

Understanding Self-Insured Group Health Plans

*Solutions For Containing Cost
While Providing Quality Benefits*



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Understanding Self-Insured Health Benefits

A common, creative and cost effective approach to funding employer health benefits.

Manage your Health Plan as you would manage your business. An introduction to self-funding.

“Become part of the Health Care solution!”

If there were a proven method to managing your health plan costs that over 57% of employers in the U.S. were utilizing today, would you be interested? Well there is a proven method, and it is called self-funding.

Plan sponsors and employers have been able to self-fund their medical plan for more than 30 years, made possible by the passage of the Employee Retirement Income Security Act (ERISA) of 1974 by the U.S. Congress. ERISA exempts self-funded plans from state insurance laws, including reserve requirements, mandated benefits, premium taxes, and consumer protection regulations¹.

Today, with the passing of the Patient Protection and Affordable Care Act (PPACA), the interest in this financial arrangement has never been higher. It's estimated that 57% of all health plans in the U.S. are self-funded², covering more than 100 million Americans³. That's up from 44% in 1999⁴, an increase of nearly 30% in 10 years. With the oncoming regulations associated with health care reform (PPACA), more employers are looking to self-fund their benefit plan as a way to regain control of their health care investment.

CONTROL

What is in your plan? Are you engaged in the design of your plan, or passive?

To run a successful business, employers must have full control over all aspects of their operation. Being in control of your business might include basic strategies such as access to analytical data to improve results and foresee opportunities, management expertise to impact productivity, and investing assets for long term financial stability.

A business leader would never consider relinquishing jurisdiction over these areas of their operation. And yet, with commercial fully-insured health plans, employers surrender all control of one of the highest single expenditures to the carrier. In addition, most fully insured programs offer canned programs (i.e. plan designs, managed care services, and analytical expertise), limiting a plan's ability to access “best in class” services from multiple vendors.

With a self-funded health plan, an employer assumes control over:

- the tactical lessons to be learned from their own historical data
- the specialized care needs of their current employee population
- the future actions necessary to achieve their unique financial objectives

INVESTMENT

Are you managing your assets, or simply paying premiums?

Sponsoring a health plan for your employees is important to the success of your business. It nurtures your company culture, attracts the highest level of talent, and reinforces loyalty from your best employees, and is likely one of the most expensive components of your entire operation. Your employees are an investment, and making and keeping them healthy is a smart way to manage that investment.

With a self-funded arrangement, employers reap the benefits of their investment through direct financial returns. A self-funded plan not only enjoys a higher level of data to illustrate its return on investment, it participates directly and immediately when plan results beat expectations.

Credible and affordable financial products such as medical stop-loss insurance for self-funded employer plans provide protection for the assets set aside for these investments and cap the risk to the plan.

Furthermore, the ability to create a benefit plan that caters to the specific health needs of an employer's unique population will directly increase employee productivity. Plans don't waste time, funds and resources on programs and benefits that aren't a match for their employees.

¹ The Kaiser Family Foundation and Health Research & Educational Trust: Employer Health Benefits – 2009 Survey; Section 10 Plan Funding, pg 156

² The Kaiser Family Foundation and Health Research & Educational Trust: Employer Health Benefits – 2009 Survey; Section 10 Plan Funding, pg 156

³ Need to verify an actual number of covered members and document source.

⁴ The Kaiser Family Foundation and Health Research & Educational Trust: Employer Health Benefits – 2009 Survey; Section 10 Plan Funding, pg 158

OPPORTUNITY

Who is the self-funded expert in your market?

Every business in every industry strives to separate itself from its competitors, and from commoditization. No two businesses are alike so no two employer health plans should be alike.

Brokers and advisors for employer health plans battle this same commodity mindset. They struggle to demonstrate innovation in the void of data unavailable from commercial carriers. And regardless of the final model of health reform that might emerge, total costs of health care continue to rise. Forward thinking businesses cannot afford to wait for a one-size-fits-all solution to the cost issue.

The opportunity exists within a self-funded plan environment for employers to take charge of their health plan destiny. The opportunity exists for self-funded employers to implement

creative plan strategies with guidance from their broker and advisors that require long-term commitments. The opportunity exists for self-funded employer groups to set a clear vision of their specific health plan goals and the actions needed to accomplish those goals.

