Self-Insuring Health Plans

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What is a self-insured health plan?

- The employer assumes the financial risk for providing health care benefits to its employees (instead of an insurance company).
- The employer also assumes the fiduciary responsibility for guaranteeing payment of benefits to its employees (instead of an insurance company).
- Self-insured employers pay for each claim from their own funds as they are presented for payment.
- With an insured plan, employers pay a premium to an insurance carrier, who then assumes all responsibility for paying all claims incurred during a policy period.
- Self-insured plans may budget only expected paid claims; not incurred claims. This can create an illusion of savings attributable to self-insurance. However, the self-insured plan sponsor is responsible for paid and incurred claims.

Paid vs. incurred claims

Paid Claims - Claims are paid when submitted

Incurred Claims - Claims paid when submitted + claims incurred but not yet submitted for payment

A self-insured plan's total liability is incurred claims, not paid claims

Self-insured liabilities

- Whether budgeted along with expected paid claims (or not), the amount of claims incurred by the plan represent its total liabilities the employer is responsible for paying.
- If the self-insured employer does not include incurred claims in its budget (i.e., its premium equivalent – and contribution formula), the employer must instead establish a separate reserve fund to pay for the difference between paid and incurred claims.
- Two other potential self-insured liabilities:
  - Claim costs that exceed the expected paid claim limit.
  - Run out claims and terminal liability costs (including administrative costs) must be paid by the employer in the event of the termination of the self-insured plan, change in plan administrators or stop loss carrier.

Self-insured health plan rules

- Most state insurance laws (benefit mandates and premium taxes) do not apply to self-insured plans. However, in some cases (e.g., public sector groups) self-insured groups are not exempt from state insurance rules.
- The Patient Protection and Affordable Care Act (ACA) imposes benefit and contribution rules that apply to self-insured plans, depending on the size of the employer. For example, the employer shared responsibility rules for "applicable large employers" apply to groups whether they are self-insured or fully-insured who have 50 or more full-time and full-time equivalent employees.
- Self-insured plans have different benefit mandates under the ACA than do fully-insured plans.

Self-insured vs. insured health plan rules

Basic differences:

- Fully insured plans are subject to state, federal insurance laws and the ACA.
- Self-insured plans are subject to ERISA (Employee Retirement and Income Security Act of 1974). ERISA rules typically exempt self-insured plans from:
  - State mandated benefits
  - State premium taxes
  - State insurance rules regarding participation, employer contributions, etc.
- However, ERISA still requires self-insured plans to be compliant with HIPAA, GINA and Federal discrimination rules.

Note: Some states require their public employers (even when self-insured) to be compliant with some or all state insurance laws. MN is one such state.

Self-insured vs. insured health plan rules

The ACA creates significant differences and cost implications between insured and self-insured plans. Self-insured employer plans are exempt from several significant ACA requirements (and their related cost implications):

- NOT required to participate in a risk-adjustment system
- NOT subject to single risk pool standards
- NOT subject to 3-1 age pricing compression and other rating mandates
- NOT subject to medical loss ratio (MLR) mandates
- NOT subject to review of premium increases
- NOT subject to the annual insurance fee scheduled in 2017 for fully insured plans
- NOT subject to Essential Health Benefits and Qualified Health Plan rules

Self-insured vs. insured health plan rules

- Several key health care reform provisions of the ACA have been incorporated into ERISA :
  - Minimum Essential and Minimum Value rules apply for large, self-insured groups
  - Employer Shared Responsibility Rules (aka “pay or play”)
  - Transitional Reinsurance Program fee
  - Patient-Centered Outcome Research Institute fee
  - Insurer fee (not applicable to stop loss insurers - yet)
  - Cadillac Tax (2020) applies to self-insured medical, dental and vision plans
- In some instances, Non-ERISA self-insured plans may be required to comply with some provisions from which ERISA plans are exempt (e.g., essential health benefits, state insurance rules, etc.)
- Highly compensated employee rules apply under IRC 105 (h) for self-insured employer sponsored plans.

