THE ADVISABILITY OF INSURANCE BY CARRIER VERSUS SELF-INSURANCE OF AN EMPLOYEE HEALTH CARE PROGRAM IN A SPECIFIC CORPORATE SITUATION

by

Robert A. Dietmeyer, B. S. C.

A Thesis submitted to the Faculty of the Graduate School, Marquette University in Partial Fulfillment of the Requirements for the Degree of Master of Business Administration

Milwaukee, Wisconsin
May 23, 1960

VITA

The writer, a native of Burlington, Iowa, graduated from Waukegan Township High School, Waukegan, Illinois, in 1944. After spending eighteen months in the United States Army he returned to civilian life to further his formal education. He graduated from the State University of Iowa in Iowa City in 1950 with a Bachelor of Science Degree in General Business.

For nine years he has been employed by Abbott Laboratories, North Chicago, Illinois and his present capacity there is as Manager of Benefit Plans. In conjunction with this assignment he entered the Graduate Program at Marquette University in 1955 and expects to graduate in June 1960.

He has been active in local affairs in Waukegan by participating in the Knights of Columbus, the Christian Family Movement, the Cana Movement, a board member of the Catholic Community Service, and Junior Achievement.

ACKNOWLEDGEMENTS

The writer wishes to express his sincere appreciation to those that made this Thesis possible. First, and of prime importance, was the moral support and heartwarming enthusiasm afforded by his wife, Catherine. There can be no doubt that without her wonderful cooperation this paper would not have been attempted. Earl Bauby, former Director of Personnel at Abbott Laboratories was also an ardent supporter in the writer's effors to complete this paper.

The most valuable assistance was given by the Thesis Committee consisting of Dr. Herbert G. Zollitsch, Chairman; Dr. Howard Launstein, and Dr. Richard Lynch. Their constructive criticism and advice were invaluable in arriving at the finished product.

Important information needed to complete the paper was supplied by several members of the insurance industry. Special thanks go to Russell Mowry of the Travelers Insurance Company and John Schenning of the Equitable Life Assurance Society. To the many other men who were helpful in supplying needed facts and figures also go the writer's sincere appreciation.

TABLE OF CONTENTS

	Page
VITA	ii
ACKNOWLEDGEMENTS	iii
LIST OF TABLES AND ILLUSTRATIONS	vi
Chapter	
I. INTRODUCTION	1
Aims Of The Study	1
Present Status Of The Problem	1
Importance Of The Study	2
Methods To Be Used In The Study	4
Limitations Of The Study	5
Definition Of Terms	5
Prerequisites Of A Self-Insured Program	9
Characteristics Of Company X	12
II. FINANCIAL CONSIDERATIONS	16
Broker's Commissions	19
Premium Taxes	21
Acquisition Costs	21
Addition To Surplus	22
Summary of Retention Expense And Reserves	23
Reserve For Outstanding and Unreported Claims	23
Contingency Reserve	26
Stop Loss Coverage	29
Use Of No Reserve	32
Use Of Actuaries	34
III. ADMINISTRATIVE CONSIDERATIONS	37
Determination Of Benefits	39
Issuance Of Certificates And Booklets	45
Claims Administration	47
Excessive Medical Fees	52
Continuance of Coverage After Separation	57
Internal Control	59
Contributory Feature	61
Employee Acceptance	63
Role of The Consultant	66

TABLE OF CONTENTS (CONTINUED)

Page

IV. LEGAL CONSIDERATIONS. 69

Legal Status of The Program 72
Developing Certificates and Policies 74
Lawsuit Problems 75

V. SUMMARY, RECOMMENDATIONS, AND CONCLUSIONS. 78

APPENDICES. 91

A. Initial Letter Accompanying Questionnaire 92
B. Copy of Questionnaire 93
C. List of Companies Participating in Survey 95
D. Survey Results 96
E. Transmittal Letter Accompanying Results 107

BIBLIOGRAPHY. 108

LIST OF TABLES AND ILLUSTRATIONS

Table		Page
1.	Company X Schedule of Benefits	14
2.	Claim Experience for Twelve Month Period Ending November 30, 1958	17
3.	Flow Chart of Procedure to Process Insurance Claims	49
4.	Estimated Savings Under Self-Insurance	80
5.	Estimate of Self-Insurance Expense	81

CHAPTER I

INTRODUCTION

AIMS OF THE STUDY

The primary purpose of this study is to determine in a specific situation whether it is advisable or not to change from a commercial carrier insured employee group program to a self-insured program with the company itself assuming all of the financial and administrative responsibility. Consideration in the study will be given to the following insurance coverages: Weekly accident and sickness, hospitalization, surgical and medical expense benefits for employees and dependents.

It is intended in this study to emphasize the various factors that should be reviewed before deciding whether or not to enter into a self-insured program.

It is hoped that this pilot study can be used as a basic guide by management groups in studying the self-insurance question in their own companies. Furthermore this study is intended to give the reader a closer insight into the operation of group insurance. This secondary aim of the study will give the reader a better appreciation of exactly what protection is being purchased with the premium dollar. It is hoped that he will be in a better position to determine whether or not he is getting value received.

PRESENT STATUS OF THE PROBLEM

At the present time it is estimated that less than one percent of all group insurance plans are self-insured.[1] It should be pointed

---

[1]Interview with Bernard McGuirk, Senior Auditor, Equitable Life Assurance Society, February, 1959.

out that in many group insurance programs there are a number of good reasons why self-insurance is not intended as the sole answer to the mounting cost problems in the group insurance field. However, with so much emphasis on employee benefits in labor negotiations, managements are becoming more and more cost conscious. Since there are so many insured groups (especially among the smaller companies) that are not in a position to administer their program as efficiently or as cheaply as a commercial insurance carrier, there has been no activity on their part toward self-insurance. On the other hand, the larger insured groups, being the most fertile field for such a program, are gradually becoming more interested in such programs. Also benefit consultant firms are advocating the self-insured approach to some of their clients, but only after very detailed investigations.

As you would expect, there is a great deal of resistance to the actual development of self-insurance by the major insurance carriers. This is done by printed releases sent to all of their sales personnel listing in detail the advantages of the insured program over the self-insured. In addition the difficulty in securing Stop Loss Insurance to tie in with the self-insured program has also hampered the development of the self-insured program, as have misconceptions as to the financial role played by the insurance carrier.

IMPORTANCE OF THE STUDY

As wages continue to rise in the American economy, together with employee benefits for which billions are being spent by management and labor throughout the country, more and more companies are becoming concerned about several important questions. First of all, where will

expenses of this kind stop and secondly, is there any way that managements can be assured that they are receiving the maximum benefit dollar for each dollar being spent. The bi-annual Survey of Fringe Benefits conducted by the United States Chamber of Commerce is perhaps the most comprehensive survey of trends in the benefit field. As shown by the 1957 survey, with fringes reaching 25 percent of payroll, they are reaching proportions undreamed of less than twenty years ago.

The benefit levels of the various plans, whether it be hospitalization insurance or pensions, are continually being liberalized with the employer assuming the full cost in many cases. In personnel relations and union negotiations it has become just about impossible to reduce the level of benefits of any of the fringes already given. This being the case, one of the only ways to try to hold the benefit cost in line or to reduce costs to any extent is in the administration of the plan. Self-insurance may be the answer to some companies in their attempt to reduce benefit costs.

It is hoped therefore that this study can be used by the managements of those companies interested in the possibilities of self-insurance as a guide to the various phases to be considered and this paper will explain to them some of the areas and mechanics of group insurance with which they may not be too familiar.

Normally most available information on the subject is quite broad so that no thought is given to the actual decision to be made. By using actual coverages, costs and other data pertaining to a specific company, a conclusion will be reached as to whether or not self-insurance should be adopted. This paper will also indicate the success

of several companies who have self-insured their programs for a number of years.

METHODS TO BE USED IN THE STUDY

As mentioned earlier, there is little information available to the public on the self-insurance of health and welfare plans. Most of the study in this area has been done by benefit consultants for specific clients so that the information is not made public. A great deal of the information used as background for this paper has been obtained from speeches, articles and several confidential company studies performed by an employee benefit consultant firm. In addition, men in the insurance field were helpful in supplying what information they had available representing their views toward the self-insurance programs.

The author could find no published surveys that would describe current practices by self-insured companies. As a result it was necessary to survey a group of firms believed to have fully or partially self-insured their health and welfare programs. A questionnaire with 21 questions was mailed to 35 companies. A copy of the questionnaire is found in Appendix B of this paper. The writer learned from the responses that a number of the companies were not self-insured so that actually twelve completed the questionnaires satisfactorily. These twelve companies, representing 33% of the companies surveyed, had medical care insurance programs on either a fully or partially self-insured basis. They were very cooperative in completing the questionnaire in addition to supplying some information not specifically requested.

The tabulated results of the survey may be found in the Appendix D of this paper. Copies of the results were sent to each of the participating companies for their information. A listing of the particular

companies surveyed will be found in Appendix C. The responses are identified only by code number, since the writer assured each participating company that its identity would remain anonymous.

LIMITATIONS OF THE STUDY

It would be well to keep in mind that the conclusions reached in this study are based on the actual cost and experience of Company X. Although the general approach in this paper may be used analyzing the self-insurance question in other companies, the conclusions reached should not be interpreted by the reader as automatically applying to any company situations other than Company X. Hence the conclusions reached in this paper should be viewed with caution in other company situations.