SUMMARY

This publication summarizes the critical areas impacting employer sponsored plans, and expanded on the many benefits that a self-funded plan realizes. You will be presented with results that speak to the success of self-funding, both statistically and through first hand accounts from real employer groups of all sizes that have met or exceeded their plan objectives. Self-funding is not for every employer group, so this document also exists to provide those considering this alternative with a definitive guide during that decision process.

Self-Funded Overview

Health care costs rank among the top concerns of U.S. Employers. How to design and finance the plans are questions that inordinately occupy benefits professionals and corporate executives. Below are a number of factors to consider when looking at self-funding as a possible alternate approach to a more traditional fully-insured arrangement.

- **Control of Plan Design/ERISA**
Federally mandated benefits apply, State mandated benefits do not apply as a result of legislation enacted in 1974 (ERISA). This allows employers to offer uniform, targeted benefits to all employees, regardless of the state in which the employer is located.
- **Improved Cash Flow**
Plans can maximize cash flow. Groups can manage the cash flow in a self-funded plan and the related interest income because claims are funded as they are paid. Fully-insured premiums constitute a form of pre-payment.
- **Elimination of Most Premium Taxes**
State taxes on most self-funded plan costs are eliminated amounting to a 1.5%-3% immediate savings from a fully insured arrangement.
- **Carrier Profit Margins and Risk Charges are Eliminated**
This amounts to a plan savings of 3%-5% annually.

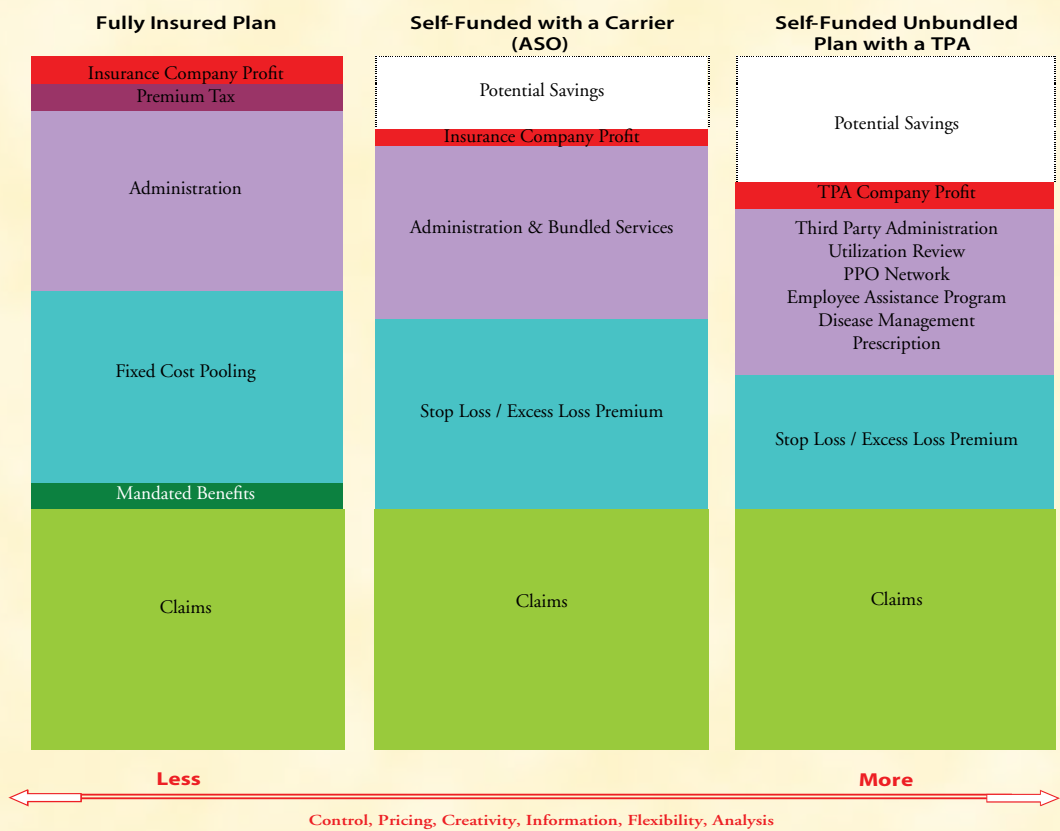
Exhibits A and B provide a side-by-side comparison of Fully-Insured and Self-Insured arrangements.