Self-insured vs. insured health plan rules

Reporting requirements for ACA rules per IRC 6055 and 6056 are the self-insured employer's responsibility (small or large group):

- IRC 6055 – Individual mandate reporting requirements (what plan information employers owe individuals and the IRS)
- IRC 6056 – Employer shared responsibility rules reporting (what information large employers owe the employee and IRS)

Self-insured savings

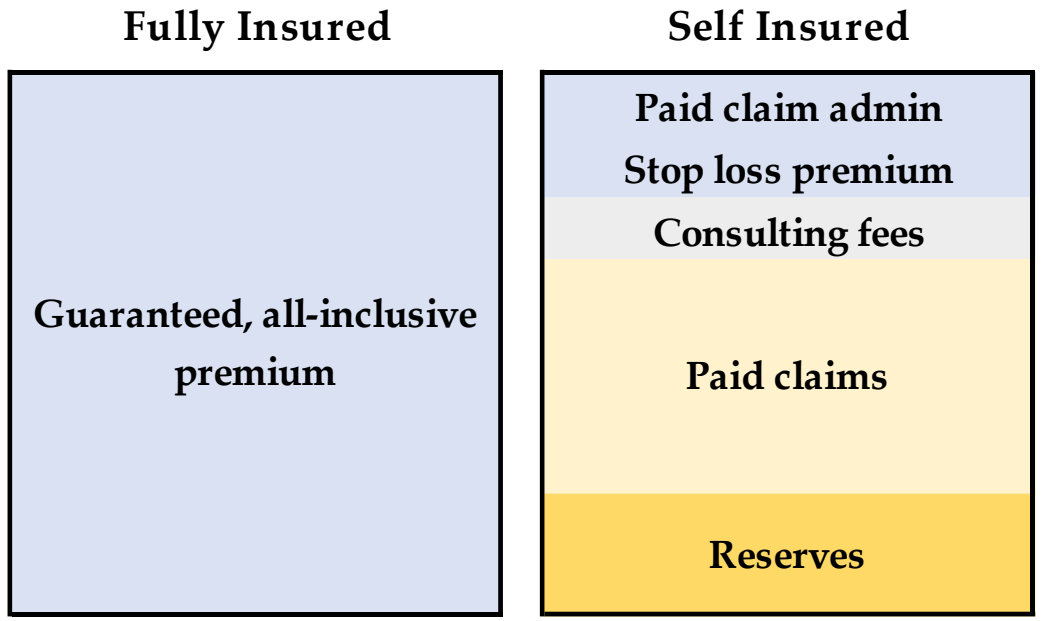
Taxes – Self-insured plans' claims costs are exempt from state insurance premium taxes, which can lower the administrative cost of the self-insured program by 4-6%. Notes: Self-insured employers must still pay premium taxes on administration, other fixed costs; including stop loss costs and commissions.

Cash flow – By retaining the funds used to pay for claims until the claims are presented for payment, the self-insured employer has the advantage of the cash flow interest gain on the retained funds vs. the cash flow interest loss due to payment of premium to an insurance company.

Reserves – By holding its own reserve funds, the self-insured employer accrues interest on the amount of money set aside for the reserves – instead of the insurance company.

Administrative costs – The self-insured employer may purchase a "lite" administrative package of services; paying only for the services they wish to purchase that will be used during the policy year. The services purchased under a self-insured plan may be on an "a la carte" basis.

Why do employers self-insure their health plans?



Fully insured premium guarantees the payment - and associated costs of administration - of all plan liabilities.

Self insured requires additional costs for administering incurred claims presented for payment after the policy period, run out stop loss claims and reserves.
Employer responsible for all payment guarantees.

Self-insured plan reserve funds

Self-insured plans require that employers establish and periodically test for adequacy three distinct reserve funds:

- Terminal plan liability reserve (for run-out claims, stop loss and other fixed costs)
- Fund to pay for claims in excess of expected claims liabilities up to the aggregate stop loss limit
- Contingency reserve fund (for unexpected claims that may occur during periods of hyper inflation, new trend pressures, etc.)

Why do employers self-insure their health plans?

Alternative to insurance company renewals: Risk assessment and equivalent rate-setting can be done using several different stop loss scenarios; without a change in plan administrator. This essentially means the group can put their plan out to bid and elect a new stop loss carrier – without having to change plan administrators. Thus, the annual renewal process is perceived to be controlled by the employer, rather than by an insurance company.

