Self-Insurance Institute of America, Inc.

Industry White Paper

A Model Self-Funded Health Plan

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A MODEL SELF-FUNDED HEALTH PLAN

Introduction

The advantages of self-funding employee benefits plans are well established and clear. Among the most widely acknowledged advantages are:

- Control over and flexibility in plan design;
- Management of the reserves and control over cash flow and investment income;
- Choice of service providers; and
- Hard dollar savings in eliminating the expense of state premium taxes and state benefit mandates.

Health care costs rank among the top concerns of U.S. employers. How to design and finance the plans in the post-managed care age with double digit health care cost trend rates are questions that inordinately occupy benefits professionals and corporate executives. In this working paper, the SIIA Benefits Committee seeks to put forward a set of "sound principles" and "best practices" to assist the employer community and the SIIA membership in the development and maintenance of self-funded health care benefits plans. The committee has chosen to divide the working paper into five sections:

- Plan design;
- Financing;
- Health care management;
- Employee education; and
- Data and benchmarking.

As is readily seen, the five sections are bound to overlap and influence one another. Nevertheless, these sections provide a conceptual framework for discussing the major issues confronting self-funded health plans.

In reviewing the information provided below, the Committee also wishes to note that the models presented are based on general principles and illustrative cost models. Each employer's specific circumstances will dictate the degree to which the principles can or should be implemented and the cost illustrations that will be applicable. Among the issues confronting an employer that will impact the applicability of the model or various parts of the model are: (1) the employer's geographic location as it affects the market for and delivery of medical services to the employer's employees; (2) the labor market in which the employer competes for employees; (3) the presence or absence of collective bargaining agreements that may require design characteristics that differ from the model; (4) the company's overall strategic objections; and (5) the economy in general. For this reason, the model is presented as a set of explanations and recommendations rather than as a prescription for design, financing, etc.

Plan Design

Plan design over the course of the past two decades has increasingly strayed from the principles of traditional insurance where the consumer budgets and plans for predictable costs and seeks insurance coverage for "catastrophic" expenses. The current push toward "consumer driven health care" is an attempt to return to those principles and to re-establish the financial discussion between patient and provider. Why is it important to return to or rely upon traditional insurance principles? These tried and true risk sharing methodologies provide long-term cost management and maintain the financial stake the "insured" and/or covered person (i.e., the consumer) has in the management of those risks, thus mitigating cost escalation. Relying on traditional insurance principles to create the outline of the model plan, the actual design would:

- Ensure the consumer is financially involved in all decisions relating to his or her care to the extent that the consumer can exercise control over his or her consumption of services;
- Automatically incorporate inflation adjustments;
- Take advantage of negotiated price concessions from providers;
- Be simple in concept and communication; and
- Not micro-manage specific areas of utilization.

The emphasis on re-establishing the consumer's role in the health care decision-making process and the financial consequences of those decisions would revise the preceding list to include:

- Ensuring financial involvement by establishing a significant financial stake for the consumer in terms of "high" deductibles and co-insurance;
- Facilitating a tax-advantaged savings vehicle for consumers to accumulate sufficient funds to defray the additional out-of-pocket expenses;
- Supplying information to the consumer to allow the consumer to review the propriety of various treatment options, and the efficiency of potential providers, to answer general health questions, and to promote healthy life-styles; and
- Ensuring a manageable level of catastrophic coverage (e.g., out-of-pocket maximums) protects the consumer against high cost treatments or unanticipated accidents or illnesses.

Each of these principles is more fully developed below.

Provide Significant Consumer Financial Involvement and Automatic Inflation Adjustment. Current plan designs involve the consumer generally in one or more of three tools:

- Deductibles. The purpose of the deductible is to place responsibility for the decision to seek services in the first place on the consumer's shoulders. Further, the deductible suggests that there are some services the consumer can plan for and, therefore, budget for that should not be the responsibility of the plan coverage.

    - ✓ *Deductible Adjustments*. Deductibles are generally established as specific dollar amounts. They do not, therefore, automatically adjust with inflation. To rectify this, a plan must be established and communicated to increase the size of deductible periodically (e.g., indexing the deductible). Another method to achieve automatic inflation adjustment is to establish the deductible as a percentage of salary. (This method, however, will not account for the difference between wage inflation and medical cost inflation.)

- ✓ *Deductible Size*: The $100 deductible of the 1960s and 1970s is worth between $480 and $635 in 2004 according to the Bureau of Labor Statistics inflation calculator. Please note, however, that the inflation calculator is based on changes in the consumer price index and not on medical inflation or health care trend. Thus, that $100 deductible could easily be in the $1,000 range – a range that is considered a "high deductible" health plan today – if it were based on these higher indexes. Increasing a $250 deductible to $500 without making any other changes could reduce claims' costs by 2.5% to 3.5%. Increasing it to $1,000 would reduce claims' costs by 8% to 9%.

- Co-pays. The managed care industry implemented nominal physician office visit and other co-pays under the assumption that the physician would manage the care. These co-pays were intended to be the actuarial equivalent of coinsurance, but they block the automatic inflation adjustment of coinsurance and remove the consumer's desire to understand the price of the services requested. With co-pays, the consumer is motivated to get the greatest value for his or her $15 or $20 (translated as more services). Co-pays have not proven to be effective cost-sharing mechanisms and should be replaced with coinsurance, except for those benefits where the plan sponsor wishes to encourage utilization, e.g., wellness benefits, etc.

- Co-insurance. To ensure a continued economic stake for the consumer in his or her medical care decisions a percentage coinsurance is appropriate. Coinsurance automatically adjusts itself with health care inflation and ensures the consumer is financially involved in all decisions to seek services.

Arguments have been made that deductibles and coinsurance are barriers to obtaining care while the health condition is less expensive to treat rather than waiting until the condition required higher cost interventions. To date, no studies have validated this assertion.

Although not generally thought of in terms of consumer financial involvement, the following are also effective plan design tools:

- Medical Necessity. Covered services should be limited to those that are truly medically necessary or appropriate based on accepted practice protocols by competent medical professionals (both physically and mentally) and those diagnostic services where the short to intermediate term value has been demonstrated (e.g., mammography, immunizations, etc.). If such "wellness" benefits are offered, they should be offered as budgets (benefits with a dollar amount limit) for the appropriate diagnostic measures to increase wise consumerism. In addition to mammography and immunizations, examples of what could be included in wellness budgets are pap smears, blood tests, flu shots, smoking and weight, etc.