Exhibit A

	Fully Insured	Self-Funded with Stop Loss	Self-Funded without Stop Loss
Group Size	Any size group	100+	1000+ or Dental 50+
Positives	No employer risk	Risk limited with Stop Loss coverages	Employer at risk
	Predictable Premiums	Cash flow - claims not funded until paid	Cash flow - claims not funded until paid
		Advantage to group when claims are lower than expected	Advantage to group when claims are lower than expected
		First year Claims Lag savings of 15-20%	First year Claims Lag savings of 15-20%
		Benefit Flexibility - No State Mandates	Benefit Flexibility - No State Mandates
		Detailed Claim Reports	Detailed Claim Reports
		No Premium Tax on Claims	No Premium Tax on Claims
		Long term lower cost	Long term lowest cost
Negatives	Limited Plan Designs - Carrier Offerings Medium term most expensive Must include State Mandates Premium Tax No cash flow advantage No benefit for lower than expected claims Limited Reporting Available	Annual Risk 10-25% of Expected Claims Cash flow fluctuations Reserves needed to switch to fully-insured Requires longer term commitment	No ceiling on claim costs or cash flow fluctuations High Risk for < 1,000 Reserves needed to switch to fully-insured Requires longer term commitment

Exhibit B



Making the Decision to Self-Fund

Self-funding is an arrangement in which an employer funds medical expenses and contracts with a third party administrator (TPA) to provide administrative services and process claims for the group's medical and dental benefit plan. Many factors affect an employer's decision to self-fund, particularly the ability to assume the risk involved. An employer can save 10-25% of costs by moving to a self-funded benefit plan.

Health benefits are an integral and significant part of a compensation package. In a competitive environment, self-funding can give an employer greater flexibility in the types and amounts of benefits it offers, aiding employer efforts to attract employees with certain skills and talents. Self-funded plans have many advantages over plans that are fully insured:

Risk Management - Charges, Commissions and Retention

One advantage is the flexibility in controlling risk. Business objectives with self-funding revolve around the best use of money devoted to benefits; controlling claims, managing, and benefiting from investments. A self-funded health plan can allocate more of each dollar toward the payment of medical claims, eliminating insurance commissions, risk charges, insurer profit and other costs involved in obtaining coverage from an insurer. Costs also decrease thanks to the sponsor's ability to exert greater control over administrative expenses and costs.

Improved Cash Flow

Self-funding allows claims to be funded as they are paid. Fully insured premiums constitute a form of pre-payment. Under self-funding, a plan can delay payment of recurring health plan costs until the services have been rendered. Insurers set health insurance premiums at levels that anticipate projected increases in healthcare costs – usually in excess of the actual rise in costs.

Innovative Plan Document Design and Control

Since the employer is the plan fiduciary, decisions surrounding plan design belong to the employer and not an insurance company. Flexibility in plan design derives from a self-funded plan's freedom from state mandated benefit laws. The employer can design its plan without the restrictions, delays and costs involved in obtaining the approval of an insurer or regulatory agency. Employers thereby make the overall compensation package more attractive, and plan design options can be tailored to the working population and company preferences. Language can be modified to fit individual plan needs, and accurately reflect the true intentions of the plan.

ERISA Preemption of State Regulation

In 1974, the Employee Retirement Income Security Act (ERISA) was enacted which pre-empted state law. ERISA offers self-funded plans the advantage of not being controlled by state laws that relate to insurance. ERISA provides regulatory stability to employers that operate in several states, so those companies

do not have to adopt a patchwork of design variations to comply with state requirements. Thus, self-funded plans are not subject to state insurance benefit mandates. Furthermore, the Federal authorities that do regulate ERISA and self-funded plans show deference to self-funded plan administrators, unlike state based regulatory entities.

Relief from State Premium Taxes

Most states impose taxes on premiums received by insurers. Insurers shift the burden of state premium taxes onto employers. A self-funded plan enjoys savings, as they are not subject to state premium taxes.

Plan Sponsor's Experience

The plan sponsor has the ability to limit its liability to the claims experience of its own employees or members. In a self-funded plan, an employer is responsible only for the risks presented by members covered under the plan, and is not responsible for the risks presented by members of any other company. Limiting exposure to its own members is an advantage to that of other organizations, where all insureds are pooled.

Risk Control

For an employer that is averse to risk, partial insurance is an important factor in self-funding. Stop-loss coverage can limit the employer's risk while allowing it to retain control over claims and benefits.