Other self-insured advantages: flexibility and choice

Benefit design – Self insured employers can customize their plan to exclude insurance-mandated benefits. In some instances, flexibilities to recognize religious preferences can be included in a self-insured plan that may not be possible in an insured program, which must include state mandated benefits.

Customized provider networks – Purchasing provider network options through an insured plan is an "off the shelf" decision; buying what the insurance company offers. Self-insured plans may customize their provider networks according to their own demographics and preferences.

Claim processing practices – In insured plans, claim adjudication follows the strict rules of the insurance company responsible for bearing the financial risk of the claims. Since the self-insured employer is responsible for assuming the risk for paying claims, it may make decisions regarding how claim appeals are managed and what claims are paid (Note: plan payments must be consistent and must be supported by stop loss carriers who may not honor claims that are not adjudicated according to standard insurance practices).

How does self-insurance work

A self-insured employer purchases the services of a health plan benefits administrator . . .

. . . to provide a range of health benefit services, including claims administration, network and health care management for medical, pharmacy, dental and disability (short term) benefits, data reporting, etc. . . .

. . . and purchases an excess risk policy from a high quality, financially sound stop loss insurer. . .

. . . that provides protection against catastrophic and unpredictable and/or intolerable losses.

How does self-insurance work

A self-insured employer must also establish and maintain an adequate reserve fund:

. . . to fund liabilities should the plan terminate, wish to revert to an insured plan and/or to provide financial insulation against unexpected increases in policy year expenses.

For a new self-insured group, the reserve fund is typically established in the first year of the self-insured program:

- Funded with the difference between claims incurred and paid in year one vs. an estimate of what claims will be paid in year two, when the group will also be responsible for funding claims incurred in year one PLUS unanticipated stop loss payment shortfalls and the expansion of the aggregate corridor in year 2.
- In all subsequent policy years, the reserve fund must be adjusted according to changes in plan design, enrollment, utilization and other health care trend factors.

NOTE: If the employer chooses to terminate their self-insured plan, they will be responsible for funding ALL run-out claim liabilities (including stop loss claims that are submitted for payment after the run out period of the stop loss contract expires). This could be a political liability (e.g., should a statewide pool program be enacted).

How does self-insurance stop loss work

Specific Stop Loss

Individual excess risk coverage provides protection for the self-insured employer for a high claim on any one covered person. Amounts in excess of the specific stop loss deductible are paid by the stop loss policy; not the employer's claim fund.

Aggregate Stop Loss

Group excess risk coverage provides a ceiling on the dollar amount of eligible expenses that an employer would pay; in total, during a policy period. This policy protects against large numbers of high claims. Claims above the aggregate stop loss limit are paid by the stop loss policy; not the employer's claim fund.

How does specific stop loss work

Specific Deductibles set a policy year maximum liability the employer pays for individual claimants:

- Covers per individual claim liability for both medical and Rx.
- Stop loss deductible is determined by the group's total paid claims.
- Specific deductibles can be purchased with or without an aggregate policy.
- Any annual or lifetime maximum benefit per person payable under a specific deductible plan is no longer allowed, per PPACA rules, as of 1-1-2014.

How does specific stop loss work

Specific Deductibles set a policy year maximum liability the employer has to pay for individual claimants:

- Since the advent of the PPACA in 2010, unlimited lifetime maximums in stop loss policies have been available to support self-insured benefit plan liabilities.
- Claims covered under the specific deductible are typically reimbursed as they are incurred; payable once the deductible has been satisfied.
- Specific deductible amounts and rates are established at the beginning of each contract period and are renewed based on stop loss incurred loss ratios. Due to the leveraging effect of the large deductible amount, trend increases for stop loss are typically double digit.

Selecting a specific stop loss deductible

The specific deducible is selected based on the:

- Employer tolerance for risk vs. stop loss premiums.
- Recommendable range of specific stop loss deductibles falls between 5% and 10% of expected total annual paid claims (small employers considering health insurance must be very careful to select the right level of stop loss).
- Related factors:
  - Size of group
  - Location(s) of employees
  - Benefit plan design
  - Loss history
  - New risk factors (ACA reporting, specialty medications, etc.)