- Benefit Limitations. For medically appropriate therapy benefits, where the value is difficult to measure or where there is generally a decreasing return on investment with on-going treatments, it is critical to institute limitations on coverage. Such limitations have the greatest value when they are expressed as a dollar amount. That way the consumer is involved in how the funds are spent. (The Committee recognizes that federal laws and regulations have restricted such dollar-based limitations for some types of therapy. For this reason, visit and/or day limits may be appropriate.) A further benefit limitation should be for experimental treatments. Generally such treatments either have not been proven effective for specific conditions or have not been accepted as part of standard treatment protocols by the medical community. Each plan sponsor must assess the viability of coverage for such treatments in conjunction with competent medical advisors.

- Network Benefits and Discounts. The general theory behind network discounts for both the health plan and for the provider is a trade off between unit price (profit for the provider) and volume of patients (an increase in units). To be of real value, there are several concepts that must be implemented:

  ✓ *Steerage*:

  - Deductible. Separate deductibles should be established for in-network and non-network benefits. Many plans have co-mingled these deductibles but it dilutes the value of the network discounts.

  - Coinsurance. The minimum differential in benefits between the in-network and the non-network coinsurance should be at least 20 percentage points or it won't be a big enough driver of consumer behavior. If the deductible is co-mingled the minimum differential should be at least 30 percentage points.

  - Out of Pocket Maximums. Out of pocket maximums will be discussed in greater detail later in the report, but assuming there are out-of-pocket maximums, just as with the deductibles, the plan should never co-mingle these for in-network and non-network benefits.

  ✓ *Non-Network Benefits*. There should be a limitation on what the plan will pay versus what is charged by non-network services, e.g., the 80th percentile of reasonable and customary charges. For those services and providers where there is no established level of reasonable and customary charges, it is appropriate to utilize specialty vendors whose purpose is to scrutinize the charges presented to ascertain whether appropriate billing practices and reasonable cost structures have been presented on the invoice. Another option that can be employed more broadly is establishing a maximum allowable fee (often based on the in-network discounts) for non-network services. While this creates the opportunity for balance billing, it reinforces the benefits of obtaining the services from a less expensive source. Finally, no benefit should be available non-network that isn't also available at a benefit differential in network.

  ✓ *Value of In-Network Benefit Differential*. The value of the in-network benefit differential to the consumer should not be greater than the value of the provider discount to the health plan. For example, assume a Preferred Provider Organization (PPO) plan design with a 90% benefit in-network and a 70% benefit out of network. Assume further that a standard office visit at the 80th percentile of R&C is $70. If the non-network benefit is 70% of that amount (70% x $70 = $49), then the plan should pay no more than $49 at 90% in-network benefit. To arrive at the discounted price of the standard office visit, we divide $49 by 90% and arrive at $54.44. Thus the discount should be at least 22.2% of R&C (not 22.2% of an inflated retail price) as shown in the following table.

Description	Non-Network	Network	Calculation
Benefits	70%	90%	
Office Visit Retail Rate (R&C)	$70.00	$70.00	
Plan Payment	$49.00	$49.00	Network plan payment <= Non-network plan payment
Allowed Should Be No More Than		$54.44	$49.00 ÷ 90%
Not Allowed Would Then Be		$15.56	$70.00 - $54.44
Calculated Minimum Discount		22.2%	$15.56 ÷ $70.00

- ✓ *New Networks within Networks*. Three tier networks are becoming more common. They differ however in their application to hospital versus professional providers.

  - For hospitals: Many networks have recognized that certain hospitals' "manufacturer's suggested retail price" is significantly higher than other hospitals whose age, sex, and morbidity adjusted experience suggests similar quality and level of care. A 60% discount off the highest cost hospital may not be as good as a 10% discount off a lower cost hospital. Some of these networks are beginning to make data available to plan sponsors to allow them to provide additional incentives for using the lesser-cost facilities. On the other hand, a disincentive may be introduced in the form of higher deductibles or coinsurance for the use of the more expensive facilities.

  - For professionals: Often professionals in a PPO network are compensated in terms of a multiple of the Medicare rate. Thus for any given area the price of the service is the same regardless of provider. Physicians that order more tests and provide more services than their peers for the same diagnoses are the ones who are driving up the cost of the plan by driving up utilization. Again, plan sponsors that have information on practice patterns can develop a third tier of network providers to encourage consumers to seek services from those providers whose costs for any given diagnosis will generally be less.

- Rx coverage.

  - ✓ *Eliminate Co-Pays*. And express benefits in terms of co-insurance percentages. See the inflationary and utilization comments regarding co-pays under "coinsurance" above.

  - ✓ *Establish Separate Prescription Deductible*. See explanation under deductible. In addition, by having a separate deductible, it can all be administered at the pharmacy through the pharmacy benefit manager. Another option is to have the general medical deductible apply to the prescription coverage (as anticipated by the high deductible health plan required for a health savings account).

  - ✓ *Allow No Non-Network Benefits*. Given the prevalence of network facilities, there is no reason to pay prescriptions out of network.

  - ✓ *Provide Incentives for Mail Order*. Do not exceed, however, the value of mail order discount over the retail discount.

  - ✓ *Adopt Three Tier Designs*. Such programs are designed to increase consumer cost sharing for high cost brand-name drugs and to ensure cost effective options in the formulary. Significant attention should be paid to the formulary construction when selecting a Prescription Benefit Manager (PBM), as it is the single biggest factor determining total prescription-benefit expense.

  - ✓ *Formulary Structure*. Although contract pricing is important the factors contained within contract pricing (discount, administrative fees, and dispensing fees) if at least similar generally have only a minor impact on the total prescription benefit cost. The real determinant is the formulary and how it is managed. When comparing PBMs, it is wise to focus on the drugs (and drug classifications) with the largest prescription utilization, and those on which the largest amounts of money are spent and their formulary

alternatives. An “apples-to-apples” price comparison based on a benefit plan’s own experience is most often the best determinant of future expense.

- ✓ *Utilize Step Therapies.* Step therapies are designed to use lower cost drugs in the same therapeutic classification before jumping directly to the most expensive drugs. If the lower cost alternatives are not effective, the more expensive prescription is made available.

- ✓ *Integrate Mental Health Benefits.* One of the most utilized drug classes is focused on the treatment of depression and anxiety. Integrating prescription coverage with mental health utilization review can be an effective means of ensuring the appropriateness of care, compliance with accepted treatment protocols, and reducing the possibilities of prolonged and repeat treatments.

- ✓ *Address Specialty Pharmaceutical (Biotech Drug) Therapies*. The biotech drug field is growing. As of the drafting of this paper, some 80 biotech drugs had been approved by the FDA and 350 were in Phase III testing. Such therapies hold great promise for treatments and cures of specific diseases, like multiple sclerosis, that have eluded more traditional treatments. The cost of these drugs, however, is significantly higher than more traditional pharmaceuticals. There is as yet no clear consensus on how best to deal with biotech treatments, but requiring your PBM to address the issue is critical to the financial health of any health benefits plan.