Value-Based Benefits and Wellness Programs

As medical costs have skyrocketed, sponsors have been taking steps to reduce medical costs by emphasizing prevention and maintenance care for chronic diagnoses. Employees have the flexibility to design and integrate into overall strategies, health risk assessments, prevention and wellness programs tailored to the employer's specific employee demographics and needs.

Improved Claims Data History

Analysis of claims using software and investigative techniques can help find areas where plan spending may be curtailed. By self-funding, plans will identify the categories constituting the majority of health care spending, and are better equipped to make future decisions.

Savings Opportunities

A self-funded plan's ability to utilize cost containment features will increase savings opportunities. The ability to have effective cost containment options will help ease rising health care costs as money recovered goes back into the plan's general fund and is once again available to pay future medical claims. Additionally, employers can monitor the conduct of its own employees to reduce costs attributable to unnecessary or fraudulent health care claims.

Stop Loss/Excess Loss Insurance

The purpose of excess loss insurance (*stop-loss*) is to provide financial protection to a self-funded plan sponsor, by capping and further defining the plan's financial exposure.

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

Excess loss insurance provides protections in two forms – specific and aggregate. Individual stop-loss, which is also referred to as specific stop-loss, protects a plan against catastrophic claim occurrences. Aggregate stop-loss, which limits a self-funded plan's financial exposure for the entire plan year (or policy year) protects against abnormal claim frequency across the entire group of individuals.

Specific Stop-Loss

Specific stop-loss coverage is purchased to limit the plan's financial exposure on any one individual. The exposure (i.e. specific deductible) should be a function of the company's size, risk tolerance, financial resources, location, plan of benefits, PPO network, and claims experience.

Example: A group purchases specific stop-loss coverage with a \$50,000 specific deductible. An individual has claims that exceed \$50,000. The stop loss carrier reimburses the plan eligible claims paid out by the plan, in excess the \$50,000 specific deductible. Therefore, if the plan paid \$300,000 in eligible claims, the stop-loss insurance carrier would reimburse the plan \$250,000. With specific coverage, the plan can file a specific claim at the time it incurs the loss. The premium for the specific stop-loss coverage is expressed as a monthly rate (e.g. per employee, single, family, composite, etc.)

Aggregate Stop-Loss

With specific stop-loss, we're protecting the plan from individual catastrophic claims. But what happens when "routine" claims are greater than what the plan had projected? Aggregate stop-loss is the answer to protect against a higher than average frequency of claims. Aggregate stop-loss limits the financial liability of the plan, for all eligible plan members (e.g. the entire group). Eligible claims, below the specific deductible, will accrue and towards an aggregate deductible, also referred to as an "aggregate attachment point," which is determined by the underwriter, and based on the plan's projected claims. An underwriter will also consider the plan's historical claims experience as well as the group's demographic, the current vs. proposed plan design, provider networks, and a number of other factors. Aggregate stop-loss claims are usually made following the conclusion of the aggregate stop loss policy

period, and determined by comparing the eligible aggregate stop-loss claims for the period to the annual attachment point. Aggregate claims in excess of the aggregate attachment point are reimbursed to the plan.

****It's important to realize that each stop-loss carrier has a unique product and policy, based on their own underwriting approach to the risk, and not all carriers offer the same products or services.***

When you combine specific and aggregate stop loss coverage, you can see how a self-funded plan can limit its overall financial liability, allowing it to leverage all of the benefits afforded through ERISA. As a plan membership increases, the need for excess loss (stop-loss) coverage shifts, and is even reduced in many cases. But, with the passing of recent health care reform legislation including increased lifetime and annual plan limits, additional risks are emerging. Stop-loss insurance is likely to become more important for those larger self-funded groups.

Stop-Loss Contract Types

When an employee is covered by a fully-insured plan and incurs a claim during the effective period of the contract, the employee simply submits the claim to the insurance carrier, and either the employee or the provider is paid the benefits due. This is known as "incurred" contract.

A stop loss contract operates differently because it is actually insuring the employer and not the individual employee. It is important to grasp this concept. When a plan is self-funded, the stop-loss contract insures the employer against catastrophic losses under the plan. The medical plan established by the employer accepts the responsibility for paying providers' claims for individuals but limits its risk with stop-loss coverage. Individual employees are not personally insured by the stop-loss carrier.

Types of contracts available can vary by stop-loss carrier.