There will be a basic limitation in this paper since the study involves one manufacturing company and one insurance company. There may be peculiarities found in the insurance program of Company X or of the cost figures used as furnished by the carrier or by the insured. Nevertheless, the figures are accurate and are the basis for the final conclusions to be made. Whether they are representative of the costs of similar sized companies or of other insurance carriers will not be determined in this paper.

DEFINITION OF TERMS

There are a number of terms used primarily in the insurance field that should be defined so that anyone reading this paper will understand as fully as possible the various areas in which the writer will delve.

Commercial Insurance Carrier: A company incorporated to provide dollar reimbursement to individuals and groups against certain

losses incurred as a result of a specific hazard. This protection is provided under certain conditions and at an exact cost to the insured.

Self-Insurance: The assumption by the insured company of the risks formerly the responsibility of the carrier with the individual company then retaining any savings gained from administering its own program and also bearing all losses.

Health Care Program: A group insurance program found generally in industry today for employees and their families providing certain benefits for the employee that is off work for an extended period of time due to a non-occupational injury or illness. Also financial assistance is available to the employee who is confined to a hospital or finds it necessary to receive medical treatment or diagnostic care in the doctor's office. Usually programs of this type are insured with commercial insurance carriers for a number of reasons that will be discussed later.

Retention: That portion of gross premium paid by the insured to the carrier that is kept to offset certain expenses, establish reserves, or as a profit. Retention consists of the following items:

> Premium Taxes - a tax paid annually by the insurance company to the particular state in which the group policy is carried. The amount of this tax varies from one-half of one percent to two percent depending upon the state involved. Its purpose is to provide

funds for the operation of the state's insurance department.

Commissions - amount paid by the carrier to the broker who represents the employer in the selection of the carrier and the coverages.

Contingency Reserve Charge - a charge made by the carrier against each of its group customers to establish and maintain reserves to meet catastrophic occurrences and unrecouped losses under policies.

Reserve for Outstanding and Unreported Claims - Although not considered officially as part of the carrier's retention, nevertheless it is a cost to the insured. This reserve is established for the carrier's protection so that in the event the contract between the insured and the carrier is cancelled this reserve is then used to pay any claims received after the cancellation date. Any of this reserve not used to pay such claims is returnable to the former insured group policy-holder. The interest on this reserve is paid to the insured company and is usually included in the annual rate credit paid by the carrier to the insured.

Administrative Expenses - the charge by the carrier for its services such as claims review and processing, printing of booklets, insurance certificates, investigating questionable claims and many other miscellaneous

services.

Profit Allocation - the portion of the retention which is actually the profit of the carrier for the many services it renders.

Accident and Sickness Benefit: Weekly benefits which may approximate a certain percentage of pay, perhaps up to a stated maximum. It is payable for a specified period to the employee who is off work because of a non-occupational accident or illness. This benefit is provided to replace the loss of income to the worker.

Hospitalization Benefits: Protection available to the employee to reimburse him partially or completely for expenses occurring as a result of the hospital confinement of himself or some member of his family.

Surgical Benefits: Reimbursements available to help him offset the surgeon's expense resulting from an operation for himself or his family.

Medical Benefits: Protection available to help the employee offset the expense of visits to the doctor's office, house visits, or hospital visits by the physician. In addition, benefits are provided for x-rays or laboratory tests as an out-patient in the hospital or in the doctor's office.

Actuary: A person specializing in the mathematics of insurance. This term is usually confined in application to fellows and associates of recognized actuarial societies in which membership is attained by examination.

Benefit Consultant Firm: A group specializing in analyzing the benefit program of specific companies to determine their shortcomings and inconsistencies with recommendations as to possible improvements. Also, they are well versed on current trends, actuarial methods, and the development of specific benefit programs.

Annual Claim Experience: Detailed data including dollars paid out to employees for insurance claims submitted during the twelve months of the policy year, number of claimants, etc.

Non-Occupational: Pertaining to accidents or illnesses suffered while the employee is off the job. In the event of illnesses or accidents while on the job, benefits would be provided under Workman's Compensation Insurance, which is not discussed in this paper.

Annual Rate Credit: A refund of premium made at the end of each policy year by the carrier to the insured company if experience for the year has been favorable enough to warrant it.

PREREQUISITES OF A SELF-INSURED PROGRAM

In order to consider seriously the question of self-insurance there are certain prerequisites that should be met.

The first one is the size of the corporation considering self-insurance. Darwin S. Liggett, Assistant Vice President of the Pacific Mutual Life Insurance Company feels that a minimum of 1,000 employees must be covered in a group plan before self-insurance could even be considered.[2] This minimum size is selected for several reasons. Of

---

[2]Darwin S. Liggett, Pacific Mutual Life Insurance Co.; a speech before 1959 National Conference of Health and Welfare Plans, Trustees, & Administrators

most importance, the group involved must be large enough so that the total retention of the insurance carrier is sufficient to warrant the investigation of self-insurance. For example, if the total retention of the carrier was say $7,500 per year then assuming that the entire program could be administered cost free, this figure would be the maximum savings that could be made. Obviously, the self-insured company is going to have certain administrative expenses that may be even larger than the carrier's expense, so that considering the size of the savings that could be made, there would appear to be very little incentive to consider self-insurance seriously. On the other hand, if the retention was $100,000 yearly by the carrier, then this might change the situation considerably. There would be enough money involved to seriously study the potential of self-insurance.

The size of the company is also important from the point of view of risk. The group insured must be large enough so that several long illnesses or sizable claims will not distort financially the experience of the plan. For the insured plan the size of the group is of little importance because the reserves of the carrier are available to offset a year of extremely poor claim experience. Such is not the case in the self-insured plan since the company itself is assuming the full risk of either an unusually poor year of claims experience or a possible catastrophe striking the insured group.

Another prerequisite is the necessity for able administration of the present plan by the present employees of Company X. If the Company does not have experienced people already available to administer the program the cost of acquiring such employees may very well be more than

the dollars that can be saved for a number of years by self-insuring.

Also in order to consider self-insurance the company must be in sound financial condition. This is necessary so that adequate funds will be available if reserves are to be established by the company. In the event no reserves are established, the company must be financially able to pay any abnormal losses that may occur.

Favorable past claim experience is also very important. What better answer is there to the possibility of a year of abnormally high claim experience than a long and consistent record of favorable claim experience. If this has not been the past experience then extreme caution should be taken in pursuing the self-insurance question any further.

Last, but not least, when considering the possibility of self-insurance the area of employer-employee relations should be examined. It should be remembered that good employee relations must be in evidence if self-insurance is to be considered. This is true since the third party protection of the carrier will be gone. In the event of employee displeasure it will be directed toward the management of the company, not toward the insurance carrier. In the event of poor employee relations, it is very possible that they will distrust the program if it is underwritten by the company itself.

These are basic prerequisites that are needed to give further attention to the study of self-insurance. They are very necessary areas however, so that if they are not met adequately the probability of the success of self-insurance is considerably lessened.

CHARACTERISTICS OF COMPANY X

It is the writer's intention that the specific company being studied will remain anonymous so that it shall be referred to as Company X throughout the study. Company X, established prior to 1900, manufactures approximately 650 products, which would be termed "necessities" as contrasted with luxuries. It had sales of about $120,000,000 with net profit after taxes of about $11,500,000 for 1958. Sales and profit have been consistently increasing over the years. It employs approximately 5,000 people in the United States and Canada, or a total of 8,000 worldwide. Its insurance program covers about 5,000 employees and retired employees in addition to about 2,750 dependent units. It first adopted group life insurance in about 1927 and accident and sickness benefits in 1934.

The employee group is not unionized and there are about 3,700 employees located at the main plant in a small midwestern city with the remaining 1,300 located throughout the United States and Canada in sales territories and distribution branches in 22 major cities. Management-employee relations have always been very good and the company has been considered a leader, to some extent, in the area of employee benefits.

In beginning the consideration of self-insurance of a health and welfare program, careful attention should be given to the actual benefit provisions of the program of Company X. This is true since these provisions will determine the extent of the liability of Company X, should it self-insure. It will be assumed that the level

of benefits is adequate so that no thought will be given to the possible liberalization of benefits at this time. This assumption would appear to be realistic as the Health Care Program at Company X was liberalized substantially within the past two years. As can be noticed in reviewing the program, the level of benefits has been set up in such a manner that it will combat inflationary increases to the extent that it will not be necessary to liberalize the benefits every few years to keep up with the projected increase in medical expenses.

The present insurance program is contributory for all employees varying in cost according to salary scale. In addition there is an increased premium per month for those employees with dependent coverage. Although the trend in industry is toward non-contributory plans, it is the philosophy of Company X that the employee should share, to a small extent at least, a part of the cost of the group plans with the company. The management of Company X feel that employees contributing to a program have a greater interest in what happens to the program since it directly involves their money.

Figure 1 on the next page will describe in some detail the benefit provisions to be found in the insurance program of Company X.

There is a $10,000 lifetime maximum for each family member. When a minimum of $1,000 of benefit has been used up, the insured employee or his dependent will apply for reinstatement so that the full $10,000 will be reinstated into force again. In the event the person involved has not returned to good health, then the maximum cannot be reinstated; but the balance of $10,000 will still be in effect. It should be pointed out however, that the medical expense and outpatient laboratory benefits do not apply toward the $10,000.