- Mental Health Coverage. Often mental health conditions are diagnosed and treated only by the individual’s primary care physician. A plan design that encourages the most effective and proven mental health therapies (which may include a combination of both pharmaceutical and psychological therapy) actually improves outcomes and reduces future plan costs. The plan design should provide incentives (e.g., a higher benefit) for working with an EAP or disease management organization to coach the individual through the options for mental health treatment and compliance with the prescribed treatment.

- Coordination of Benefits. With the number of dual income households, it is critical to get the benefit of coordinating with other insurance (benefit plans). Many plans institute very strict COB provisions, but this tends to have a relatively low value to the plan compared with the negative perception for the participant. As long as a full “premium” or employee contribution is being received, it is not out of line to use a COB provision that would pay 100% of the remaining balance not to exceed the plan’s benefit if it had been primary.

Be Simple in Concept and Communication. Complex plan designs generally create more frustration and misunderstandings than they save in claims costs, and employees do not appreciate what they do not understand. Utilizing one plan option that pays all covered services at the same level (with appropriate limits on certain services) eases communication and eliminates the gaming that takes place in more complex designs. When multiple plan options are offered side by side, it is critical that no option cover something the other options do not, and that the differences among the options are easy to understand. For example, varying only the deductible and the coinsurance as in the example below allows for quick and accurate comparison shopping.

	Option A	Option B	Option C
Deductible	$250/$500 in network No benefit out of network	$500/$1,000 in network $500/$1,000 non-network	$1,000/$2,000 in network $1,000/$2,000 non-network
Coinsurance	90% in network No benefit out of network	80% in network 60% non-network	70% in network 50% non-network
Out of pocket maximum	$3,000/$6,000 in network No benefit out of network	$3,000/$6,000 in network $3,000/$6,000 non-network	$3,000/$6,000 in network $3,000/$6,000 non-network

In today's world of high deductible health plans, Option A may seem to be out of step. Indeed, it may be, but there are still many plans in the market with this level of benefit coverage. To mitigate the level of benefits offered, no out of network coverage is offered. Such an option may be appropriate assuming the value of the network warrants it.

The pricing among the options should be based on the benefit value differences, but that will be discussed in the section on financing. Additional benefits to the plan sponsor of this simplicity of design are: 1) the ease and lowered expense of communications; 2) the reduced incidence of differences in interpretation between the Plan Administrator and the excess loss insurance carrier; and 3) consistency of perceived value by the consumers (employees).

Don't Micro Manage Utilization. Experience has shown that every time a plan has tried to correct a perceived utilization problem in a specific covered service through a special co-pay or limitation, expenses in another area have increased. If the consumer is truly involved in the financial consequences of his or her choices and if the coverage percentage is the same (see above) regardless of where the services are performed or by whom, the consumer will tend to seek the services in the most cost-effective place and from the most cost-effective provider type, assuming this information is made available to the consumer.

Facilitate Tax-Advantaged Savings Vehicles for Consumers. Beginning with flexible spending accounts (FSAs) in the early 1980s, employers have been able to facilitate tax-advantaged savings for their employees' out-of-pocket expenses. Unfortunately, over the years some of the advantages of FSAs were curtailed through the use-it-or-lose-it and uniform coverage rules. More recently we had the Health Reimbursement Accounts that allowed employer contributions to offset the pain of instituting higher deductibles, but employees were not allowed to contribute. The passage of the 2003 Medicare Prescription Drug Improvement, and Modernization Act gave employers a great tool to assist with the implementation of greater consumer responsibility – the Health Savings Account or HSA. These accounts allow for both or either employer or employee contributions, roll over balances from year to year, and elimination of the uniform coverage rule. The HSA can only be offered in conjunction with a High Deductible Health Plan and beginning in 2006 cannot have prescription coverage below the deductible. Tax deductibility for the consumer is limited to the lesser of the deductible or a defined amount that is indexed for inflation. Employers who do more than simply allow for contributions to an individually established HSA may also be subject to ERISA compliance with regard to the HSAs. The chart below compares key features of FSAs, HRAs, and HSAs. It was published earlier this year in Ernie Clevenger's electronic newsletter MyHealthGuide and was prepared by MyHealthGuide and the U.S. Department of Labor (see the website (www.bls.gov/opub/cwc/cm20031022ar01p1.htm#appendixa).

Comparison of Key Features
Flexible Spending Accounts, Health Reimbursement Accounts and Health Savings Accounts

	Flexible Spending Account	**Health Reimbursement Arrangement**	**Health Savings Accounts**
Initial legislation or regulation	Revenue Act of 1978	U.S. Department of the Treasury Revenue Ruling 2002-41	Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003
Date effective	January 1, 1979	June 26, 2002	January 1, 2004

	Flexible Spending Account	Health Reimbursement Arrangement	Health Savings Accounts
Internal Revenue Code reference	Internal Revenue Code section 125	Internal Revenue Code section 105-106	Internal Revenue Code section 223
Eligibility	All employees except self-employed	All employees	Any individual who is covered by a high-deductible health plan may establish an HSA ... and is not also covered by any other health plan that is not an HDHP (with certain exceptions for plans providing certain limited types of coverage)
Qualified medical expenses	Unreimbursed medical care expenses as defined by Internal Revenue Code section 213, excluding premiums for health insurance coverage and long-term care expenses	Unreimbursed medical care expenses as defined by Internal Revenue Code section 213	Qualified medical expenses as defined in section 213(d) (including nonprescription drugs as described in Rev. Rul. 2003-102, 2003-38 I.R.B. 559)
Nonqualified medical expenses	Expenses not under Internal Revenue Code section 213 Health insurance premiums under a continuation of coverage arrangement (such as COBRA) Health insurance premiums when receiving unemployment compensation Qualified long-term care insurance premiums	Expenses not under Internal Revenue Code section 213	Expenses covered by insurance or otherwise.
Must be covered by a health insurance plan	No	No	Yes, a high-deductible health plan (HDHP).