Incurred and Paid (12/12) contract

The stop-loss contract used most often in the first year of a self-funded plan is known as “incurred and paid” or “12/12” contract.

In order for an employer’s plan to be reimbursed for a claim covered by a 12/12 contract, the claim must be incurred during the 12 months of the policy period and paid during that same 12-month period.

Contracts with Run-In

Run-in refers to claims incurred prior to the effective date of the current stop loss policy. If an employer’s plan has been self-funded for some time, there will be claims incurred at the end of a previous policy year but not yet paid due to a claims lag. Usually, the employer would like to have stop-loss insurance for those claims. Stop-loss policies with run-in are offered to cover claims incurred within a specified time period starting before the effective date of the current policy and running to the termination date of the current policy period. These same claims must be paid during the current policy period. The claim-occurrence period is usually 3, 6, or 12 months prior to the effective date of the current policy or in the case of a renewal, it can be the time period back to the original effective date of the first policy with the current stop-loss carrier. These contracts are commonly known as 15/12, 18/12, 24/12, or Paid/12. There is an additional premium charge for these contracts and the longer the run-in, the higher the charge.

Contracts with Run-Out

Run-out refers to claims incurred within the current stop loss policy but not paid by the plan as of the termination date of the current stop-loss policy. Stop-loss carriers offer contracts that cover claims incurred within the timeframe of the current policy and paid in the time period between the effective date and the end of a specified number of months after the end of the current policy period, usually 3, 6, or 12 months. These contracts are commonly known as a 12/15, 12/18, or 12/24. There is also an additional premium charge for these contracts that increases as the run-out period increases.

Are you a candidate?

Based on the extensive analysis above, the advantage of self-funding health benefits are broad and advantageous for any employer group however not every employer group should be self funded. Why?

There are certain attributes that an employer group must have to successfully manage their health benefits and spending.

First and foremost, the group needs to have some level of risk tolerance. Even with stop-loss protection, the employer group is still responsible for a layer of claims under the individual stop-loss deductible. Predicting employer’s liability is much more credible if the group has a steady employee population and stable claims experience. In addition, self-funding health benefits will give an employer greater plan design flexibility and greater control over healthcare spending as long as the group is willing to get involved.

The intent of the next section of this brochure is to share with fully insured employers groups testimonials from employers that made the decision to self-fund their health benefits.



Self-Insured Health Success Stories

Tennessee School's Plan Will Reward Healthy Living

A large dose of common sense has changed the health care landscape for the self-insured employee health plan of Wilson County (Tennessee) Schools. The teachers association there in mutual cooperation with the Board of Education approved a two-tiered plan that will provide significant financial incentives for healthy living.

Beginning after a year-and-a-half phase-in period, employees and dependents will be enrolled in one of two plans: a Standard Plan with a \$1,500 annual individual deductible or a Preferred Plan with a \$500 individual deductible. Entry into the Preferred Plan will require a health risk assessment indicating healthy behavioral choices involving smoking, weight as measured by body mass index (BMI), and standardized measurements of cholesterol, blood pressure and blood sugar.

It has been projected that a majority of all health care expenses can be traced to the results of those lifestyle behaviors. Wilson County Schools administrators believe that reducing those health risks will comparatively reduce increases in health care costs over the long term.

To be instituted, the plan had to pass review by representatives of the employees' bargaining units. Mickey Hall, deputy director of schools, said he wasn't sure how well the new concept would be accepted but was gratified by the response.

"Our employees really have a good understanding of our objectives," he said. "They know that as a self-insured plan, this is really their plan and we're all in this together. It was vital that they agree to be part of the solution. They were very interested in helping all our employees keep good benefits while the plan maintains affordable costs."

In addition to lower deductibles for the Preferred Plan, its members will realize proportional savings in out-of-pocket costs as well. Educational programs and videos will prepare employees for the health risk assessments that will determine which plan they will enter.

Wilson County Schools employees have already had access to programs promoting weight loss and smoking cessation. The 1,600 employees are also served by three clinics operated by the county.

While developing a plan that could provide good health care at reasonable cost, Wilson County was addressing the needs of its employees but may also have contributed to national health care reform.

The schools health plan's new tiered system, with unique incentives for healthy lifestyles, could be a groundbreaking event for employee group health plans elsewhere according to consultant Bob Shupe, president of ESPinc that works with several dozen Tennessee public entities.