TABLE 1

SCHEDULE OF INSURANCE BENEFITS

OF COMPANY X

Weekly Earnings	Weekly Accident and Sickness Benefit	Hospital Benefit*	Surgical Benefit*	Medical Expense Benefit*	Maternity Benefit
Less than $45.00	$ 30.00	$500.00 in full plus 80% of expenses over $500	80% of Surgeon's Charge	80% of Physician's Charge for in-hospital calls Office calls $3.00 Home Calls $5.00	Female employees $250.00 lump sum allowance Dependents $175.00 for Hospital Expense Only.
$45.00 to $55.00	35.00				
$55.00 to $65.00	40.00				
$65.00 to $75.00	45.00				
$75.00 to $85.00	50.00				
$85.00 to $95.00	55.00				
$95.00 and over	60.00				

* Coverage identical for Employees and Dependents

In the event the employee leaves the company by resignation, he cannot continue his group insurance coverage. On the other hand, in the event he retires from the company then he may continue coverage in effect for his wife and himself. The hospital and surgical coverages are the same as for the active employees except that the lifetime limit is reduced from $10,000 to $5,000. In addition, there is no reinstatement privilege for the retired employees. Under the office and home call coverage there is a yearly maximum of $100.

CHAPTER II

FINANCIAL CONSIDERATIONS

The Introduction explained broadly the actual coverage available which is important to this study. It is necessary to know the insurance coverage provided before looking at the experience figures. They should now be more meaningful. Table 2 on the next page illustrates the cost of the program in question for a one year period. The Exhibit has been prepared on a basis similar to that used by a large insurance company to give a birds-eye view of the premium and experience figures for one year. The column entitled "Incurred Claims" includes certain reserves that will be discussed later. Company X paid $900,000 in premium for a year and received back in the form of benefits to its employees, additional reserves, and annual dividend, a total of $834,500. This means that the carrier kept $65,500 for the year. Also, there was an additional $62,000 kept to be added to the Reserve for Outstanding and Unreported Claims by the carrier. This makes a total of $127,500, which has not been returned to the policyholder for the year 1958.

This figure is the basis for asking the question of whether or not the company itself could have administered the program during the year for cost of less than $127,500. If so, then there is an excellent possibility that it should consider self-insurance. On the other hand, if such is not the case, then it would appear that insurance is the answer to its situation.

It is a basic concept of either the insured or self-insured program that assuming the same benefits are provided under either one,

TABLE 2

COMPANY X

CLAIM EXPERIENCE FOR TWELVE MONTHS
PERIOD ENDING DECEMBER 31, 1958

	Cash Premium	Incurred Claims*
Employee Coverages		
Accident & Health	$150,000	$140,000
Hospitalization	125,000	105,000
Surgical	60,000	50,000
Medical Expense	125,000	105,000
Total	$460,000	$400,000
Dependent Coverages		
Hospitalization	$175,000	$170,000
Surgical	65,000	55,000
Medical Expense	200,000	202,000
Total	$440,000	$427,000
Grand Total	$900,000	$827,000
Annual Dividend		$ 7,500
Balance Retained by Carrier		$ 65,500

*Includes additions to reserves for Outstanding and Unreported Claims of $62,000.

then it can be expected that claim experience will be the same in either program. This being the case, then this is a fixed cost, so to speak, so that it is assumed that this expense of $765,000 will continue. The maximum savings that then could take place for the year under the program in question would be $127,500, the total of the insurance company's retention and the addition for the year to the Reserve for Outstanding and Unreported Claims. To save the full amount under the self-insured program, the employer would have to administer the program cost free. Obviously this could not be done since there are certain basic expenses that must be incurred regardless of who handles the program. Items such as certificates, claims processing, booklets, must be prepared regardless of the kind of program adopted.

In studying the figures shown in Table 2 it should be emphasized that the figures shown there are not expected to be typical of the future years of the insurance program. This is true since if the benefit level had not been liberalized the previous year and the size of the insured group remained constant, it would be expected that the $62,000 expense to increase the Reserve for Outstanding and Unreported Claims would be eliminated. Any increase in this reserve would usually be made the year following a liberalization of benefits, but would then remain unchanged thereafter unless the size of the insured group or the benefit level increased. As a result with the program of Company X the normal annual retention in the future will approximate $50,000 according to estimates made by the carrier. Obviously over a period of years this latter figure is the one that should be kept in mind as the determinant of whether Company X can operate more economically than the carrier. In a typical

year in which the reserves were not being increased the $62,000 that formerly went into the reserves would be returned to Company X as an increase in the annual dividend. Over a period of years however, it would be expected that the inflationary increase in medical expenses will more than eat up the full amount that would have been used in the reserve.

Consideration will now be given to the many items that make up the $127,500 and how these expenses would be regarded under both the insured and self-insured programs.

BROKER'S COMMISSION

The broker's commission is one of the few expenses that might be listed as an absolute savings under the self-insured program. Commissions referred to are those paid annually to the insurance broker for services he renders to the policyholder. Payment is usually required by law so that for the insured program, commissions will be an outright expense. Most major stock insurance carriers pay commissions in accordance with what is referred to as a "decremental scale." Commissions are based on the amount of annual premium payment received by the insurance company from the policyholder. The commission scales are generally set up on a basis whereby a higher commission is paid for each "renewal" year. Such commissions may also be leveled off by taking the first year commissions and the commissions payable for nine renewal years and dividing by ten so that the same commission amount is paid in each year. In this study, it was determined that the original paid premium for one year would amount to $900,000. As a result, it is

estimated that the ten year level premium would amount to $6,000 per year for the insurance broker.[1] In the event that during the ten year period, the coverage might be liberalized which would, of course, mean a subsequent increase in premium, the commissions paid the first year thereafter and in subsequent years would increase above $6,000.

Outside the cost factor itself, what purpose does the broker serve? Some brokers are very familiar with the group insurance field and its trends, problems and ramifications. Men of this caliber are in a position to help the insured considerably in keeping abreast of what is going on in the group insurance field. On the other hand, there are brokers eager to do a good job who have perhaps only one or two group cases so that they do not have enough business in the group line to actually warrant their learning in any amount of detail just what is going on group-wise. In this type of situation, the broker might just as well be eliminated since he is of very little use. In such a situation, the insured learns to deal strictly or directly with the carrier since their men will be more familiar with the problems being faced and how they can be solved. Ideally, it might appear that the answer would be to retain a firm of brokers who have men that are experts in all forms of insurance to advise on problems and to actually bargain in the insurance market to obtain the best coverage at the lowest possible cost. Nevertheless in Company X, an individual broker is used and there is a question as to whether or not such expense can

---

[1]Martin E. Segal, Self-Insured Versus Insured Pension and Welfare Programs, a paper presented at the Ninth Annual Conference on Labor of New York University, June 6, 1956.

be justified. Elimination of this expense appears to be a direct savings to the self-insured program of about $6,000 yearly.

In 1958 the Company increased its coverage substantially so that its annual premium increased about 25 percent. This being the case it is entirely possible that at the end of 1958, the broker's commission might have been three or four times the $6,000 cited on the decremental basis. For 1958 this expense will be estimated at a cost of $18,000.

PREMIUM TAXES

Here is another area in the self-insurance field that may be referred to as an outright savings since it applies to insured plans only. This form of tax is levied by various states as a percentage of the annual premium paid by the insured. On the average it amounts to about 2%[2], but will vary depending on the particular state involved. Under the self-insured program, this tax is not applicable so that in Company X there would have been an outright savings of about $17,500 for 1958. It should be pointed out, however, that there is a possibility that this form of tax will eventually apply to the self-insured plans since there is talk of passing the necessary legislation on the state level. Major insurance companies are in favor of such legislation for obvious reasons.

ACQUISITION COSTS

This expense represents costs for advertising, salesmen, and service men, booklets, certificates and circulars, to be distributed among those covered by the plan. It is estimated that this expense

---

[2]John Liner, "Self-Insurance of Group Welfare Plans," Harvard Business Review, January-February, 1956, page 98.

can vary from 1% to 2% of premium[3] when looking at the insured plan so that for Company X this expense is estimated to be $12,000. It should be pointed out that this form of expense is expected to be higher for a year in which the benefit level of the plan has been changed since new certificates and booklets would be needed and there would be more service required in putting the new changes into effect. In a typical year much of the service normally gained in this area would not be needed.

Under the self-insured program much of this expense would be duplicated by the staff of Company X. From a cost point of view it is difficult to say whether this cost would be higher or lower than the charge by the carrier. This is true since the carrier usually applies a factor in arriving at this charge so that in reality the insured group might receive more or less service than for which they were actually charged. It will be assumed in this paper that Company X can perform these functions at the same cost as the carrier since it does have its own legal department and employees with considerable experience in the group insurance field. This might actually be a liberal estimate for this type of expense since Company X will have no expense for salesmen or advertising. Since the cost would be very difficult to determine, the benefit of the doubt will be given toward the insured plan.

ADDITION TO SURPLUS

This portion of the carrier's retention is estimated to amount to 2% of premiums paid and is the book profit for the insurance carrier. This expense would be saved under the self-insured plan. In the

---

[3] Ibid.

example, this savings would amount to about $18,000 per year.

SUMMARY OF RETENTION EXPENSE AND RESERVE

The following figures summarize the various expenses of the carrier which make up the retention as explained in the preceeding pages. These figures are very important in reaching the conclusions stated at the end of this paper and are based on the year 1958 only.

Broker's Commission	$18,000 *
Premium Taxes	17,500
Acquisition Costs	12,000
Addition To Surplus	18,000
Reserve For Outstanding And Unreported Claims	62,000
Total	$127,500

*10 year average $6,000 annually. Actual figure for 1958 estimated to be $18,000.