	Flexible Spending Account	Health Reimbursement Arrangement	Health Savings Accounts
Contributor	Employee, employer, or both	Employer	Both employee and employer in any of 3 ways: 1. Employee and family members can make tax deductible contributions to the HSA even if the individual does not itemize deductions 2. Employer can make contributions that are not taxed to either the employer or the employee 3. Employers with cafeteria plans can allow employees to contribute untaxed salary through a salary reduction plan.
Contribution limits	No statutory limit; limits may be set by employer	No statutory limit; limits may be set by employer	The maximum contribution is now the full amount of the deductible.
Funds carried over to next year	No	Yes	Yes
Portability	Account cannot be maintained if the employee is no longer working for the employer	At employer discretion	Amounts contributed to an HSA belong to individuals and are completely portable. Every year the money not spent would stay in the account and gain interest tax-free, just like an IRA. Unused amounts remain available for later years (unlike amounts in Flexible Spending Arrangements that are forfeited if not used by the end of the year). Funds distributed from the HSA are not taxed if they are used to pay qualifying medical expenses. To encourage saving for health expenses after retirement, HSA owners between age 55 and 65 are allowed to make additional catch-up contributions ($500 in 2004) to their HSAs.

Supply Information to Help Consumers Make Decisions. This point will be discussed below under the consumer education section. Suffice it to say here that if a health plan intends to place more financial accountability upon the consumers of health care services, that same health plan and its sponsor need to help the consumer understand the options with regard to treatments and the providers of those treatments. In addition, the plan must help its participants understand the financial and quality of life benefits of implementing healthier life styles. Finally, if the information is to be used, it must be from a credible source and in a language the participants can fully comprehend.

Provide Appropriate Levels of Catastrophic Coverage. In a group health plan, the catastrophic coverage is provided by the out-of-pocket maximum, which limits the amount a participant would have to cover out of his or her own pocket before the benefit plan takes over and pays 100% of any additional costs. These limits have commonly been a function of the percentage of co-insurance and the level of benefits at which the plan sponsor is willing to assume full liability because the

consumer is truly in a high cost situation. For example, an out-of-pocket maximum of $3,000 on a 90% in-network benefit means that the covered participant would have to exceed $30,000 in in-network paid benefits before he or she could rely on the plan for 100% coverage. Generally speaking, once an individual incurs that level of expense, his or her control over the remainder of expenses is limited at best.

Over the years, the out-of-pocket maximums have tended to increase as the deductibles increase. It is interesting to note that the High Deductible Health Plans related to HSAs under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 say that the single deductible cannot be less than $1,000, but the single out-of-pocket maximum *cannot be more than* $5,000. If an employer offers several options ranging from low deductibles to high deductibles it is common to see that the same plans range from low out-of-pocket maximums to high out-of-pocket maximums respectively. Sound insurance principles, however, would suggest that out-of-pocket maximums could remain constant or relatively constant across the plans to help induce the participant to take responsibility for the first dollar coverage (through the deductible) but still provide a backstop to the participant's total outlay. Such a participant is more willing to take the up-front risk if he or she can depend on a reasonable limit to total out-of-pocket costs. (See the three-option example above.) Non-network out-of-pocket maximums should help drive the consumer in network for services. For this reason, it is recommended that the out-of-network out-of-pocket maximum be a minimum of two times the in-network out-of-pocket maximum.

Finally, out-of-pocket maximums like deductibles are usually stated as defined dollar amounts that do not vary with inflation. A plan must be in place and communicated to adjust those out-of-pocket maximums with inflation. Increasing a $1,500 out-of-pocket maximum to $3,000 could save approximately 3% of claims expenses without changing the deductible.

Financing

The financing of the overall plan expense comes from employer and employee contributions and, with double digit inflation, health care costs are rapidly becoming the most expensive labor costs next to salaries and wages themselves. To control costs, many employers who are new to self-funding have a tendency to focus on the predictable and definable costs of the plan – administrative fees, excess loss premiums, access fees, etc., but these more definable expenses generally account only for between 8% and 12% of total plan costs on average. What is critical in the financing of the plan is to use plan design, communication, administrative, and health management tools together with appropriate financing techniques to beat trend. This section of the working paper will concentrate on the components of health care cost trend, calculating of costs, setting reserves; optimizing the risk pool; developing employee contribution strategies; excess loss insurance; and alternate risk financing vehicles.

Health Care Cost Trend. Health Care Cost Trend does not equal inflation. Instead, it is the measure of how health plans expect their claims costs to increase from year to year. The components of trend start with the medical price index, an element of the consumer price index. The medical price index measures price inflation on a market basket of health care goods and services, but it does not measure mix or utilization of the goods and services. Further, it does not measure the impact of new technologies or of new uses for existing technologies. On top of price inflation, trend must estimate both the mix of services and the introduction of new services. Added to inflation and utilization are the effects of leveraging (deductibles not adjusting for inflation), cost shifting, defensive medicine practices, and demographic shifts, etc. A 12% health care cost trend might be built in the following fashion:

Price inflation	3.5%
Utilization	2.0%
New Technology	2.0%
Leveraging	1.0%
Cost Shifting	1.0%
Demographic Shifts	1.0%
Defensive Medicine	0.5%
Regulatory and other	1.0%
	12.0%

Understanding the components of cost increases helps plan sponsors focus attention on those areas of greatest impact. For example, if a plan, through appropriate health care management interventions, can promote healthier life styles and management of chronic conditions, that same plan can trim the utilization and demographic portions of trend. At the same time, if plan design promotes automatic inflation adjustments and wise consumerism the impact of leveraging and utilization is lessened. Combined, the plan may be able to beat inflation by 2 to 3 percentage points. On $1,000,000 of claims in the base year, over 5 years the compound savings is 6% or over $350,000.

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Calculating Costs. The cost of health care benefits is dependent on plan design, because design dictates to a great extent the cost of claims and the impact of trend. Other factors that contribute to the overall plan expense include: administrative fees, health care management fees (see next section), excess loss premiums, network access fees, advisory services, and the change in appropriate reserves. The two most important reasons for calculating the costs are 1) for budgeting purposes, and 2) to establish a premium equivalency for use in establishing employee contributions.

Many plans use the excess loss underwriter's aggregate projections as the basis for setting the budget for the next year's claims and then layer on top the other fees.

Larger employers tend to use one or more years' experience trended forward with a risk adjustment to account for the potential that the projections could be lower or higher than actual experience. This risk adjustment is similar to the risk corridor that excess loss carriers place on aggregate insurance quotations. The allocation of the total budgeted costs to premium equivalencies are based on the projected number of enrollees in each enrollment tier and the relative risk among the tiers (e.g., in a three tier plan, the enrollee plus one may carry an average risk factor of 1.8 to 2.2 times the average risk factor of the employee only coverage and the average risk factor for the enrollee plus two or more may carry an average risk factor of 2.8 to 3.5 times the employee only coverage). These relative risk factors are derived from the claims experience in the various tiers.