"With all you have read about problems of public entities addressing cost reduction in employee benefits, this shows that people can work together," Shupe said. He agreed that the Wilson County plan might have broad implications for other groups addressing the problems of health care cost increases.

"Washington only talks about the financial side of health care reform while it ignores the delivery side," he said. "A system can't succeed without addressing both elements. The Wilson County plan is finding new money to pay for health care by reducing costs somewhere else."



Self-Insured Health Success Stories

Builder Sundt Construction Offers Model Self-Insured Employee Healthcare Plan

The company that built the foundation – literally! – of the atomic age and U.S. space exploration now feels it offers an efficient healthcare infrastructure, and it took that message to Congress during deliberations over national healthcare reform.

Sundt Construction, Inc., has a flair for large projects. The firm established by Norwegian immigrant Mauritz Martinson Sundt 120 years ago in New Mexico grew into one of the nation's largest general contractors with credits that include the Los Alamos, New Mexico, complex where the first atomic bomb was built during World War II, and Launch Pad 39-A at Cape Canaveral, Florida, site of the first U.S. moon missions.

With its headquarters in Tempe, Arizona, Sundt is now wholly owned by its 1,100 employees and has offices in California, Nevada and Texas. The company adopted its self-insured employee health benefit plan in 1981 and believes that it presents a model for efficient and high quality healthcare.

That was the message of Chairman and CEO J. Doug Pruitt, who by letter invited members of Congress to visit Sundt to see the workings of a healthcare plan that “has improved the quality of our health care for our employee owners while reducing their and the company’s costs.”

Pruitt’s letter stated, “Being self-funded allows us to choose the best of the best for each product and service that we need to efficiently operate our employee benefits plan. This has involved managing our providers and holding them accountable through performance metrics, asking for multiple year rate guarantees, and keeping an eye on trends in the market and what other providers offer to keep our providers in check.”

The letter also stated the company’s concern over some provisions of proposed healthcare reform that “will not improve on our current structure but inhibit it.” Pruitt cited an employer mandate, a tax on self-insurance and lack of a firewall that would prevent escalating costs for fewer remaining persons in an employer’s plan.

“We believe we can provide excellent health care at a reasonable cost for most Americans and we don’t need to mortgage future generations to do it,” Pruitt’s letter concluded.

While the Sundt employee health benefits plan is now nearly 30 years old, it continues to evolve through an ongoing improvement process.

“Sundt is really big on strategic planning, and we extend that approach to our benefits plans,” says Kari Louie, corporate director of human resources. “We have an annual review

process with Lovitt & Touché to look at performance of vendors, trends and possible improvements.”

Lovitt & Touché of Tucson, represented by vice president Doug Adelberg, has long served as Sundt’s employee benefits consultant. The firm is the largest independent agency in the Southwest, doing business continuously since 1911. It manages total premium volume of close to \$300 million and employs a professional staff of more than 180 among five offices.

Examples of recent improvements to Sundt’s self-insured healthcare plan include:

- Savings of more than \$1M during the first year with a new pharmacy plan that includes the convenience of mail-order maintenance medication with zero co-pay for generic drugs. The plan includes outreach consulting to help educate employees about medication options.
- An onsite physician clinic with free employee visits, lab work and prescriptions to employees and dependents. Savings on physician care average 10 to 15 percent for the company, and shorter time away for doctor visits enhances employee productivity.
- Adoption of the Blue Cross & Blue Shield provider network for Sundt’s Arizona population. This change resulted in estimated annual savings of 15 percent from the previous leased network. New provider relationships are being negotiated for the firms California, Nevada and Texas populations.
- Future improvement of the company’s wellness program including communications tactics to improve employee participation. “We’re planning a focus group of company employees to develop new ideas to make the program attractive,” Louie said.

Through all the improvements of its program Sundt continues to offer a healthcare plan that is free of monthly cost to employees and dependents. That is designated as the “bronze” plan and is joined with “silver” and “gold” plans that offer enhanced benefit levels and a sliding deductible scale.

A summary of Sundt’s plan was provided in the letter to Congressional representatives of the firm’s operational centers, concluding with CEO Pruitt’s offer “to have further dialogue on our efforts to control cost and sustain or improve the quality of healthcare for the 1,100 employee owners of our company and have an honest debate about the necessary reforms to the healthcare system in this country.”