RESERVE FOR OUTSTANDING AND UNREPORTED CLAIMS

This reserve is required so that funds may be set aside by the insurance carrier to pay outstanding claims at the date the insurance contract might be cancelled by the insured. The carrier wishes to be certain that there are adequate funds available to take care of the claims that are presented by the employees of the insured after termination of the contract for the expenses incurred while the contract was still in force.

The amount to be kept in these reserves is determined by the insurance carrier and may vary from year to year depending on the overall experience of the carrier. For example, in the insurance

program being reviewed, we would expect to find reserves of the following size:

Weekly Health & Accident	18%
Hospital, surgical and medical expense	24%

Reserves of this nature operate on the wash principle, that is, new reserves are set up annually and the previous year's reserves are deducted.[4] This total reserve for Company X amounts to $210,000, which has been accumulated over a period of twenty-two years, although over twenty-five percent of the total reserve was set up in the last year following liberalization of the benefits. In connection with the Company's contribution to this reserve for 1958 it amounted to $62,000. This amount is unusually large as is normally the case at the end of the year in which major liberalization of the benefit schedule takes place. In what might be referred to as a typical year (a year in which there is no change in the level of benefits) it would be expected that there would practically be no increase in the size of the reserve or at the most the contribution would amount to less than $10,000.

In the event that the insured actually cancels the coverage, either to self-insure or to place the group insurance coverage with another carrier, it is possible that part of this reserve will be returned to the insured. The general policy of most major insurance companies is to return any of the unused reserve to the insured in the form of a dividend after cancellation of the contract, assuming the cancellation becomes effective on the anniversary date of the policy

---

[4]Interview with John E. Schenning, Service Manager Equitable Life Assurance Society, April, 1959.

year. In the event that the contract is cancelled at a date other than the anniversary date, then no funds are returned to the insured, regardless of the size of the reserve at the time of cancellation.[5]

Under the self-insured plan, what is the role of the Reserve for Outstanding and Unreported Claims? There is no doubt that in the event a self-insured program is terminated the company has a definite liability to pay any outstanding or unreported claims. As a result, the administrator of the self-insured plan should be aware of this specific liability. Generally, an actual cash Reserve is not established in the self-insured plan to offset this liability. In all probability, this is true since the actual cash itself would not be directly used unless the self-insured program is terminated and the company returns to an insured program. Also, apparently the companies using the self-insured approach are in a sound financial condition so that they feel this additional liability may be adequately met out of their current cash funds.

In the twelve companies surveyed by the writer, each was questioned as to whether or not it had established such a Reserve. Eight companies answered no, while the remaining four explained that the liability was covered by means of their contingency reserve.

It might be appropriate to footnote on a company's balance sheet this liability, which it is estimated would not exceed 25 percent of one year's claim experience. This approach would indicate an awareness by management of the liability involved, although an actual cash reserve would not be used.

---

[5] Ibid.

CONTINGENCY RESERVES

In the self-insurance question, this is one of the most controversial areas to be discussed. The Contingency Reserve is established to guarantee the ability of the carrier to meet any events which might develop beyond those specifically anticipated in normal reserves or premiums. The carrier takes the position that since this reserve is for the protection of all policyholders, it follows that each policyholder is called upon to contribute to it and that no particular policyholder has any portion of it allocated exclusively to their insurance contract.

Hence, assuming no abnormal loss during the year, this contribution by each of the groups provides funds for investment by the carrier, from which it will gain the benefit, since this form of reserve is the carrier's property.

In the self-insured plan some financial arrangement can be made to be certain that in the event of a year of excessive claims, it will have adequate reserves set up to meet such a contingency. Several approaches can be used. The first is to set up its own Contingency Reserve by annual contributions to such a fund. The amount to be contributed to such a reserve is questionable since there is no set formula that can be applied in arriving at such a figure. Generally speaking, there are any number of opinions available concerning the size of the reserve. These opinions may be found in the survey results in Appendix D. It would appear that such a reserve would or should approximate a certain percentage of annual claim experience and should be set up over a period of three to five years. Once such a reserve

has been established, there is no longer any need to increase its size unless there is a substantial increase in either claim experience or the number of employees insured. Normally a specific answer to the size of the reserve would be furnished by the actuarial firm to be employed from time to time to determine and project the future claim experience. It should be pointed out in connection with the insured plan that should the insured's experience be bad enough to warrant use of this reserve in paying claims in any particular year, it can be normally expected that the following year the premium of the insured will be increased so that it will not be necessary the following year to use the money from this fund. The self-insured company, by establishing its own Contingency Reserve, will be in a position to invest these funds itself so that the income from these funds can then be used to further increase the size of the fund. Naturally if the self-insured company uses part of its reserve, it will be faced with the necessity of making up that loss.

In the discussion of catastrophic or excessive losses, the insurance carrier will point out that its basic purpose is to provide a spreading of risk. Employee insurance losses will fluctuate substantially. At times, they may become quite large as epidemics arise or catastrophes occur. Important adverse general health trends may develop rather suddenly. Even a large corporation needs advance protection against major contingencies like these.[6] The most outstanding example in recent times was the Texas City disaster of a few years ago.

---

[6]Equitable Life Assurance Society, Group Competition Manual, Advantages of an Insured Plan over Self-Insured Plan. Release No. General - 5, June 21, 1956.

In that episode, the group insurance companies performed a particularly valuable service in absorbing tremendous insurance losses at a time when an affected corporation, even though large, suffered a general strain of some seriousness. One nationwide company with a plant employing about 575 people, although it was an innocent bystander, withstood tremendous damage and loss under the group program.[7]

There would appear to be little doubt that past contributions made by the insured company toward the carrier's Contingency Reserve will be lost completely by adopting self-insurance. This could then mean that in the event that the self-insured company should ever contemplate returning to an insured basis it would be necessary that the first year an extra 20% be contributed over and above regular costs, most of which will be earmarked for the Contingency Reserve.

Regarding catastrophes, it should be pointed out that in the event of a major explosion in one of the buildings of the insured, it would have no effect on the program being discussed in this paper. The reason for this is that an occupational accident would be covered under Workmen's Compensation Insurance, which is not a subject to be discussed in this paper.

Before leaving the Contingency Reserve subject, an example of just how such a reserve actually operates in the fully insured plan may be helpful. As previously pointed out, the reserve was originally setup as a safeguard against a possible catastrophe and each company insured by the carrier is required to contribute to it. For example; assume that Company X suffered a bad year as far as claim experience

---

[7] Ibid.

was concerned. With an annual premium of $900,000 they actually incurred claims totaling $1,000,000. Under the risk concept as it pertains to individual policies, there is a pooling of risk so that the few insureds that will actually suffer a loss, will be compensated completely or partially for this loss with no subsequent increase in premium. The idea behind this is that the insured is willing to pay a reasonable amount each year (the premium) for the peace of mind in knowing that should the possible loss occur, he will not suffer undue financial hardship.

In the group plan, however, insurance operates somewhat differently. First of all, the insurance carrier sets the premium for the year at a figure somewhat higher than the expected claims, reserves, and retention. This then allows it to pay normal claims with no problem, make a profit and return a dividend to the insured. However, should a poor year of claim experience strike so that it is necessary to use funds from the Contingency Reserve, the Company will have to increase its annual premium to replenish the Contingency Reserve Fund.[8] This is why group insurance can be called at best "one year insurance."[9]

STOP LOSS INSURANCE

In considering the question of the Contingency Reserve, there is a second avenue that can be followed and that is the adoption of Stop Loss Insurance. Although this approach has been used very little up to the

---

[8]John Liner, "Self-Insurance of Group Welfare Plans," Harvard Business Review, January-February, 1956, Page 96.

[9]Harold A. Faggen, a speech given before the National Conference of Health and Welfare Administrators, New York, New York, 1958.

present time, it is one that should be considered. There has been very little use of this coverage because of its lack of availability. The reason for this would appear obvious, since promotion of such plans would, of course, result in much lower premiums for the carrier. There are few major carriers who will promote self-insurance since they feel they are in a better position to insure the program than to have it placed on a self-insured basis.

Stop Loss Coverage is a form of insurance available to provide benefits after the satisfaction of a deductible, which does not apply on a per-loss or per-claim basis, but rather on a cumulative basis over a specified period of time (usually twelve months).[10] There would be an initial deductible available which would amount to X number of dollars in claims during the year; the projected claim experience. (For the purpose of this paper an annual deductible of $900,000 will be used.) In the event that the claims paid exceeded $900,000, anywhere from 75% to 100% of losses over the deductible amount would be paid by the insurance carrier to the insured, (depending on the policy and amount of protection purchased.) In the event that the claim experience for the particular year did not reach the $900,000 figure, it would be expected that the insurance carrier would return to the insured part of the premium in the form of a sizeable dividend for that particular year. This would be true in view of the good claim experience for the year.

---

[10] Palmer, David V., The Use of Excess Insurance, Its Impact on Risk Management, Page 7, a speech before the American Management Association, 1958.

Interestingly enough in the author's survey of twelve self-insured companies, none of them used any form of Stop Loss insurance coverage. This was apparently true since such coverage was not available in the early twentieth century when a number of the self-insured plans were adopted.

There are several advantages and disadvantages to the Stop Loss Coverage approach. First of all, the use of this type of insurance would eliminate the dollar trading concept, which is so evident in group plans today. For example, in a coverage such as Medical Expense where reimbursement is provided for visits by the employee or his family to the doctor's office, there is little doubt that after observing claim experience for a few years the insured company can determine very accurately in advance just what its claim experience will be for the approaching year. Also it can be reliably assumed that expenses of this nature will not reach unusual proportions. As a result, in view of the large number of small dollar claims that can be expected the insurance company is just giving back the employee part of the premium paid, knowing full well that the kind of expense involved will not be of any serious hardship to him. Supposedly, insurance programs are established to help the insured with large expenses that he is not in a position to handle himself, at least without serious financial hardship.