Assuming that all plan costs are shared among the enrollment tiers based on the relationship of the risk factors among the tiers and there are three tiers, the formula for calculating the monthly premium equivalency for the employee only coverage is:

$$X = (Y \div 12) / [A + (B \bullet R_a) + (C \bullet R_b)]$$

Where: X = Single monthly premium equivalent
Y = Total projected annual cost of the plan
A = Projected number of enrollees in employee only coverage
B = Projected number of enrollees in employee plus one coverage
C = Projected number of enrollees in employee plus two or more coverage
R_a = Relative risk factor for employee plus one coverage
R_b = Relative risk factor for employee plus two or more coverage

The other tiers' monthly premium equivalency is calculated by multiplying the employee only monthly premium equivalency by the applicable relative risk factor. Of course, there are other methods of calculating this premium equivalency, but this analysis provides the plan sponsor a means for ensuring he or she knows both the total costs and how those costs are shared among the enrollees.

Setting Reserves. Often overlooked, the maintenance of appropriate reserves is **critical** to the financial health of a self-funded health care plan. Insurance premiums are set on an incurred basis, but more often than not, self-funded plans rely only on current contributions to meet claims and other expenses. Reserves not only fund run out and/or termination expenses, they provide an important cash flow tool for the plan to absorb the peaks and valleys of week-to-week and year-to-year experience. Reserves may be kept in general assets, in trust (e.g., a 501(c)(9) VEBA), a captive insurer, or another alternative risk financing vehicle described below, etc.

Four types of reserves may or may not be applicable in any particular plan's case, but each is described below:

- Incurred But Not Reported (IBNR) Claims Reserve. The purpose of this reserve is to establish sufficient funds to pay claims that are incurred during the coverage period but have not yet been reported to the claims administrator. An adjunct to this reserve figure are the claims that have been reported but have not yet been paid. In years past, it was quite common for these two reserve figures to be the equivalent of 3-1/2 to 4 months' worth of claims or more. EDI claims transmissions, PPO contracts, and improved claims adjudication systems have significantly reduced this. Today, it is more common to see such reserves in the 2 to 3 months range. Each plan's IBNR reserve can be determined from its claims lag reports.

- Administrative Reserve. Should a self-funded plan become insured or terminate, there will be run out claims. The claims expense should be charged against the IBNR reserve, but there are also administrative expenses for those run-out claims that can range from three to five months or more of standard administrative expenses.

- Risk Factor Reserve. Most excess loss insurers offer aggregate coverage at an attachment point that is 125% of expected claims. Thus the plan sponsor is responsible for expected claims plus an additional 25% before the excess loss insurance kicks in. If the plan does not have aggregate insurance, a risk factor on the trended claims is recommended (see "calculating costs" above). A plan sponsor may or may not choose to establish a reserve for the full aggregate corridor or risk factor, but a risk factor reserve is appropriate.

- Rate Stabilization Reserve. The purpose of this reserve is to help offset the costs of a particularly bad year where an otherwise large increase might be called for at the next renewal. The size of the rate stabilization reserve is purely under the purview of the plan sponsor, but it need not be particularly large.

These four reserves combined will generally not exceed 25% to 35% of total annual plan costs. If such reserves have not been established, they can be built up over the course of a few years. Some employers have simply determined that those reserves will be handled out of general corporate assets. The problem with this approach is that the incurred costs of the program are not shared with plan participants as they are incurred. Assuming reserves have been established, the change in reserves due to trend and inflation should also be included in the annual rate adjustment.

Optimizing the Risk Pool. Traditional group insurance principles rely on spreading risk across the greatest number of covered lives. Any splintering of the risk pool automatically inserts adverse selection into the equation. Where only one plan option is offered, there is only one risk pool, but where multiple plan options are offered, the spreading of risk is sub-optimized. This is especially true where a self-funded plan is offered along side a fully insured option. In most, but certainly not all cases, the self-funded option has the richer benefits or the broader access to providers – both of which tend to increase the costs and accelerate adverse selection, especially when each subset of the original pool is experience rated. If multiple options are to be offered, they can almost always all be self-funded and offered as part of the same risk pool. Further the procurement of excess loss insurance across the pool is eased again because the risk is being spread across a larger number of enrollees. To mitigate the potential of adverse selection, the plan will experience rate the entire pool, but establish premium equivalency rates for the different options. The premium equivalency rates should be based on the relative benefit value among the plans – not based on the utilization in each option. While it is true that one option may subsidize another to a certain extent, cross subsidization is a basic principle of group benefits.

The benefit plans used to illustrate simplicity above provide a good illustration of how this might work. Assume that the value difference between a $250 deductible to a $500 deductible is worth 3% and the value difference between a $250 deductible and a $1,000 deductible is worth 7%. Assume further that the coinsurance difference between the high option plan and the medium option plan is worth 11% and the coinsurance difference between the high option plan and the low option plan is worth 22%. That means that the medium option plan's premium equivalency would be 86% of the high option plan, and the low option plan's premium equivalency would be 71% of the high option. Given enrollment of 500 employee only, 150 employee plus one, and 350 enrollee plus two or more, and if we assume the high option plan's total expenses were $6,800 per enrollee per year, that the tiering structure for enrollee plus one is 2.1 times the enrollee only coverage, and that tiering structure for enrollee plus two or more is 3.2 times the enrollee only coverage, then the table below shows the premium equivalencies by plan and by tier.

	Option A	Option B	Option C
Enrollee Only	292.85	251.85	207.92
Enrollee Plus One	614.99	528.89	436.64
Enrollee Plus Two or More	937.12	805.92	665.36

Employee Contribution Strategies. The review of trend, the cost calculation, the setting of reserves, and optimizing the risk pool now places the plan sponsor in a position to address employee contribution strategies based on fully incurred premium equivalents. In the past, many employers have either contributed a constant percentage of the premium equivalent for all plans and all tiers (e.g., 80%) or they have paid 100% of the employee only coverage and a lesser (e.g., 75%) of the dependent's coverage. Of course as the plan costs have risen, the employer contributions have risen proportionately. More recently employers have sought to define their contribution in terms of a specified dollar amount that can be adjusted annually depending upon labor market conditions, the health of the company's bottom line, and other factors. No single strategy for arriving at an employer's contribution can be considered the best method; rather, each employer must consider current contribution levels and develop a plan to arrive at a desired dollar amount or percentage contribution for enrollee coverage and for dependent coverage and then communicate not only the enrollee contribution amount but the employer contribution amount so that enrollees are aware of the total cost of their coverage.

Current surveys suggest that employers are contributing approximately 80% toward employee only coverage and approximately 70% toward family coverage (according to the 2003 edition of "National Survey of Employer-Sponsored Health Plans" conducted by Mercer Human Resources Consulting). It is recommended that all enrollees, regardless of tier contribute something toward the cost of his or her coverage, unless under a multiple option plan, the low option costs allow an incentive to choose that option.