Self-Insured Health Success Stories

Ambulance Service Uses Self-Insured Health Plan as Recruiting Advantage

Not many years ago American Ambulance Service of Norwich, Connecticut, felt like a “farm team” for area hospitals who attempted to recruit their employees partially on the promise of generous health plans.

No more. American Ambulance turned to self-insurance to create an employee health plan that can withstand just about any competitive encroachment. “That has subsided now,” says Janet Welch, human resources director. “Becoming self-insured about ten years ago provided a wonderful opportunity to recruit and retain the best employees.”

“American Ambulance learned that even a moderate-sized organization could design a self-insured plan to compete with larger employers at a good value compared to traditional fully-insured plans,” says Gary D’Orsi, director of sales and marketing of Pequot Health Care of Mashantucket CT, which provides TPA services to American Ambulance.

American Ambulance covers the Eastern Connecticut market from its headquarters in Norwich and onsite emergency crews at the Foxwoods and MGM Grand casinos. “I tell people that self-insurance may not work for every organization but it definitely works for us,” Ms. Welch says. “The key is having strong trusting relationships with our partners including our broker and TPA to know they will be working in our best interests.”

The American Ambulance plan has generally low deductibles or provides full coverage for in-network medical services including prescription drugs, vision care and a dental plan.

Preventive care is emphasized through a schedule of physicals and cancer screenings.

American Ambulance employees may select the health savings account (HSA) option that is presented along with the fee-for-service plan during each annual open enrollment period. “We invite our employees to come to open enrollment meetings and again sign up for the following year,” Ms. Welch says. “We want them to understand their benefits along with any changes that may occur.”

“The HSA is becoming an increasingly popular option depending on employees’ lifestyles and health issues. It has to be a good fit for them,” Ms. Welch says. “At our presentations we include people from the bank and our broker to tell them how it works. Educating the employees is the best tool for helping the plans run smoothly.”

Ms. Welch says that the HSA has become progressively more accepted and now is the choice of about 15 percent of American Ambulance employees. “Employees discussing it among themselves is the HSA’s best advertising,” she says.

Like self-insurers everywhere, American Ambulance is looking at possible implications of national health reform as it phases in. “We have to look at everything,” Ms. Welch says, “and we believe we will be a grandfathered plan. Through all the seminars we have attended and discussions with our TPA and broker we feel we’re ahead of the game at least for the coming year.”



Self-Insured Health Success Stories

Health System Builds Self-Insured Plan For Its Employees, Other Regional Groups

Creative use of self-insurance helped solve challenges of providing employee health benefits for a major diversified health care institution and also launched an employee health care network for participation by other employers.

The Catholic Health System (CHS) of Buffalo, New York, is comprised of four hospitals, seven long-term care centers, three home care divisions, 11 primary care sites plus laboratory and imaging facilities with total employment of 8,100. Through the 1990s the medical system experienced a continual rise in costs of traditional health care for its employees.

“While private sector community-rated health plan costs were steadily going up, we knew that our costs to patients were more stable, reflecting about a ten percent advantage under the market,” says Mike Moley, senior vice president-human resources, who joined CHS after similar roles for Goodyear Dunlop and benefits roles United Mine Workers and Travelers Insurance.

Moley led the establishment in 2008 of the Catholic Health First Choice plan that was offered to the system’s employees on an optional basis. Known as a Hospital Preferred Provider Network (HPPN), it is self-funded by the system with a stop-loss policy written by HM Insurance Group.

For 2010, First Choice in-network cost increases were 6.5% compared to out of network increases of 10% and community increases of 12%. Moreover, First Choice increased the utilization of CHS facilities by its employees from 38% to 53%. A recent survey by an independent research firm among First Choice participants indicated that 89% of the respondents rated First Choice as very good to excellent.

Significantly, CHS does not discount its costs to the plan. “It wasn’t necessary because our costs were already lower than the market and we didn’t want to shift our overhead to others in our community,” Moley says. “We pay ourselves the same amount as others pay us, and that amount is less than our competitors charge because our base costs are lower.”

Catholic Health First Choice began with emphasis on wellness coverage, illness prevention and disease management. Zero copays were established for nearly all in-network care notably including preventive procedures of mammograms, PSA tests, colonoscopies, annual routine physicals, vision exams and OB/GYN visits.