Aggregate stop loss

Provides an annual limit for total employer claim liability:

- Claim liability limit is called the "aggregate attachment" point. This limit is typically set at 125% of expected paid claims. The attachment point is also expressed as a per employee -dependent monthly rate, sometimes referred to as a "monthly deductible factor".
- Any health benefit can be included in the aggregate; such as medical, dental, vision, prescription drugs and short-term disability. Medical and Rx are typically included. Vision, dental and disability are usually not.
- The maximum reimbursement to the employer for claims in excess of the aggregate attachment point is usually limited per contract period. The typical limit is $1,000,000 per policy period. After that level is paid, the employer must pay any excess for the remainder of the policy period.

Aggregate stop loss renewal

Aggregate stop loss sets the premium equivalent rates for the employer, similar to an insurance company rate renewal:

- New monthly deductible factors and aggregate rates are established at the beginning of each plan year.
- Reimbursement under the aggregate contract typically occurs at the end of the plan year. Interim accommodations are available.
- Aggregate stop loss attachment points are recalibrated each year according to incurred claims and health care trend, just as is the case in insured programs. Hence, self-insured programs are similarly renewed (just as insured plans) each year.

Stop loss contracting

Stop loss policies vary regarding what liabilities they accept:

Paid period: During what period will they apply to paid claims?

Incurred period: During what period will they apply to incurred claims?

Run-out provisions: How long will they pay past policy termination?
Run-in provisions: Will they accept liabilities from past policy periods?

- What limits may be applied to individual claimants?
- What limits will apply to run-out, run-in and policy payments?

Stop loss contracting

Specific and Aggregate contracts:

- 12/12 Incurred and Paid – provides coverage for claims that are both incurred and paid during the 12 month policy year. The least expensive option; but also the least coverage protection.
- 12/15 Incurred and Paid – provides run-out protection for claims incurred within the 12 month policy year period that may be submitted for payment as long as three months after the end of the policy year.
- 15/12 Incurred and Paid – provides run-in protection; coverage for claims incurred three months prior to the 12 month policy year that are submitted for payment during the 12 month policy year.
- "Paid Policy" - Provides continuous, uninterrupted coverage when claims are incurred in one contract year but submitted for payment in the next (assumes renewal of the spec contract)
- Other options: 24/12, 12/24, 15/15, 18/15, 18/12

Stop loss options

Aggregating Specific Deductible

A partially self-funded arrangement for reducing specific stop loss premium. (see next page for example)

Monthly Aggregate Accommodation

Provides monthly funding when aggregate attachment is reached during the policy year.

Specific Advance Reimbursement

Carrier advances funds for specific claims as they are incurred instead of at the end of the contract period.