The second advantage of Stop Loss Coverage is that it would reduce the insurance expense of the company involved considerably over a period of time as contrasted with the fully insured program. In addition, of course, by adopting such coverage the insuring company

would eliminate completely the need for establishing Contingency Reserves. On the other hand, adoption of this avenue would defeat one of the prime purposes of the self-insured program and that is to eliminate insurance completely. Obviously to purchase such coverage is going to mean expense to Company X and profit for the insurance company involved.

As to the possible cost of such coverage, it is just about impossible to obtain such a figure on a health and welfare program. The only estimate available at this time is discussed by Kennard W. Becker, Mutual Life Insurance Company, Cleveland, that such an approach might reduce the insurance companies retention up to as much as 50% of its normal retention for insuring the full schedule of benefits under the health and welfare program. This percentage would hardly seem liberal enough in the case of Company X, since in most years the carrier would not be required to make any payment, through the use of the high deductible of say $900,000. Hence, only when total claims passed $900,000 annually would the carrier enter the picture.

The amount of premium would also depend on the amount of deductible. If the deductible was placed considerably above the estimated claim experience so that there was little probability that the claim experience for the year would ever surpass the deductible, there would, of course, be considerably less cost as far as insurance premium is concerned.

USE OF NO RESERVE

In considering protection against excessive claims loss there is a third approach for the self-insured company to consider. This approach

would be to establish no reserves at all. The idea behind this is that Company X normally maintains sizeable cash and investment accounts. Why then should any reserves at all be set up since these funds, or at least part of them, would be available in the event of excessive claim losses. Whether or not this particular avenue is the answer might depend on just what kind of legal agreement was set up to encompass the plan. For example consideration would be given to a trust, an employee benefit association, or the company maintaining complete direct control of the program and its administration. This question will be discussed in more detail in the legal considerations to self-insurance.

In reviewing the claim experience of Company X for the past 22 years, it has always been less than the premium paid. It should be pointed out, however, that in the survey conducted of self-insured companies, the question was asked as to whether or not a Contingency Reserve had been set up as a means of offsetting the expense of a bad claims year, and if so, what percent of annual claim experience was placed in the reserve. The answers varied from none to as high as 300%. The size depended to some extent on the size of the insured group, with the smaller groups having higher reserves. This might be expected since with the smaller group, there would be a greater possibility of poor experience as it would be much more difficult to predict the future claim experience. Just a few serious illnesses could change the experience markedly. Most of the companies surveyed had some form of Contingency Reserve.

There are several reasons why Company X might be justified in establishing no Contingency Reserve. The size of the insured group of 5,000 employees and 8,250 dependents is large enough so that the Law of Large Numbers would apply. According to this law, "the greater the number of exposures, the more nearly will the actual results obtained approach the probable result expected with an infinite number of exposures."[11] In attempting to learn at what point in size this law would apply to an insured group, several expert opinions have been offered. Roger Patrick, Actuary of Edwin Shields Hewitt and Associates, believes that approximately one thousand or more employees would be needed. D. S. Liggett, Assistant Vice President of Pacific Mutual Life Insurance Company feels that a minimum of one thousand insured employees is needed before self-insurance can be considered.

USE OF ACTUARIES

There are several areas in which the consulting actuary can render service and advice in connection with a self-insured program. He would ordinarily assist the employer in designing the plan and would make estimates of the cost program. Such estimates would be based on published experience, modified to take into account recent trends and significant variations in the program from the type of benefits for which published statistics are available.[12] The actuary

---

[11] Robert I. Mehr and Emerson Cammack, Principles of Insurance, Richard D. Irwin, Chicago, Illinois, 1954, P.16

[12] Interview with B. Russell Thomas, Wyatt and Company, March, 1959.

might also advise the employer to obtain Stop Loss Insurance, so as to limit liability in any year of operation of the plan. The actuary might also give advice as to the desirability of accumulating contingency reserves in a trust fund or on the company's books. The approach sometimes used is that the company charges itself the standard premium rate for the coverage and sets this amount aside in a separate fund out of which to pay claims. Any excess of premium over claims may be accumulated in the separate fund until it reaches 50% or 100% of one years premiums. There is no doubt that the self-insured plan requires the use of the actuary in determining the level of benefits, projected costs and future liability of the plan. Obviously service of this kind is not rendered free of charge. It is difficult to specify exactly the possible cost of such a service, however, an estimate given by a member of Wyatt and Company, nationwide actuarial firm is that normal actuarial service for a plan the size of the one in question would average about $4,000 a year. Here then is a definite expense that is evident in the self-insured plan, but is included in the regular service provided by the insurance carrier in the insured program. The insurance carrier is quick to point out that service of this kind is a normal part of their function so that they have experts available to perform such duties. Also since the cost of these experts is spread over a large number of insured groups, the cost per group is much smaller than would be true under the self-insured program. However, the actuarial firm has the advantage of serving a number of different clients each of whom may have been served by different

insurance carriers. Hence, the actuarial firm may be in a position to give advice based on much broader experience than the carrier. In the establishment of the self-insured program under consideration in this paper, however, there would be little use for an actuarial firm at the start. The reason for this is that since the schedule of benefits will remain unchanged if the insured program was to become self-insured, past experience would be a far better criterion of what could be expected of future costs than use of standard actuarial data to try to determine future costs or claim experience. This is true since actual past experience takes into consideration any local factors or trends that may affect the particular risk involved in the group plan in question. There might be unusual conditions in local medical practices, whereby the local hospital and doctors may charge more or less than would normally be expected in the particular state involved. In addition, the past experience figures can be very helpful in projecting the future costs of the self-insured program as the company grows in size and inflation continues to affect local medical costs.[13] If we can assume that medical expenses in the area will continue to increase at a rate of about 5% annually and that employment in the company will continue to grow at a rate of about 2% annually, then it should not be very difficult to predict what an average year of claim experience should amount to for Company X. Obviously these causes of rising claim experience cannot be eliminated whether the insured or self-insured approach is used.

---

[13] Ibid.

CHAPTER III

ADMINISTRATIVE CONSIDERATIONS

In this area the concern is with the actual mechanics of operating the insured program to the satisfaction of the employees, management, and the insurance carrier. Regardless of how sound the financial aspects of the self-insured program may be, if the program is not properly administered, the plan will certainly fail. This failure may be caused by lack of employee acceptance or ultimately from the financial problems that will arise from poor administration.

Here is an area in which the employer, if he is to consider the possibility of self-insurance, must be certain that he has available competent and experienced employees who will be in a position to see that the program is operated correctly.

Insurance companies point out, very justifiably, that the new forms of group insurance such as the comprehensive plan of hospitalization and surgery, or the base plan-major medical concept require extra care and specialized attention, with respect to claims administration. The lack of schedules of benefits and the absence of compartmentalization of charges (such as are used for other forms of health insurance) make it necessary to rely on concepts like "reasonable and necessary" in defining covered charges.

Furthermore, the benefit structure often makes it necessary to trace different illnesses and to relate medical expenditures over a considerable period of time. Medical interpretations, careful scrutiny of charges and special investigations are frequently necessary. The services of a trained claims staff with adequate professional consultants are essential.[1]

---

[1]Equitable Life Assurance Society, op. cit.

Further, the insurance industry contends that in a larger context, this new form of insurance depends in a substantial measure on the integrity and the ethics of the medical profession and others on whose charges the benefits directly rest. Lacking the usual limitations and schedules of benefits, this type of insurance is subject to overcharging, overprescribing and overutilization. The insurance companies are fully aware of these dangers and are attempting to achieve maximum cooperation. It is also necessary in specific claim situations to deal directly with individual practitioners, hospitals, medical grievance committees and others. In many instances, the employment by the insurer of professional people for this contact work is almost necessary to achieve satisfaction or support and cooperation. The insurance companies, individually and through cooperative arrangements are geared to handle these functions.

Such activities are most important in safeguarding the financial experience under Major Medical Expense Insurance and Comprehensive Insurance.[2]

There is no question that there are a number of dangers to the more liberal forms of group insurance such as the comprehensive plans and major medical coverage. However, there is no reason why the inherent dangers of these coverages involving overutilization cannot be combated by the managers of the self-insured plan as well as by the insurance carrier itself. In looking over the whole area of the administrative concepts of group insurance, there is no reason why the various problems that arise cannot be combated on a self-insured basis if the people responsible for the self-insured program have the necessary

---

[2] Ibid.

experience. Programs with local medical societies can often times be carried out more effectively by Company X itself than by the insurance carrier since the local medical group has more of a personal interest in the employees of Company X. Many physicians realize that from the point of view of community relations, an amiable relationship with the local self-insured program will mean more to them than to the relatively distant third party, the insurance company, who may be only acting in its capacity from a dollar point of view.

DETERMINATION OF BENEFITS

In the insurance program of Company X, there is a basic assumption being made that should the program become self-insured, there will be no increase in benefits. The reason for this is that the present benefit schedule is felt to be quite adequate to meet medical costs at the present time. The program is so geared that regardless of the employee's location in the United States, the plan will do a good job for him. In addition, the insured plan was revised and liberalized within the past two years so that there appears to be no immediate need to further liberalize it at this time. In addition, of course, by using the same benefit schedule, much more importance can be placed on the past claim experience of the insurance program as one of the indicators of future costs.