If multiple options are offered, it is important that the employer maintain a flat contribution amount (however arrived at) for each option so that consumers are aware of the financial consequences of their choices. Using the premium equivalency example above, assume the employer chooses to set a defined dollar amount for contributions based on the medium option plan. Assume further that the employer has contributed 70% toward enrollee only coverage in the past and 65% toward the coverage categories with dependents. Using the former methodology to establish the baseline, the table below shows the total premium equivalent, the employer contribution, and the employee contribution toward each plan.

	Option A	Option B	Option C
Enrollee Only			
• Total Premium Equivalent	$292.85	$251.85	$207.92
• Employer Contribution	$205.00	$205.00	$205.00
• Employee Contribution	$87.85	$46.85	$2.92
Enrollee Plus One			
• Total Premium Equivalent	$614.99	$528.89	$436.64
• Employer Contribution	$399.74	$399.74	$399.74
• Employee Contribution	$215.25	$129.15	$36.90
Enrollee Plus Two or More			
• Total Premium Equivalent	$937.12	$805.92	$665.36
• Employer Contribution	$609.13	$609.13	$609.13
• Employee Contribution	$327.99	$196.79	$56.23

Excess Loss Insurance. The purpose of excess loss insurance (stop loss) is to provide financial protection to the plan sponsor (as the risk taker for the costs of the plan). The reimbursements from the excess loss insurance are provided if a plan sponsor's expenses for the plan

exceed predicted amounts in total (aggregate coverage) or if a plan sponsor's expenses for a covered individual in the plan exceed the plan sponsor's cash flow coverage (specific coverage). Please note: excess loss coverage is not health care coverage nor is it reinsurance. It is an employer or plan sponsor indemnification. Reimbursements are made for losses in excess of expectations, not for medical claims. They are made for an accumulation of eligible and paid expenses under the provisions of the plan sponsor's health care plan which are in excess of the specific or aggregate attachment points (described below).

As a plan increases in size, the need for excess loss coverage declines because with a larger risk pool the claims costs become more statistically valid and predictable and the cash flow becomes large enough to withstand large claims hits. Every plan sponsor that purchases excess loss coverage should be familiar with the following:

- Specific Coverage. As noted above, specific coverage is designed to protect a plan sponsor's cash flow in the event any covered individual has claims for the year in excess of a reasonable amount given the size of the risk pool and premium base. Thus a smaller plan may have a specific deductible of $50,000 per individual and a larger plan may have a specific deductible of $200,000 or more. The premiums for the excess loss insurance become a fixed and budget-able expense for the plan, eliminating the potential variable costs above the deductible. In recent years, many self-funded plans have seen an increase in the size and number of so-called "lasers." A laser is an increase in the general specific deductible for an individual whose current health condition clearly indicates expenses in excess of the general deductible for the group. From the standpoint of the excess loss carrier, the identified individual represents a clear probability of a known loss. Some carriers will build the laser into the premium, while others require the special deductible for the identified individual(s). Some employers would rather have the special higher deductible if they believe the probability of incurring the projected amount to be small (for example with known terminations, etc.)

- Aggregate Coverage. Called "sleep insurance" in years past, the aggregate is the plan sponsor's protection against experience significantly exceeding projected total claims costs. Most (in fact almost all) excess loss insurers place a 25% corridor on the expected claims before the aggregate coverage will kick in. Even with that additional risk corridor the plan sponsor has a limit on the amount it will have to pay in any one coverage period. If claims are appropriately estimated, the chances of hitting the aggregate attachment point are relatively small so the premium is also relatively small.

- Aggregating Specific Coverage. An aggregating specific policy allows a plan sponsor to take some additional self-insured risk in exchange for lower specific premiums. If a plan sponsor had a specific deductible of $75,000 and, given the size of the risk pool, it was anticipated that it might have two claims exceed that deductible, the plan sponsor could assume an additional amount of risk (for example $25,000 above the $150,000 aggregate of the specific deductibles for the two expected hits). Some excess loss carriers would then be willing to reduce a portion of the premium for that additional corridor of risk the employer has retained. There are numerous variations on aggregating specific contracts the description of which would be too extensive for this paper. Nevertheless, the foregoing provides a general description of the concept.

- Claims basis (also known as the contract basis). The claims basis represents the timeframe for which a given policy covers incurred and paid claims. There are almost as many variations to claims bases as there are policies available. The most common are 12/12, 12/15, 15/12, 24/12, 12/24, and "paid". The first number in the combination represents the

time period for dates of service or incurring a claim. The second number represents the time period for dates of payment for a claim incurred in the incurral time period. Thus under a 12/12, the claim must be incurred and paid within the twelve months the policy covers. If it is paid a day later, no coverage is extended. Under a 12/15, claims incurred during the twelve months of the policy have up to three months beyond the end of the coverage period to be paid, allowing for the majority of run-out claims. Under a 15/12, rather than having a three-month run-out period, the plan sponsor has a three-month run-in period. A paid contract covers anything that is paid during the coverage period, regardless of date of service. A 12/12 policy is the least expensive, but it is also very dangerous. It is often recommended after converting from a fully insured contract because the fully insured contract has responsibility for any claim incurred while the policy was in place. If, however, upon renewal, the plan sponsor has difficulty obtaining run-in coverage, additional liability lands squarely on the shoulders of the plan sponsor.

- Disclosure. At the time of underwriting, any excess loss carrier is required by the standards of prudent underwriting to understand claims history and any potential large claim that may be in the offing. It is the responsibility of the plan sponsor in conjunction with the claims administrator to provide or disclose this information. Most underwriters want three years of paid claims history, a large claims report together with case management reports, a claims lag report, and a listing of claims or pre-certifications – even if the claims have not yet been received – in order to evaluate its risk and set premiums. In addition, underwriters will ask employers to declare any other known situations such as disabilities, COBRA enrollees with potential high cost claims, etc. If the excess loss carrier perceives that full and accurate disclosure was not received during the underwriting process, it may contest any claim it believes could and should have been disclosed. This is the area of greatest contention between carriers and insureds. As a result, SIIA is working to develop a standard format for disclosures to reduce this risk.

- "Reinsurance." This term is sometimes used erroneously to describe excess loss insurance. Reinsurance is a contract between two licensed insurance companies.

As a final note regarding excess loss coverage, it is critical that the plan sponsor, as the insured, review the policy exclusions and coverages against the plan's exclusions and coverages. Some excess loss insurance policies follow the provisions and fortunes of the plan as long as the plan is administered in accordance with the written plan documents. Other policies have limits or exclusions that place additional (and unanticipated) liability upon the plan sponsor if those same limits and exclusions are not in the plan document. Stated simply, it is important to know the carrier (reputation and reliability), know the policy, and leverage the relationship with the carrier to ease administration and claims submissions.

