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HEALTH CARE LAW

Self-Insured Health Plans: The Risks and Rewards

Attorneys should understand the necessary documents and what is involved in administering the plans

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Due to the rising cost of health coverage, an increasing number of New Jersey employers are establishing "self-insured" health plans for their employees in place of traditional insured plans.

A self-insured health plan is a plan under which covered expenses are paid, in the first instance, from a source other than insurance. Covered expenses may be paid either from the employer's general assets or from a trust established under the plan.

A self-insured plan offers many potential cost-saving benefits. Most of the funds that would be transferred to a carrier (i.e., the reserves for claims) remain with the employer, improving the employer's cash flow. State premium taxes are also eliminated. Also, because self-insured plans are not subject to state laws regulating insurance, employers can elect not to provide certain state-mandated benefits.

Typically, an employer establishing a self-insured plan will set an affordable limit on its obligation to pay claims and obtain "stop-loss" insurance coverage for large claims. Stop-loss insurance may be structured as either: (i) an individual stop-loss policy under which the carrier pays a covered individual's claims if such claims, when combined with his or her other claims, exceed a certain threshold amount; or (ii) an aggregate stop-loss insurance policy under which the carrier pays the covered claims once the combined claims of all covered individuals exceed a designated threshold amount. The type of stop-loss insurance arrangement and the threshold limit at which claims should be paid depend upon several factors, including the number of plan participants, the group's prior claims experience, the employer's financial strength and the premium cost as compared to the potential benefit of maintaining such insurance.

The stop-loss or excess risk policy, as any type of excess risk or umbrella policy, must be properly integrated with the primary coverage to ensure there are no inadvertent gaps in coverage.

Unlike a traditional insured plan where the carrier provides all of the necessary documentation, the documentation needed for a self-insured plan is generally more involved. The primary documents needed to maintain a self-insured plan are the plan document or booklet, the stop-loss policy and the administrative services agreement (ASA).

The plan document or booklet is the operative document distributed to the participants and describes all of the coverages, benefits and exclusions from coverage. Unless it is contained in a separate document, it should also contain a description of any provider network.

Although exempt from state laws regulating insurance, a self-insured plan is a "health and welfare" plan subject to the Employee Retirement Income Security Act's requirements. Unless contained in a separate document, the plan document or booklet must meet the content requirements of ERISA §102, including a description of the procedure for appealing a denied claim. This document should also explain what it means for a plan to be self-insured and indicate how the coverages provided are coordinated with the coverages provided under the related stop-loss policy.

The ASA is a critical component of a self-insured plan and is, in our experience, the most important document for an employer to have reviewed by an attorney familiar with self-insured plans. In contrast to an insured plan

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under which all of the necessary documentation and services are likely to be bundled by the carrier, it is often not apparent who is responsible for each aspect of a self-insured plan. For example, when your client's broker presents a proposal for a self-insured plan, whose proposal is being presented? Is it a product packaged by the broker, the stop-loss carrier or a noncarrier third-party administrator?

Similarly, who will determine that all of the plan's components, including the setting of the self-insured coverage limits, the determination of whether to prefund the projected claims, the processing and payment of claims, the preparation of communication materials and the integration of the stop-loss coverage with the self-insured limits, fit together and are properly coordinated with each other? Also, who will determine that the arrangement complies with all applicable laws, including ERISA, the Health Insurance Portability and Accountability Act and the Consolidated Omnibus Budget Reconciliation Act? It is important for attorneys to review ASAs and all other aspects of the arrangement with these issues in mind.

This article is not intended to provide a detailed analysis of the income tax consequences of a self-insured group health plan. However, a couple of important distinctions between the treatment to employers and participants under these plans as compared to conventional insured plans should be noted. First, self-insured plans are subject to the nondiscrimination requirements of Internal Revenue Code §105. That section provides, in pertinent part, that self-insured plans may not discriminate in favor of highly compensated employees. Thus, an employer maintaining a self-insured plan which excludes a group of employees for reasons other than age or service with the employer, or which provides more favorable benefits for highly compensated as compared to nonhighly compensated employees, may cause its highly compensated employees to recognize income as a result of their participation in and receipt of benefits under the plan.

Second, while an employer's payments under a self-insured plan are generally deductible as ordinary and necessary expenses under IRC §162, as are premiums paid under an insured plan, a different set of rules apply to an employer that maintains a self-insured plan and prefunds a trust or other account, the corpus of which is used to pay covered claims as they occur in the future. Rather than being currently deductible under IRC §162, the deductibility of an employer's payments into such a vehicle is determined under IRC §419, which generally limits an employer's current deductions to those contributions that are actuarially projected to be needed to pay current claims.

Fiduciary issues are an additional area of concern. ERISA defines a fiduciary as a party who exercises any discretionary authority or control over a plan's management or administration. In most instances, an employer, as well as one or more of its officers, will be a fiduciary of its self-insured plan even if they rely upon a broker, consultant or other party to establish the plan. This imposes a high standard on employers, even if they do not know they are fiduciaries. Specifically, employers must act as an expert would act under similar circumstances in maintaining the plan and communicating it to their employees. For example, employers are responsible for explaining that the plan is self-insured (i.e., it is not backed by a state fund, there is no requirement for a minimum reserve for claims to be maintained, etc.). If the cost of coverage is substantially less than under an insured plan, the fiduciaries need to understand the reasons for the savings and the risks associated with it, and properly disclose these items to their employees.

If it seems too good to be true, it probably is. We recently received a fax that read "ATTENTION: Business Owner — Health Care for the Entire Family — as Low as $54 per month." We considered whether it would be prudent to recommend this coverage to our firm. We then looked at the U.S. Department of Labor Web site and learned the DOL has initiated 622 civil and 113 criminal investigations against unscrupulous health plan promoters, affecting more than 1.9 million participants and their beneficiaries. To date, the DOL has filed 64 civil complaints, indicted 95 individuals with 70 convictions, many of which involve coverage marketed through multiple employer welfare arrangements (MEWA). Simply stated, a MEWA provides health and welfare benefits to two or more employers that are not parties to bona fide collective bargaining agreements. We concluded: you get what you pay for.

In 2002, legislation known as the "Self-Funded Multiple Employer Welfare Arrangement Regulation Act" was signed into law in New Jersey. As explained on the Web site maintained by the State Department of Banking and Insurance, this legislation is designed to protect New Jersey residents from "scams in which criminals market various low-cost fraudulent health plans…." The regulations promulgated under this act went into effect earlier this year. While the initial registration and periodic reporting requirements contained in the regulations are arguably unduly burdensome on legitimate group health plans, they will, hopefully, help eliminate many of the bogus plans from the marketplace in our state.

Due to the recent increase in popularity of self-insured plans, it is important for attorneys to be familiar with these plans and the benefits they can provide. Attorneys and their clients need to understand the necessary documents and what is involved in administering these plans. They must also be sensitive to the numerous laws applicable to self-insured plans, including ERISA, COBRA, HIPAA and the IRC. In addition, they must be wary of the self-insured plans that seem too good to be true. With this base of knowledge as a starting point, attorneys can provide a valuable service to clients when asked to review and advise on any self-insured health plans under consideration. ■