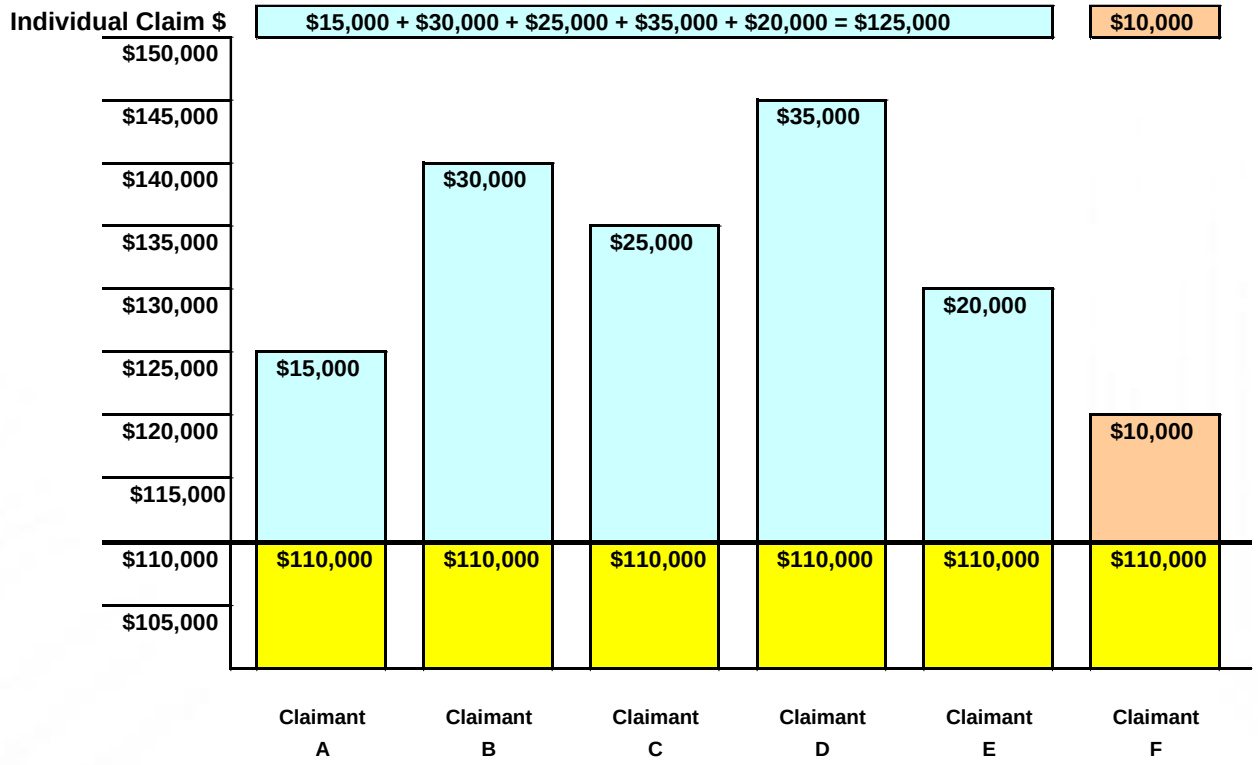
Terminal Liability Coverage

Provides additional coverage for run out stop loss claims.

Split Funded Aggregate

Splits the liability for any claims between 110% and 125%. The additional liability is split from 25% - 75% of the corridor to meet different risk appetites. Usually offered to groups new to self-insurance.

Aggregating specific deductibles



"**Aggregating Specific Deductible**" is a way for employers to trade additional risk for lower specific deductible premiums. Essentially, two deductibles are used to combine aggregate and specific stop loss:

Example	Specific Stop Loss Deductible:	**$110,000**
	Aggregating Specific Deductible:	**$125,000**

Profile of a likely self-insured candidate

- Organization is financially stable
- Has few and/or predictable numbers of high claims
- Has a stable employee population with high participation in their health plan for both single and employees with families.
- Has a stable, credible (and favorable) claim liability history (minimum of 150 life years)
- Has practical use of self-insured cash flow advantages
- Has practical need for – and interest in – designing their own health benefits; irrespective of insured mandates.
- Can realistically fund reserves and set aside those funds for health benefit use only
- **Has measured and confirmed minimal ACA liabilities regarding future eligibility and potential high risk pool transferees.**

Who offers self-insured plans?

- **Insurance companies** offer "administrative services only" self-insured contracts; usually with only the choice of their stop loss policies and provider networks. Pharmacy programs are usually offered through their benefit manager (PBM).
- **Third party administrators** (TPAs) who pay claims and put together provider networks for both medical and pharmacy. Typically, the TPA provides access to a choice of stop loss reinsurers (usually two to three for each industry) and links those programs with its proposed claims services and provider networks.
- **Specialty third party programs** may include TPAs that are subsidiaries of provider organizations (e.g., Mayo Health Plan) or other organizations.
- **Pools** may also offer self-insured plans to participating member groups. These groups are typically charged a fixed rate by the pool; similar to insurance premiums. The pool assumes self-insured liability for claims and expenses in excess of the fixed rate; similar to an insured plan.

Each type of program has its own unique advantages and liabilities.

What to watch for:

- **Stop loss *paid* contract language:** Usually stop loss-eligible claims have to be submitted for payment during the contract term for the stop loss policy to cover them. This is different than insured policies, which cover claims that are incurred during the policy period regardless of when they are submitted for payment.

- **Run-out claim provisions** in stop loss policies are rare and often inadequate; making it difficult for an employer to go back to an insured plan once they become self-funded. (Insurance companies will generally not administer or pay run-in claims).