Alternative Risk Financing Vehicles. With the relaxation of regulations surrounding captive insurance for employee benefit plans and with the Department of Labor implementing a fast-track exemption/approval process, several employers have explored and some have developed programs to capture a portion of the excess loss risk through a captive insurance program. In so doing, these employers have reduced their excess loss insurance costs. Such alternative risk financing options have taken several forms, among which are: a single employer captive, participating in a captive through a dedicated cell, and the formulation of a captive insurance company owned and operated by several employers that have banded together to share risk on their own programs. An obstacle to these captive programs is obtaining reinsurance on the pool or on specific claims within the pool. With the lowered capacity in the reinsurance market since 2001, it can be difficult to procure reinsurance coverage for smaller programs with a premium base of less than $10,000,000. As a result, employers are combining their property and casualty risks with their employee benefit risks.

Health Care Management

Health care management services were originally introduced to help plans oversee the utilization of in-patient hospital services and to manage high cost cases for appropriateness of setting for the prescribed treatment protocols. Since that time, health care management has grown to include disease management, promotion of healthy life styles, predictive modeling, and population management. Key to the success of any of these programs is the extent to which intervention can impact cost and utilization. Each is an important component of a sound health benefits plan, and each is described in greater detail below.

In-Patient and Out-Patient Utilization Review. The purpose of most utilization review (or utilization management) programs (often called pre-certification) in today's world is not to deny medically appropriate services; rather it is to encourage treatment patterns that comply with generally accepted standards. It has the subsidiary benefit of alerting the health plan to potentially high cost situations so that case management can be more quickly involved. The value of pre-certification is easily demonstrated in an in-patient setting where hospitals and other providers are motivated to increase bed days. Under these circumstances pre-certification can ensure hospital stays are not increased beyond necessity. Pre-certification for out-patient procedures has become far more advisable as more and more expensive treatments have been shifted to the out-patient arena. For out-patient pre-certification, the main purpose is not to limit unnecessary bed days, of course, but to ensure that treatment plans comply with generally accepted standards and that the health plan is made aware of potentially high cost diagnoses so that risks can be identified and appropriate case management can be implemented to mitigate the risks where possible.

Case Management. Case management has a dual role: 1) to review potentially high cost treatment regimens and settings, identifying ways to reduce costs without impacting appropriate care; and 2) to provide information to the patient and his or her providers, allowing the patient to be a wiser consumer of medical care and to allow the provider to assess options. Additionally, case management programs often promote maternity wellness activities aimed at education and sound prenatal health issues, but with the additional purpose of detecting high-risk pregnancies and intervening to reduce the risk of high cost premature deliveries.

Disease Management. Whereas case management is generally well accepted in the health benefits industry for episodic high cost care, disease management is still in its infancy for chronic conditions that, if not properly managed, eventually turn into high cost cases or simply increase utilization every year. Disease management is becoming far more critical as health plans realize that much of their costs are associated with conditions such as asthma, diabetes, heart conditions, weight control issues, and smoking. Every bit as important are mental health management services, though these are truly in their infancy. Appropriate day-to-day management of the condition is critical both to managing the costs and to improving quality of life. The management of these chronic conditions is generally the responsibility of the afflicted individual. These individuals often lack the information to know how best to manage their condition. Their often brief encounters with their health care providers do not allow for the level of information exchange and personal coaching that ensures compliance with prescribed and recognized treatments. Thus having specifically designed communications, high touch intake, and professional intervention programs to ensure diagnostic tests are received, medication is taken, and life style changes are implemented greatly reduce the future costs for the individuals with chronic conditions. The best disease management programs are implemented in conjunction with predictive modeling (discussed below) and incorporate data feeds from medical and prescription claims as well as health risk assessments to properly identify and prioritize the intervention from professional

nursing staff that work in conjunction with the consumer's physician. Employers have been slow to embrace these programs due to concerns over short and long-term returns on investment.

Population Management. This term is sometimes used interchangeably with disease management, but instead of focusing on the chronic illness, population management seeks to identify those individuals where claims patterns suggest a more effective utilization of the benefit plan would provide both less expensive and more effective care. The migraine headache sufferer who continues to use the emergency room instead of the physician's office together with taking appropriate medication is an example of such an opportunity to intervene and improve care while reducing costs. In addition, population management also includes periodic general communications to plan participants encouraging healthy eating and exercise habits, stress control, etc.

Predictive Modeling. Disease management programs that do not rely on predictive modeling cannot adequately focus resources on the individuals who are at greatest risk for becoming high cost cases and who show the greatest willingness to make the changes necessary to manage their conditions. Predictive modeling uses claims, prescription, and health risk assessment data to identify and stratify plan participants into various risk categories. Please note: if the algorithms of the predictive modeling program only use one source of data or do not incorporate health risk assessment data, they are incomplete. Based on diagnosis codes, NDC codes, claims utilization patterns, etc., the predictive modeling algorithms identify those who are compliant with treatment protocols, those who are semi-compliant, and those who are non-compliant. In addition, with the information gleaned from the health risk assessment, an additional dimension is added that provides a measure of the willingness of the consumers to implement the behavioral changes necessary to manage their chronic condition better. For the compliant participants, an ongoing communications program is all that is necessary to reinforce their compliance. For the semi-compliant, specialized communications including videos, self-administered test kits, etc., are effective to help steer them toward greater compliance. For the non-compliant where the risk of high costs is indicated, in addition to the communications, an intake program directs them to work with a specially trained nurse to help them become and maintain compliance.

It is the appropriate interventions of health care management programs that make the difference. When the data is turned into information and the information is turned into communication, and the communication is turned into changes, costs may be more easily managed. Utilization review intervenes to ensure proposed lengths of stay and treatments follow recognized and accepted protocols for the diagnosis and also allow for early case management. Case management intervenes to ensure settings of care are appropriate and options and treatment issues are fully explained to the consumer of those services. Disease management intervenes to ensure chronic cases are managed and the consumer is compliant with treatment prescribed by physicians and accepted by the provider community. Population management intervenes to identify and counsel with those who may not be utilizing the benefits as effectively as they should be. Finally, predictive modeling ensures that the interventions are focused in those areas that offer the greatest return on investment.

Consumer (Employee) Education

Consumers cannot consume wisely without appropriate information and in the language and setting that the consumer comprehends and trusts. The health care community does not have the equivalent of Consumer's Reports, but there is a significant amount of information that plans and plan sponsors can make available usually through their claims administrators. There are two types of information that should be shared with plan participants in their roles as consumers: 1) plan financial information; and 2) decision making assistance.