The administration of the self-insured program is concerned with the determination of who is entitled to what benefits, how much of the coverage has been used up, is the employee actively at work and insured, etc. Routine problems of this kind are not unusual to those administering either the insured or self-insured plan. Normally, in a

program of the size of Company X the employee group insurance section is either a specific part of the Industrial Relations or Personnel Department or a separate department under the Industrial Relations Manager or Personnel Manager. This group will have gained considerable experience in the reviewing and processing of insurance claims while the program was on an insured basis so that there would be very few problems which could not be handled on a self-insured basis.

In looking at the administrative considerations first, as a matter of background, a review should be made of the various insurance approaches in the claims administration procedure which will serve to compare with the self-insured approach. Also, this approach will show how the employees of Company X have been able to build up an extensive background in the employee insurance field.

Basically, there are two different administrative practices that are used in insured programs the size of the one being studied. These two approaches place the insured in the position of acting as the agent of the insurance company, while the latter serves to give advice when it is requested and to audit the payments made by the insured. The first approach and the simplest of the two is termed the "draft book system." This accounting system is used where the insured company involved is large enough so that it would not be economical for the insurance carrier to administer the major portion of the entire employee insurance program. As a result, the insured, using its own employees, accepts the responsibility for running the program. On this basis, the insurance company supplies the insurance

forms, certificates, booklets, and the advice of their claims people on the questionable claims that arise. The insured, however, actually certifies to the local hospital and doctors as to the employee coverage, receives the claim forms from the employee or local hospitals, reviews the claims, processes them and issues a draft payable either directly to the employee or to the doctor or hospital he designates. The drafts are supplied by the carrier and are written on the carrier's bank account. When the claims are processed, a copy of each claim is sent to the insurance company together with a copy of the draft. Since it is necessary to use drafts and send copies to the carrier, this requirement eliminates the possibility of writing the insurance checks on tabulating machines by the insured. As a result, the checks must be hand typed and then signed by machine. In an insurance program the size of the one in question, it would not be unusual to write 27,000 checks in a one year period. As might be expected when typing this number of checks, the question arises as to the wisdom of such a procedure. Eight full time women are required to process the claims for Company X using the draft book system. It would appear that the draft book system is designed for the insured groups in which the number of claims is too large to make it economical for each claim to be sent to the insurance company, but where there are not enough claims so that the number of checks written by typewriter becomes burdensome. Company X would not be able to use this system efficiently if it did not have its office and home call coverage which results in approximately 17,000 small claims yearly. The insured, by using the draft book system, receives certain direct savings from the carrier. This savings amounts to, in

Company X's situation, 2% of the premium paid for the year and 2% of the claim experience for the year. In Company X's situation, this would amount to $18,000 and $15,000 or a total of $33,000. It should be pointed out, however, that although this would be the reduction in the retention of the carrier, this amount will not necessarily be saved by Company X as it will have to assume part of these duties itself. Under the draft book system, the insured is in a position to obtain a great deal of experience in solving the problems typical to an employee insurance program, since the insured is on the firing line, so to speak, in dealing with the employee and the local medical people. Legally, however, the insured does not have any right to decline payment of an insurance claim without referring the claim to the carrier for review and their approval or disapproval. Since the insured is acting only as the agent of the carrier, he is not in a position to refuse payment of such claims, but must let the carrier decide the question involved. This is, in many cases, an advantage since the carrier then assumes the blame in the event that benefits must be denied to the employee and Company X is not held responsible in the employee's mind.

When on the draft book basis, Company X calculates the total premium payable to the carrier each month since the insured is the only one that has the basic information needed for the premium computation. Naturally, the basic per-employee cost is set by the employed carrier. The information supplied by Company X includes such facts as the number of employees becoming insured for the first time during the month, the number of employees leaving the employ of the company, hence

the insurance program, and the number of employees receiving salary increases causing them to change insurance classes under the weekly benefit coverage. In addition, the change in the dependent status of the insured employee is important and once begun is typical of the information available to the employer, hence, putting him in the role of calculating the monthly insurance premium. As would be expected, the monthly premium statement is sent to the home office of the carrier together with a check covering the amount of the premium as calculated. Company X used this system for ten years. In 1958, however, it was discarded in favor of a new administrative approach termed "self-claims administration" by the insurance carrier.

Self-claims administration came into being as a result of numerous requests by larger insured groups as a means by which they could practically self-administer the insurance program, but the carrier still underwrite the basic hazard and also provide a number of services. Under the self-claims administration technique Company X sets up its own bank account with its own money to pay employee insurance claims. Company X uses its own checks so that the insured employee may tend to believe the program is already self-insured. The insured company processes the insurance claims completely so that ordinarily the carrier does not see the claim itself until many months after it has been paid, if then. Once a year the carrier sends an auditor to audit a sampling of the claims paid by the insured so that the vast majority of claims will never be reviewed by the insurance carrier. At the end of the month, Company X will calculate the normal monthly premium that it would pay to the carrier. From this figure, however, it would deduct the total

amount of dollars paid out in claims during the month and pay only the difference to the carrier. In the event that the claim experience for the month was higher than the premium, the insurance carrier would actually issue a check to the insured group for the amount of the over-allowance. Under the self-claims administration approach, the basic services provided by the carrier are the auditing function, preparation of insurance booklets, certificates, complying with state requirements for the insured group and giving advice on questionable insurance claims received from employees. As a result, the insured group is concerned with issuing the checks as economically as possible which would normally be by tabulating equipment. At the present time, the self-claims administration approach is the only one that will allow the insured group to use tabulating equipment. The type of claims administration used may mean a sizeable reduction in retention by the carrier in view of the added duties that are assumed by Company X. In the program being reviewed the reduction in retention per year would amount to about $12,000 to $15,000.

Consideration should be given to the facts of just how the program would actually be administered. Company X, after gaining practical experience from using the draft book system and then graduating to the self-administered plan, will have gained a great deal of experience in the day to day claims problems that arise. Can this same group then assume the additional responsibilities that were formerly the function of the insurance company? This problem will be studied in more detail shortly. In connection with the area of determination of benefits, there appears to be no doubt that this portion of the insured program could be handled satisfactorily under the self-insured plan, since

basically these duties are already being assumed by the insured group under the self-administered plan. Determining who is eligible for coverage and the coverage itself to which they are entitled while confined is normally considered as a routine part of the employer's duties whether insured or self-insured.

ISSUANCE OF CERTIFICATES AND BOOKLETS

Here the problem arises as to the communication of the insurance program to the employees together with some form of written presentation to be given to them to comply with state insurance laws. It would be expected that policies or individual certificates would be presented to all insured employees explaining in detail the coverage to which they and their dependents are entitled. Here is a service area in which the insurance carrier performs a definite function for the insured group. In connection with the individual certificates there is a problem of expressing in written language the terms of the coverage. The carrier has prepared hundreds of such certificates for as many different companies so that it has specialists available whose sole task is to develop the wording to be used in the certificates. As a result, the insurance carrier has designated terminology that it prefers to use in describing the benefits available to the insured group. Through experience, the carrier has learned the legal meaning that is placed on much of its terminology through court decisions resulting from law suits. Also the carrier has in its employ, lawyers who specialize in this type of practice and are constantly reviewing court decisions concerning insurance suits and interpretations given to insurance policies and certificates by local courts. In addition, through the years, certain standard

phraseology has come to be so well defined that by using it there can be no legal question as to the meaning intended. Advice of this nature can be of invaluable assistance to the insured group especially when introducing new forms of coverage where there is no standard terminology available.

The company that is to consider the self-insurance question must decide just how this particular area will be handled. There would appear to be no doubt that the employees handling the insurance program itself are not in a position to prepare such material except on a rough basis since the area involves a number of legal problems. Hence it is necessary that the insured group use the services of its own legal department if they feel that they have a man qualified to develop the proper terminology. If such an individual is not available, then there are legal firms available who will be glad to render such a service for a fee. On the other hand, perhaps the use of an actuarial firm is the answer, since they normally will have lawyers on their staff or have access to such experts, so that the necessary answers can be obtained. It should be noted that an expense of this kind, in addition to being a small one, is not expected to reoccur each year. It is possible that if the level of benefits is not changed for a number of years, there will be no need for the further development of certificate terminology until such a change occurs. In addition, the previous terminology used in the insured contract can be of real assistance to the individual or group concerned with the preparation of new wording. Several of the twelve companies surveyed by the writer have never had an insured plan and have been

issuing their own certificates for at least thirty years.

There is little problem in considering the area of employee booklets. They have come to be considered, by the employee, as a normal part of the health and welfare program of today. Their purpose is to explain to the employees in a non-technical language the benefits to which they are entitled under the program. This being the case the booklet, as such, can be prepared by the group administering the program together with the advertising and legal departments of the company itself. The elimination of the insurance carrier may actually be an advantage to the employee group since it is possible, that the insurance carrier will become so concerned with the insurance terminology to be used that the final language will be difficult for the employee to comprehend and thus, defeat the basic purpose of the booklet. From a cost point of view, it might be expected that the self-insured group could not have the certificates and booklets printed as cheaply as the insurance carrier because of the carrier's volume business in this line. However, it is true that a company as large as Company X will have built up over the years its own printing sources so that it may be possible to have the work done at the same cost as the carrier. If not the cost difference should be negligible regardless of who is responsible for the printing.