- **Run-in claim provisions** that provide adequate protection when changing stop loss carriers are usually longer than most SL carriers are willing to provide. Not having an adequate run in period can expose the employer to additional liabilities when switching SL programs.

- **Administrative services contracts usually do not apply to run-out claim payments in a self insurance plan**. This means that in order to change plan administrators, self-insured employers need a pre-agreement to pay clause in their administrative contract with their plan administrator (e.g., TPA).

What to watch for:

Individual benefit limits are defined in most stop loss policies.

- In some cases, run-in limits will be assigned to either specific and/or aggregate claims: e.g., specific and aggregate payouts for run-in claims (claims incurred under a prior plan year) will be limited to a defined dollar amount.
- In most cases, aggregate stop loss liability will be limited to $1,000,000 per contract period. Higher limits are available; some stop loss carriers have no limits. No limit plans are typical of ASO programs offered by insurance companies.

Covered expenses may be defined in the stop loss contract differently than they are under the Summary Plan Description. Close scrutiny is required. For example, some stop loss policies require the use of assigned "centers of excellence" or specialty providers for transplant coverage. Such policies may exclude coverage for transplants outside of their specialty networks.

What to watch for:

Specific Stop Loss Lasering

- Lasering is the practice of the stop loss policy either excluding certain claimants from coverage altogether, or providing a limited amount of coverage for certain, named claimants – once their high claim liability is known. Lasering can be assessed based on a claim $ limit or on a medical condition.

- Lasering is often used as a pricing tactic for keeping stop loss premiums "competitive" or "more affordable" for the other employees. In reality, it permits the stop loss carrier to selectively decide whether or not to cover individuals who need protection the most; transferring those liabilities back to the employer.

- Lasered amounts do NOT apply towards the aggregate stop loss (in most cases).

Note: Not all stop loss carriers use lasering. These carriers may be considered preferred stop loss insurers by some groups. Other self-insured groups may regard lasering as an effective cost-control technique.

What to watch for:

- **Funding the aggregate corridor** – The difference between expected claims and aggregate claims liability can be considerable; up to another 25% of expected claims. This additional claims exposure is the employer's responsibility and must be funded if incurred.

- **Base employee contributions on total liability** – The employee contribution, the so-called "premium equivalent" rate should be based on the entire projected liability of the program, not the expected liability. This means that the rate should include the aggregate corridor.

- **Premium equivalent rate should also include reserves** – Establishing a proper reserve is a critical component of any self-insured program. In the first year of a self-insured program, it is recommended that the initial rates reflect the first year reserve build-up rate. On going rates in subsequent years should reflect and changes necessary to maintain the reserve fund at adequate levels. *Reserves are not "savings"!*

Self-insured plan termination issues

- Employer is responsible to pay run outs (for all claims).
  - High claims run outs belong to the employer unless they are covered under a special stop loss run out provision.
- What will be the administrative cost for paying run out claims?
- Prior administrator is best, since they had their network pricing contracts and stop loss administration in place when the claims were incurred. Prior administrator provides the best chance for accurate benefits claims adjudication and consistency for all claims incurred during the prior plan period.
- Employer stop loss run-outs liability depends on Terminal Liability Option (if any) and/or run-in contract provisions with the new stop loss carrier.
- There will be no run-in provisions available to the employer returning to an insured contract. The self-insured employer must pay all of the terminal claim liabilities associated with its self-insured plan for the year prior to – and in addition to - its new insured plan year.

Market trends affecting self-insured decisions

- Health benefit trend is escalating; increasing the projected costs of claims for both insured and self-insured plans.
- The ACA may affect self-insured decision (positive or negative); for smaller groups eligible for community rating.
- Neither insured and self-insured plans are providing effective cost control of provider fees.
- "New networks" and contracting methods are not yet providing any measurable savings. (Note: Network options are available to both insured as well as self-insured programs. It is inaccurate to suggest they are only available to one or the other).
- Greater numbers and the frequency of high claims are occurring as the health of the general population reflects general aging and poor lifestyle choices that adversely affect health.