Plan Financial Information. The summary annual report required by ERISA did little to provide any usable information about the plan. The type of financial information participants can really use includes: the total cost of the plan, the amount the employer contributes and the amount the employee contributes toward coverage. Sadly, many employees assume they are paying the lion's share of the premium equivalency. In addition, the plan sponsor can share with the employees how cooperating with case management and disease management can help control costs. Explaining how using network providers reduces costs has also been effective in increasing in-network utilization. This information makes the consumers partners in cost management. Simple communications about how much more an emergency room visit costs than a physician office visit, for example, have proven to reduce the number of non-essential emergency room visits.

Decision Making Assistance. Because few of us are well versed in the workings of our automobiles, we are often at the mercy of our auto mechanics to advise us on what is needed. Nevertheless, even the most un-mechanical of us have a tendency to ask how much the work is going to cost before we approve the work and to ask why the work is necessary and what will be done. Even then we may get a second opinion or at least another quote before we proceed. We are in a similar position with our own bodies. We rely upon our physicians to diagnose the problem and recommend a course of treatment. Few of us, however, ever ask how much the procedure is going to cost, if there are any alternatives, what exactly is going to be done, and why. Sometimes, we don't have the vocabulary to understand the response or we just want the pain to stop. To become wise consumers, we have to be willing to ask questions, compare providers, and look for alternatives. For those with high cost treatments, case management can provide much of this type of information to consumers. The same is true for those in disease management with nurse intervention. For the rest of the plan participants in addition to the standard eligibility, enrollment, claims look-up, and other web-based functions offered by claims administrators, the plan should provide:

- Reputable Websites. Make search engines of reputable websites available to do research on specific conditions and provider effectiveness. Just one search engine or one website is not enough. Many conditions have dedicated advocacy and research organizations tied to them. The best information on arthritis is available through the Arthritis Foundation. The best information on heart disease is available through the American Heart Association. Encouraging participants to use reputable websites, to print off information and take it to the doctor's office is simply promoting wise consumerism.

- Provider Effectiveness and Cost Information.

  - ✓ Physicians. Supplying provider cost can be very difficult and deceiving. For example, a plan may show a comparison of physician office visits using CPT code 99213. Once the physician actually sees the patient, that office visit may be billed differently and it may result in lab tests, etc., that increase the expected cost. More recently programs have been developed that simply list providers whose utilization patterns indicate less costly

overall charges (see the related discussion under Plan Design, New Networks within Networks). With most in-network physician contracts pegged at a multiple of the Medicare Rate, it is more important to look at the number of services a provider recommends than at the price.

- ✓ Hospitals. For hospitals, two types of information are appropriate to share. First, there are several free websites currently available that rate hospitals in terms of cost and quality of care. These websites together with training on how to use them should be made available to participants. Second, more networks are making available to plan sponsors comparisons of discounted charges. The plan sponsors are then making benefit design changes to encourage the utilization of the less expense facilities.

- General Questions. Again, case management and disease management participants have an advantage in that they have nurses assigned to them of whom they can ask specific questions. Although internet and printed resources providing triaging capabilities are available, simply asking a medical professional about a fever or a specific symptom, etc., can forestall unnecessary care and ensure that necessary care is obtained quickly. The 24-hour nurse lines available through many health care management and claims administrators are ideal for this type of inquiry.

- Promotion of Healthy Life-Styles. Discussed earlier under population management, the on-going promotion of healthy life styles is perhaps the greatest deterrent to future costs. Providing information on how various manageable conditions effect plan costs when properly managed versus when unmanaged can provide additional encouragement to get chronic conditions, weight, smoking, high blood pressure, stress and depression etc., under control.

Data and Benchmarking

Too much data and not enough information is the complaint of most plan sponsors. Reams of paper that are ineffectively summarized or trended do not allow for a quick or relatively easy review of the health of the health benefits plan. What most sponsors want to see is a twelve-month rolling or building summary of the most important indicators of the status of the plan. Among the more prevalent indicators are total charges, total payments, payments per enrollee, payments by various service code groupings (based on place of service, type of provider, and/or diagnosis), what providers receive the greatest number of dollars and why, and how effective the network is in terms of utilization and discounts. Simple summaries, however, are not enough. When an adverse trend is identified or a significant divergence from the norm is presented, the plan sponsor needs to have the ability to drill down to the details to find the reasons behind the changes.

Two types of comparisons are then appropriate. The first comparison is against the plan's own historical data. The second comparison is against the plan sponsor's regional and/or industry peers. The first comparison can be performed with the rolling or building twelve-month summaries. The second comes from surveys available from various national consulting firms. Although the comparisons are important, they will be influenced by plan design, health care management, etc. What may be more critical than specific comparisons is whether the plan is beating trend or improving its own results.

Conclusion

It has been the goal of this working paper and the SIIA Benefits Committee to set forth a set of sound principles and practices that utilize tried and true insurance concepts and incorporate some of the best practices and newest ideas to help the SIIA membership cope with the increased costs of providing self-funded health care benefits to the members' employees. Self-funding provides significant value by providing the employer:

- Control over and flexibility in plan design;
- Management of the reserves and control over cash flow and investment income;
- Choice of service providers; and
- Hard dollar savings in eliminating the expense of state premium taxes and state benefit mandates.

Establishing and maintaining the consumer's financial stake in his or her health care is essential to gaining and maintaining control over costs. Plan design tools can facilitate that consumerism. Beyond plan design, plan sponsors must also optimize the value of the financial tools they have to mitigate adverse selection and ensure contributions and protections are in place and adequate. Health care management provides both a sentinel effect and a means to help participants manage health conditions and implement healthy life styles. Each of these in turn reduces future costs. Employee education is essential in developing wise consumers of health care. Employees must have the information to ask questions, understand answers, review options, and discuss costs. Benchmarking one's plan against the competition and against the market in general is always wise. Nevertheless, more important is beating trend and improving cost management over past experience, and there are ways to develop dashboard like monitoring reports to make the review of that relatively quick and easy and that also provide drill down research opportunities when issues are identified.

NOTE: The Self-Insurance Institute of America, Inc. (SIIA) has published this document as a reference guide, detailing suggested approaches to setting up and operating self-funded group plans. Please note that none of the information contained herein should be deemed to be legal advice. Readers are encouraged to seek qualified legal counsel in order to ensure compliance with applicable state and federal laws. This document is a work product of the SIIA Benefits Committee and special recognition should be given to Ron Desnup, who served as the principal author.

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