CLAIMS ADMINISTRATION

This area will discuss the actual mechanics of claims review and processing in addition to the following two areas:

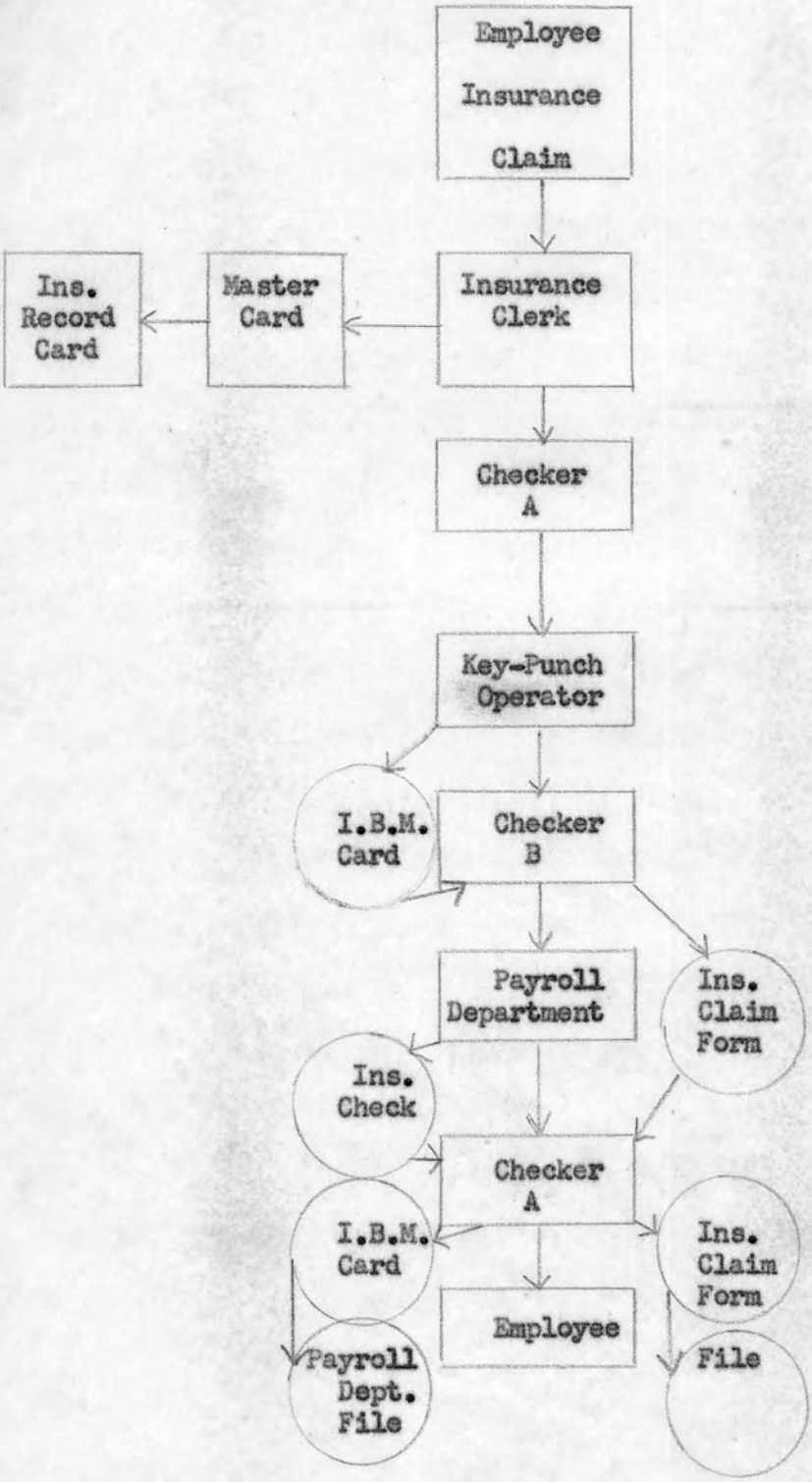
1. excessive charges by physicians
2. continuance of benefits after separation

Earlier, there was discussed briefly the basic administrative concepts under the insured plan, namely draft book and self-claims administration. In looking at the self-claims administration in more detail, it can be seen that under the self-insured plan a very similar procedure can be followed satisfactorily. By following through a typical claim filed, the mechanical technique usually required to properly process the insurance claim by Company X will be better understood. The claim is received by the Employee Insurance Department. (Please see Table 3 on next page). After an initial review of the claim is made by the clerk in the Insurance Department, a check is then made of the master insurance coverage file to determine if the employee involved is currently insured. Assuming that he is, the card is pulled and certain routine information is typed on the insurance claim form by the clerk such as the employee's identification number, department, effective date of coverage, etc. At that time a check is made to determine that the claim in question has not been previously paid so that it will not erroneously be paid again. Assuming that a hospital claim is being used as an example, the clerk must be careful to determine if the employee may have used part of his regular hospital benefit in a previous confinement so that the present claim might then be considered as a continuation of the earlier confinement. The clerk will compute the amount to which X employee is entitled. This is referred to as "billing" the claim. Figures are actually placed on the face of the claim form next to the charges itemized by the hospital as to how much can be paid under the company's insured plan. At this point, the claim is then passed along to another clerk who is referred

TABLE 3

EMPLOYEE INSURANCE CLAIM

PROCEDURE



to as the "checker", who is responsible for double checking the claim including the billing in its entirety. This double checking is necessary, since if an error was made in the original billing or the clerk misunderstood either the billing or the charges listed, there will be no later opportunity to detect the error by Company X. Assuming that the checker finds nothing wrong with the claim, it is then passed along to the "key-puncher" who is responsible for punching up a tabulating card indicating a number of pertinent facts concerning the particular claim in process. From this punched card, will be issued the actual insurance check eventually. Once the card is punched, it is then passed to a second clerk for verification to be certain that it is punched correctly. At this point, the card is passed along to another department which has a tabulating machine which will actually write the check and a check signing machine to sign the check. In the meantime, the original claim form has been returned to the checker, not to the original clerk who was processing the claim. The next morning the completed check is returned to the keypunch clerk who will make the necessary reconciliation for the day to be certain that the total dollars written for the day via checks tally out with a tabulated listing run at the same time as the insurance checks. Once the key-punch clerk is certain that the figures balance, the check is then returned to the clerk, who has been holding the claim form while the check was being made out. The check may then be mailed directly to the employee or to the hospital. In a normal day, there would be approximately 100 to 125 checks written in this manner. The usual time to process a claim is three to four days

if all of the required information has been supplied by the employee. Once the check is mailed, with the check number, amount and the date entered on the claim form, the form is filed away in the employee's folder. At the time the hospital claim is being processed, a card is typed up by the insurance clerk who originally processed the claim. This card indicates a number of pertinent facts concerning the particular claim and is filed in a card file kept near the insurance clerks. Whenever a hospital claim is processed for the same employee, this file is consulted to be certain that the claim has not been previously paid. It is possible on occasion for the employee or the hospital to file, through oversight, the same claim more than once so that precautions must be taken to eliminate the possibility of duplicate payments. It is interesting to observe that nowhere in the entire claims procedure has the carrier served any purpose. In all fairness it should be pointed out that using a conservative estimate, 97% of all the claims can be processed in this manner. In the remaining 3% of claims, however, a number of various problems may arise that cannot necessarily be decided by the insurance group handling the claims administration for Company X. As a result, it will be necessary to either contact the carrier or refer the claim itself to the carrier for their decision. All claims raising a question of coverage that cannot be answered by Company X will be referred to the carrier for a decision.

In reviewing the procedure under the self-claims administration plan, it should be immediately apparent that there is no reason why the same procedure cannot be adopted by the employer for his self-insured plan. This is one of the possible dangers to the carrier in

allowing the insured group to administer the plan, in that the group begins to see just how efficiently it can handle the program and the continually lessening role that is played by the carrier. This will soon raise the question in the mind of the insured group as to whether or not it could handle the program just as well as the carrier.

The procedure outlined above was developed by Company X, not by the carrier, which might be considered as another evidence of the ability of the employer to cope with the administrative problems of the self-insured plan. Under the insured program, since Company X maintains the only month to month record of the actual claim experience, it is necessary for him to pass along these figures to the carrier. First of all, these figures are used to substantiate the dollars spent in paying claims for the month and also so that experience studies can be made by the carrier. Obviously, such experience figures should be maintained under the self-insured program so that the employer could either perform his own experience studies to determine trends and project future costs, or hire an actuarial firm to perform this service, as discussed earlier.

EXCESSIVE MEDICAL FEES

Excessive medical fees constitute one of the most important problems of the day in the group insurance field. They may be defined as any charge rendered by a physician, surgeon, or registered nurse which can be considered as more than normal and reasonable for the particular service rendered. An example would be a surgical charge of $750 for setting a broken arm for a plant employee. First of all,

someone must determine that the charge is actually excessive. Under the insured self-administered plan now being used by Company X the carrier will supply the insured company with a schedule of surgical allowances, which in a program with the benefits of the level being discussed would include maximum allowances up to $400. This means that the most difficult surgical procedures would be worth an insurance benefit of $400, with less serious procedures proportionately less. With this allowance schedule as a guide, if the charge shown on the claim form is more than $50 above the schedule allowance the charge is then considered to be excessive. The area of the country will usually make a difference as to what is considered as a normal and reasonable charge. For example, a $400 charge for a Caesarian Section would not be considered excessive for a claim received from an employee in the state of California, while it would be for an employee living in Decatur, Georgia.