Market trends affecting self-insured decisions

- Specialty medications – and their high, unpredictable costs – are accelerating and present a significant unknown liability to self-insured plan sponsors. Specialty medications are also putting pressure on stop loss markets.
- Stop loss contracts are becoming more specialized, as carriers attempt to isolate unpalatable risks from their high claims pools. This is making self-insuring far riskier for groups that have substantial adverse claim activity.
- Speculation that emerging stop loss markets will enable small(er) employers to self-insure have not produces adequate cost savings justifying the risk of becoming self-insured. (Stop loss markets are available; just very expensive).

Conclusion: General market conditions are currently risk-adverse

Self-insurance: fact vs. fiction

Common Perceptions	Point / Counterpoint
Self-insurance allows employers to avoid the ACA and state benefit mandates	The most significant ACA mandates apply to self-insured plans; such as no pre-existing conditions limitation, minimum essential coverage, employer shared responsibility requirements, etc. Some state mandated benefits may be excluded – if it is the employer's intent to no longer cover them *.
Self-insurance requires much more management "work" than a fully-insured plan	Self-insured plans have many more moving parts and pieces that need to be subject to closer scrutiny than do insured plans. Risk quantification is much more significant to the employer. Cost transparency also requires analytical effort.
Self-insurance is only for "larger" groups	Size helps define credibility and risk, but is not the only, or even major, self-insurance consideration.
Administrative costs the main difference between insured and self-insured plans	Both insured and self-insured plans have comparable administrative and other fixed costs. However, it cannot be assumed that claims costs are the same under both programs. Differences – significant differences – can and often do exist.
Self-insurance provides tax savings and cash flow advantages.	Tax savings exist, but with interest rates at rock bottom lows, the cash flow advantages are not all that significant. In some cases, reserve earnings may not justify the risk of holding them.

* For public employers, any reduction in benefits transitioning from an insured to a self-insured plan must be approved by their unions per MN Statute 471.6161 s 5 re: "aggregate benefit value" rule.

Transparency and self-insurance

Who Pays?

Plan Component	Fully Insured	Self-Insured
Administration	Included in Premium	Paid as a fee to PA *
Stop Loss	Included in Premium	Paid as a fee to PA
Provider Fees	Included in Premium	Paid as a fee to PA
Commissions/Fees	Included in Premium	Paid as a fee to PA
Taxes	Included in Premium	Paid as a fee to PA
Paid Claims	Included in Premium	Paid by Plan Sponsor
Reserves	Included in Premium	Held by Plan Sponsor
Terminal Claims	Included in Premium	Held by Plan Sponsor

* Plan Administrator

A properly managed self-insured plan re-evaluates its reserve and terminal claims liability at least annually.

Self-insured pool options/advantages

- Pools are generally the fiduciary, not the employer. The pool holds the risk.
- Pools hold – and guarantee – adequate reserves and make all payments on behalf of the groups – based on incurred claims; not just paid claims.
- Pools pay aggregate stop loss corridor claims, not the groups
- Pool stop loss policies generally cover all incurred claim liabilities; even if a group leaves the pool.
- Some pools provide more flexibility when it comes to provider network selection, plan design, etc. Some are less flexible.
- Pools generally provide protection against high claims volatility that exceeds the protection a group can achieve on its own with stop loss.
- Pools provide the main advantage of self-insured savings – taxes.

With interest rates at an all-time low, the cash flow advantages of groups paying their own claims and holding their own reserves are usually offset by the advantages of pooling.

Group Liability	Self-Insured Direct	Self-Insured Pooled	Fully-Insured Direct
fixed premium	no	yes	yes
administration	yes	yes	yes
specific stop loss	yes	yes	na
aggregate stop loss	yes	na	na
expected claims	yes	yes	yes
aggregate corridor reserve	yes	no	no
IBNR/Terminal Reserves	yes	no	no
Fiduciary responsibility	yes	no	no

Three funding methods compared on the basis of employer liability

How to obtain a self-insured proposal

- Self-insurance is but one of several viable methods for funding a health benefits program. Make sure it is the right method for you!
- Do not buy a self-insured plan from a benefit consultant preaching self-insurance as a universal solution for rising health care costs. Health benefit costs are driven by health care costs – whether you are insured or self-insured.
- A good benefit consultant will be careful to work with you objectively; pointing out the pros and cons of all funding methods. They will not promote one method over another, but help you select the one that is right for you.
- If you decide on self-insurance, make sure your organization understands the risks associated with becoming a claim fiduciary for your employees' health benefits plan.
- Make sure you include an "exit strategy" as part of your self-insured plan.

