think it's going to stop or start sledding, one way or another," said state Rep. Jo Oldson, a Democratic from Iowa House District 61, according to Radiolowa. "And basically what it's doing is transferring the liability back to an individual, most likely a child."

Republican Rep. Dave Heaton, 71, said prior to the committee's vote that he feared the law did not take into account fundamental changes in the nature of sledding over the years, particularly the design and speed capabilities of today's sleds.

"I'm thinking of my old Coaster, you know, the one where you could steer it, but now when I see what they're doing out there on this lake that we can cross out there in Clive (Iowa), they're on these discs, and spew!" Rep. Heaton said. "With that lack of control, all of a sudden I'm starting to say, 'I don't know whether I want to go this route.'"

However, some members of the committee argued that it was the state's cities and towns that were being unduly burdened by the high cost of injury litigation, especially considering the inherently voluntary nature of the act, according to Radiolowa.

"I cannot understand why any city or municipality should be responsible for and legally liable for a child that decides to get on a disc just because they want to tumble off of it," said Republican Rep. Chip Baltimore.

Members also grappled with the question of whether there exists a legally enforceable definition of sledding that could be applied to the proposed law. According to Radiolowa, Republican Rep. Chris Hagenow joked that sledding, for legal purposes, was similar to pornography in that one might not be able to define it, but can clearly recognize it on sight.

"Among other things, (it is) included but not limited to getting onto some sort of flat, slippery piece of equipment and heading down a hill that's covered with snow," Rep. Hagenow said.

Ramp removal really bites for skaters

As the old saying goes, it's all fun and games until someone gets bitten by an unidentified dog.

Well, maybe that's not exactly how the saying goes, but that's what happened at one Phoenix hotspot, where a man's encounter with an ill-tempered pooch has led to the removal of a skateboard ramp, according to a Phoenix New Times report.

Martin Lieberman, owner of the Conspire coffee shop and music venue, said he plans to strike the popular half pipe ramp behind his establishment after he was sued for negligence this year.

But that lawsuit has little, if anything, to do with the ramp itself.

In a lawsuit filed in Maricopa County Superior Court, Mesa, Ariz., resident Robert Maida claims he was attacked by a dog behind the Conspire building in December 2010. The dog, whose owner never was identified, managed to jump up and bite Mr. Maida's face off during the attack.

He has sued Mr. Lieberman, the Conspire staff and organizers of a craft fair for local artists for negligence and "failure to secure premises," the New Times reported.

Mr. Lieberman is contesting the allegations, but no matter how the case goes, it seems the half-pipe is doomed to be a casualty. When Mr. Lieberman's insurers inspected the property in response to Mr. Maida's lawsuit, they determined the ramp was a "hazardous structure," the New Times report said.

Non-scents in New Hampshire

A bill before New Hampshire's House of Representatives would ban state employees from using perfumes, colognes or other scented products while working with the public.

Banning scents is not a silly proposal, said New Hampshire Rep. Michele Peckham, one of two Republican sponsors of H.B. 1444. Many people experience violent reactions to strong scents and the potential ban would address a serious health issue, Rep. Peckham told the media.

Reports say some private employers already have prohibited employees from wearing scents or using air fresheners in their offices. In 2008, a Detroit city worker reportedly sued her employer under the Americans with Disabilities Act and later won a $100,000 settlement after alleging scents worn by co-workers caused her to suffer breathing problems, nausea, coughing and migraines.

Chemical sensitivities can be similar to allergic reactions suffered by people who don't tolerate mold or pollen, allergists say.

But at least one blogger has raised several potential problems for enforcing workplace scent bans.

"What I'd like to know is: How are these policies enforced?" wrote Deborah Kotz, author of Boston.com's Daily dose blog. "Do scent monitors patrol hallways sniffing wrists, underarms and necks? And what about those strong fabric softeners that leave a scent on our clothes?"

The New Hampshire legislation includes no penalties for public-facing employees who do wear cologne or perfume.

CITIZEN CRITICIZES CITIZENS OVER ITS CITI-SINS

A frustrated Florida folk singer took to YouTube with a new tune to protest his state-run insurance company.

Kevin Roth of Oakland Park, Fla., last week wrote and posted a song on YouTube after receiving a letter from Citizens Property Insurance Corp. saying the insurer was reducing the coverage on his home, according to news reports.

In the song, called "Citi-Sins," Mr. Roth says the insurer is a "rip-off of the poor," and "when it comes to state insurance, it's screw the public need."

Mr. Roth has performed across the country at music festivals and concerts, made television and radio appearances and also performed at the White House, according to his official website.

Citizens is a nonprofit government corporation that provides insurance coverage to hundreds of thousands Florida property owners.

In the song, Mr. Roth also criticizes Florida Gov. Rick Scott, who ordered the insurance company to downsize by reducing coverage in efforts to incentivize homeowners to seek coverage from private carriers, according to news reports.

"Gov. Scott doesn't plan to hit a recording studio on the issue anytime soon, but he and Kevin Roth have been singing a similar song (figuratively speaking)," Lane Wright, Gov. Scott's press secretary, wrote in an email to The Palm Beach Post in response to the song. "Citizens is broken. It needs to be fixed."

Citizens also faces lawsuits filed by Florida homeowners for using a valuation system that forced policyholders to pay more in premiums, according to news reports.

According to the YouTube posting, the song will be available Feb. 21 on iTunes.

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