CHS is working on establishing a disease management program through the 850 physicians who belong to the Catholic Independent Practice Association (CIPA) in Western New York. “Our goal is to establish a disease prevention program through CIPA that will include care coordinators in physicians’ offices. Disease management will be imbedded in the doctors’ offices rather than being a remotely-accessed service,” Mr. Moley says.

Catholic Health First Choice has recently been offered for participation by other employers in the region. One employer group of 800 will save \$1.7 million in 2011 by participating according to Mr. Moley.

All Catholic Health System employee health benefit claims including those of First Choice are administered by Blue Cross & Blue Shield of Western New York. Mr. Moley comments, “This is a great opportunity for collaboration with other elements of the health insurance industry.”

“This kind of collaboration appears to be a national trend,” says Beata Madey, senior vice president-underwriting of HM Insurance Group in Pittsburgh. “The CHS program may serve as a model for employers to create new efficient health plans.” She cites recent ventures into self-insurance by such traditional health insurance carriers as BCBS, United Health and others.

Mr. Moley believes that the emphasis on preventive care, disease management and cost reduction serve the philosophic goals of national health care reform. “We’re excited about the progress we have made,” he says. “It’s all about managing costs both in institutional economies and in preventing illnesses to provide an overall value for the community.”



Self-Insured Health Success Stories

Butler Health Plan Brings Transparency To Southwest Ohio School Districts

Healthcare has added many new entries to its lexicon in recent years, none apparently more attractive – or difficult to define – than the term “transparency.” For a good model of that quality, visit the Butler Health Plan in southwest Ohio, a 25-year-old self-insured employee health plan covering 15 school districts.

Butler Health Plan members can shop on a password-protected page of the plan’s website to compare negotiated prices for 50 medical procedures at hospitals throughout the covered region.

“Yes, you can call that transparency,” says Executive Director Stephanie Hearn. “Members can compare discounts within the PPO network. There is a broad selection of hospitals with significant price variations.”

Hearn claims that price comparisons can be beneficial to plan members whose copays could vary by several hundred dollars depending on the cost of their medical procedure. “And when one member chooses a lower cost procedure, we’ve paid for the service,” she adds.

That kind of attention to cost-efficiency has helped to restrain overall costs of the plan. Hearn says that the average premium rate increase over the last 15 years is in the seven percent range, or about half of the national market average.

Further, the Butler Health Plan pays out 94 cents of every premium dollar on claims. The other six cents pays for TPA service by Allied Benefit Systems, Inc. of Chicago, access to the PPO network and stop-loss insurance.

The Butler Health Plan grew from its 1985 founding for school districts in Butler County, just north of the Cincinnati metroplex. Over the years the plan expanded to serve 20,000 employees and dependents in 15 school districts. Hearn says that membership remains open to additional districts.

Hearn credits good relations with employee organizations for the plan’s successful momentum over 25 years. Employees

are represented with two seats on the seven-member board of directors. In addition, a Benefits Information Committee is comprised of three representatives from each member school district. That committee meets twice a year and communicates proposed changes back to the districts. “That’s how we know we’re staying in touch with our 20,000 members,” Hearn says.

The Butler Health Plan has already met the “best practice” standards created by the State Employee Healthcare Board for implementation this year. “We have been recognized as a leader among Ohio school health plans and have been described as an ‘early adopter’ of the best practices,” Hearn reports.

The Butler Health Plan was early to adopt the wellness principle that projects that a dollar invested in preventive care today would return several dollars in the future in reduced necessary treatment for chronic health conditions often associated with behavioral issues of obesity and smoking.

“We offer health risk assessments including 34-panel blood tests at all member buildings each year,” Hearn says. Costs of the program are included in members’ premiums. Preventive exams such as mammograms and colonoscopies are also covered.

Wellness programs are directed to each member school district. “We identify any specific issues that are trending in our member employee groups,” Hearn says. “Of course we usually find that the advice is to eat less and move more, and there are still areas where smoking cessation programs are needed.” Volunteer Wellness Coordinators for each district organize health screenings, flu immunization clinics and educational/promotional efforts to stimulate healthy lifestyles.

“Everyone associated with the Butler Health Plan is extremely proud of it,” Hearn says, with pardonable pride. “It’s a very easy plan to represent.”



About SIIA

The Self-Insurance Institute of America, Inc. (SIIA) is a national trade association that represents companies involved in the self-insurance/alternative risk transfer marketplace. Additional information about SIIA can be accessed on at www.siiia.org, or by calling 800/851-7789.