Self-insured plan tasks, roles and responsibilities

Employer

- Plan administrator – medical and pharmacy
- Administrative services: incurred and paid; with run out agreement
- Health care provider network – medical and pharmacy
- Contribution formula development

Reinsurer

- Specific stop loss – medical and pharmacy
- Aggregate stop loss – medical and pharmacy
- Claim projections and reporting
- Contracting (run in and run out agreements)

Consultant

- Claims projections/stop loss negotiations
- Premium equivalent calculation
- Plan administrator negotiations
- Reserves (estimation of adequacy and ready funds for aggregate corridor payments)
- Change in accrued claims liability calculation for IBNR and terminal liabilities

Self-insured plan consulting costs and commissions

- Self-insured plans require more work by you and your consultant; leading to increased management time for you and higher consulting fees and commissions. Be very wary of anyone suggesting self-insurance is "simple" and no different to administer than an insured plan. Be even more wary of anyone who claims they will "do it all for you".
- Consulting fees are usually charged as a separate "broker fee" in the list of fixed costs (also including administration, stop loss and special program fees, such as disease management).
- Stop loss fees typically include a commission equal to 15% of the stop loss premium; payable to your consultant.
- Other extra charges may be incurred (e.g., for health savings account administration, banking and claim reports, reserve analysis, preparation of Summary Plan Descriptions, ACA reporting services, etc.). Be sure to get an itemized list of all expenses associated with the proper management of your plan up front.

Final thoughts (for consultants)

Whether an employer feels they are better off insured or self-insured, in both cases, they are *correct*.

Self-insurance may be an effective strategy for avoiding the higher costs due to insured health care reform rules.

Do not market self-insurance as a "cure" for avoiding high claims or trend. They are not.

Do not underestimate self-insured costs and what it means to assume fiduciary responsibility for health benefits.

Be objective; do not advocate one funding method vs. another:

- ✓ Maintain premium-equivalent financial discipline at all times.
- ✓ Be aware of your client's risk sensitivity.
- ✓ Be transparent: illustrate your fees and quantify them in your renewal exhibit

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Bill Colopoulos is a healthcare economist and benefits consultant providing high quality consultative health plan audit and benefit management services to employers and their employees. Formally trained as a health care economist, Bill provides expertise in wellness and prevention, funding group benefit programs and health and welfare plan employer administration.

Bill has an extensive background. He has managed several large pooled health insurance programs and has helped employers design and implement financial policies that leverage economies of scale; improve and maintain the financial integrity of his clients' benefit programs.

Bill's 30 year career includes client management work for major insurance companies. He has served as a National Account Executive for CIGNA Corporation, Marketing Manager of Disability Reinsurance for ReliaStar and Director of Pharmacy Management for United Health Group. He is currently the President of Next Generation Healthcare Economics, a healthcare economic think-tank and benefits consulting firm that Bill founded in 2007.

Bill is a noted authority in many different aspects of health benefits, including medical, pharmacy and disability. He has written numerous published articles on topics of interest to employee benefit managers. Bill also provides continuing education classes for his fellow professionals. He is currently an instructor at the Kaplan Professional School providing the following courses: Health Care Economics, Health Care in Other Nations, Healthcare Reform: A "to do" List for Employers and Self-Insuring Health Benefit Plans.

Currently, Bill specializes in helping health and welfare plan sponsors audit and manage their group benefit plans. His work has also focused on exploring patient-focused cost control strategies to facilitate the education, design and implementation of wellness incentive-based health plans. Recently, he has advised his clients on the impact of healthcare reform and how to measure employer and employee health care affordability. In 2012, he worked with the state of Minnesota's Health Exchange Advisory Task Force, serving as a member of the Small Employer and Employees Technical Work Group.

Bill received a B.A. in Economics from Connecticut College. He has also conducted graduate studies in economics at the University of Pennsylvania and is a member of the American Economic Association, National Association of Health Underwriters and the Society of Human Resources Managers.