



Self-Insuring a Small Business: Potential Risks Associated with Self-Funded Health Plans

The Office of the Health Insurance Commissioner (OHIC) is issuing this notification to small employers in order to understand the difference between fully-insured and self-funded health plans, as well as the relevant risks associated with the self-insured market.

Fully-insured health plans versus self-funded health plans

In a fully-insured health plan, an employer pays a set premium to the health insurer, and in return, all claims for medically necessary covered benefits are paid for by the health plan. Fully-insured health plans are under OHIC's jurisdiction and are subject to all federal and state insurance laws and regulations. This includes required coverage of certain minimum health care services and state mandated benefits.

If the employer opts for a self-funded plan, the employer funds the cost of all health services covered by the health plan. Although employers may elect to have a third-party administrator (TPA) handle claims processing, the employer is ultimately financially responsible for the payment of these claims. Self-funded plans are not under OHIC's jurisdiction and may not be subject to certain state mandated benefit laws and minimum essential health benefits but are required to comply with federal laws and regulations, such as the Employee Retirement Income Security Act (ERISA).

Some companies may be attracted to self-funded policies based on perceived financial advantages. In response to concerns raised by some local businesses, OHIC would like to make small businesses aware of some of the risks associated with self-funded plans that may not be fully disclosed at the time of purchase:

Some potential risks of self-funded health plans

1. **Financial Risk:** The specific demographics and health status of the employees can open the employer up for higher than expected and unexpected claims. While employers who elect to offer a self-insured plan can purchase "stop loss" insurance to help account for high-cost claims, employers are responsible for payment of all claims until they reach the "stop loss" level. With stop-loss policies, there is an "aggregate attachment point" (which is the maximum claims liability for the entire group) and/or a "specific attachment point" (which relates to health claims of an individual employee or dependent). In the State of Rhode Island, the aggregate attachment point may be **no less than** 120% of the expected claim, and the specific attachment point may be **no less than** \$20,000.
2. **Unpredictability:** With a fully-funded plan, the company can budget its monthly expenses as they relate to healthcare claims and annual costs; however, this is not the

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case with a self-insured plan. The company may have the ability to project expected claims but will not be able to predict healthcare costs on a month by month basis, as claims will fluctuate.

3. **Covered Services:** Though self-insured policies must abide by any relevant federal laws; they are not required to comply with Rhode Island state laws and required benefits. Some of these state laws include the requirement to provide coverage for dialysis, mastectomy treatment, infertility treatment, bariatric surgery, etc. While the plan *may* cover these services, it is not required. Some employers and/or employees may not be aware that some services are not covered until after the services have been rendered and a denial notification is received. Ask your health plan advisor or broker for a list of RI required benefits to make an informed decision about the limitations of the product you are purchasing.
4. **Administrative Risk:** Employers must be aware of federal non-discrimination rules applying to employer-sponsored health plans. Health factors, including current or future health conditions, may not be used to deny access to the employer-offered health coverage, discontinue existing coverage, or charge different rates for such coverage. Employers who violate these rules may be subject to US Department of Labor action.
5. **Protection and Enforcement:** Self-funded plans are not subject to state jurisdiction. Therefore, OHIC's authority is limited in regard to regulating these types of plans, including the ability to assist you and your employees in resolving complaints, denials, and appeals.

OHIC would advise that small employers with fewer than 50 employees conduct due diligence when considering self-funded health plans. We urge such employers to consider the consequences of one or more employee with specific health care needs for which services may not be covered, or the impact of experiencing higher than expected claims.