Although a charge may originally be thought to be excessive, only careful investigation will determine if such is the case. The reason for this is that the normal claim form does not allow the surgeon or physician to explain in detail any complications he may have encountered that might warrant a charge larger than normal. In the event of a possible excessive charge under an insured plan, the claim would be referred to the claims office of the insurance carrier for review. If they agreed that the charge appeared to be excessive, in all probability, they would send a claims man to talk to the surgeon. In the event the questionable claim was from an employee residing out of the state the insurance carrier would refer the claim to a member

of its nearest claims office so that a representative of the carrier would talk to the surgeon personally. This type of problem would normally arise in less than 1% of the claims received.

Even in such a small number of claims, in most cases the surgeon would merely explain the unusual nature of the surgical procedure together with the complications that were not originally expected. The investigator would then pass along this information to the claims people in the home office of the carrier for their review and approval. If approved, the insured group would then be authorized to go ahead and pay the claim. Here is one of the real services that can be performed by the insurance carrier. This is especially true because of their experience in the claims field and because most of the larger insurance companies have nationwide claims offices so that the claim can be investigated regardless of where it originates in the United States. Under the insured plan consider the approach that would be used if the surgeon could not substantiate the large charge that he had made to the insured patient. The insurance carrier would request that he reduce his charge to a more reasonable figure. In the event that he refused to do this it is possible that the insurance carrier, through its own medical people, would set its own dollar figure as to what the operation was actually worth and then authorize Company X to issue a check for that amount or a percentage of that figure depending on just what the surgical coverage called for in the particular coverage in question. As a result, the employee would then have to arrange to talk personally with the physician or surgeon as to the payment of the balance of the bill. Additional

pressure would be exerted directly by the employee on the surgeon to reduce his charge when he learns that it is considered excessive.

There is another recourse that is open to the employee. He may make a claim before the local medical society grievance committee citing the facts and contending that the charge was too large. Membership of this committee is made up entirely of doctors, who will then review in detail the surgery performed together with the charge rendered to determine if the charge was a fair one. If they felt that it was not, they would then request the surgeon involved to lower it. Considering the ethics of the medical profession, this request would undoubtedly be followed by the surgeon.

Now look at the problem of excessive charges as it would be handled under the self-insured plan. In Company X, the employees located in distribution branches and sales territories would be spread out all over the United States. As a result it is not conceivable that the employer would be able to personally approach the surgeon involved in some excessive charge claims because of the distance from the employer's home office. In such a case the employer must resort to written inquiries concerning the details of the charge in question. This approach is not as satisfactory as the face to face approach.

Assuming, however, that the surgeon was local so that a member of Company X could contact him in person, Company X is then facing the possibility of losing community goodwill by directly approaching the surgeon. In situations of this kind it appears that the insurance carrier will play a necessary role.

It is interesting to review the answers given to the writer's survey of self-insured companies in connection with the excessive medical fees problem. Several of the respondents answered that they did not have this problem. However, the majority of companies surveyed showed that they had set up some formal means of reviewing claims to determine whether or not the charges submitted were in line or not. In the event the charges were questionable then, after discussing the charge with local medical authorities, the physician involved would be contacted by the employer so that the fee could be discussed.

It should be pointed out that the excessive fee problem will exist in both insured and self-insured plans having a Major Medical or Comprehensive type coverage which pays the claim based on a percentage of the charge rendered. The other approach in paying medical fees is the use of a flat allowance based on the type of surgery or medical care involved, regardless of the fee (except that the allowance can not be greater than the charge.) This approach eliminates the problem for the employer since his allowance will be a flat amount so the individual insured employee will then have to determine how the balance of the bill will be paid if the fee was excessive. There is a major disadvantage of this type of coverage, in that it does not take into consideration the higher cost areas in some parts of the United States which would result in higher medical fees.

In concluding this area, it should be pointed out that the number of claims in which there will be a problem of excessive charges will be very few. Hence this area should not be a stumbling block to the possibility of adopting self-insurance. In all fairness, however, here is

an area where the insurance carrier, because of its nationwide claims investigation service, can render a service that cannot, in some situations, be duplicated by the employer. This would be true to some extent with Company X since its employees are located throughout the United States and Canada.

CONTINUANCE OF COVERAGE AFTER SEPARATION

In this area the concern is with the continuation of coverage for employees separating from the company through resignation or retirement. The first question that must be faced is the Company's responsibility toward former employees. Generally there is a feeling by many companies that their primary obligation and interest is toward those employees who are still with them and they are not inclined to do anything for those who have left via the resignation route. In addition, insurance carriers are not very enthused about the converting of hospital and other coverages from a group basis to an individual basis. This is true since, to some extent, the poorer risk is the one who will take the coverage on an individual basis and the administrative cost of handling the conversion by the insurance company is quite high. In many cases, it is not economically possible for them to offer the same coverage to the separated employee that was available on a group basis. This is true since the benefits were so liberal, that on an individual basis, the premium cost to the person would be prohibitive. Perhaps the outstanding exception to the non-continuation of benefits to the separating employee is the Blue Cross-Blue Shield approach in which it is quite common under most of their plans for conversion privileges to be offered. However, the benefits often times are reduced to the person taking the coverage on

an individual basis. Keep in mind also, that Blue Cross was originally established by the hospitals themselves as a non-profit organization, hence, they have much more of an inducement to offer the conversion privilege. It is interesting to note that it would be just about an administrative and financial impossibility for a self-insured plan to offer coverage to employees leaving the company's employ via resignation. This would be true because of the sizable increase in the number of those insured under the plan, which would mean an increased company contribution to the self-insured program. This fact is born out by the writer's recent survey which showed clearly that none of the 12 companies using self-insurance allowed resigning employees to continue coverage once they had left the company.

On the other hand in looking at those employees that leave for retirement the story is just the opposite. For 66% of the companies answering the survey, coverage is continued for their retiring employees. This is typical of the national trend being followed by both insured and self-insured groups. The reason is that there has been a sudden realization by the insurance industry that the over 65 group can be insured safely and that if this is not done, the United States Government will do it by liberalizing the existing Social Security Law. The last two sessions of Congress have seen the introduction of the Forand Bill which would incorporate into the existing Social Security Act, hospital coverage of 60 days per year with all expenses paid for those people receiving social security benefits who might become ill. It is entirely possible that it will be passed in the present session of

Congress since this is an election year. As might be expected, strong lobbies are opposing it on the grounds that it is unnecessary. Although the American Medical Association is opposed to the bill, it may pass eventually because of the unavailability of adequate coverage for the older person at a reasonable rate. The bill has succeeded in spurring the insurance industry into providing better coverage for this age group, however much needs to be done yet in this area.

There is little problem administratively in providing the coverage to the retired group for the self-insured company. It should be pointed out that whether the plan is insured or self-insured the claim experience for this group will usually be considerably higher than that of the active employee group.

It is usual, however, in view of the expected higher claim experience to set a lower lifetime maximum of this group as compared to those available for active employees. In addition, when the lifetime limit which is usually set somewhere between $1,000 to $2,500 is used up, there is no way to reinstate it, hence the retiree will be without coverage for the rest of his life under either the insured or self-insured plan.

INTERNAL CONTROL

In this area the concern is with the auditing procedures used in verifying payment of claims. First, to insure that the employees processing claims are using the proper benefit schedule so that the proper amounts are being paid on the claims being processed. In addition it should be determined that there can be no dishonesty or questionable practices on the part of the employees responsible for processing the claims.

Under the insured plan this is accomplished by traveling auditors who will take a random sampling of claims for review. Under the self-administration insured plan the auditors might take a series of cancelled checks which were issued in payment of insurance claims. With these checks, after reviewing the face of the checks and the endorsement, they will refer to the original claim form to review the claim and the manner in which the benefits were calculated. The sampling of claims will allow a review of approximately 10% of all claims processed in one year, which is adequate according to the carrier. This sampling of claims assumes that the results are favorable to the insured company being audited. In addition the insurance company's auditors will determine whether Company X is paying the appropriate total premium to the insurance carrier by verifying the figures used in calculating the premium statement by the employer for one particular month in the year. In addition, they will review the acceptance records to be certain that the employer actually possesses a signed authorization by the individual insured so that deductions may be made from his pay check for payment of his insurance premium. A report is then made to the management of Company X and the carrier as to the findings of the auditors and any recommendations that may be of assistance in providing additional safeguards in the processing of claims.

It would seem that under the insured program there might be some advantage to their audit procedure because of the limitless experience in this area. They are in a position to easily determine the current position of the reliability of the claims procedure of Company X. Naturally the carrier will render a charge for the auditing service

that takes place. The amount of this charge is not itemized; however, it is included in the retention figure of the insurance company. It has been estimated that for a program the size under consideration, a semi-annual audit would cost about $1,800 and require about four weeks of time. Once the self-administered insured program had been in effect for over one year, the number of audits would be reduced to one a year. If self-insured, auditing can be performed either by an internal audit group of the company, or by an outside public accounting firm or both. Since the self-insured program would be entirely company managed it might seem wise, from an employee relations point of view, to have an outside accounting firm perform audit services. It is estimated that an acceptable audit similar to that performed by the insurance company under the insured program would cost about $1,000 per year for one audit annually. A second advantage to an outside auditing firm would be the elimination of possible collusion between a member of the claims processing group of Company X and a member of the internal audit group.

In the twelve companies surveyed by the writer, about 50% of them used the services of an outside auditor while the other 50% used their own internal auditing group.

CONTRIBUTORY FEATURE

Of primary importance in the consideration of the self-insured program is the policy to be followed by the company in regard to employee contributions. Will the employees contribute towards the cost of the plan? This will affect, to some extent, management's thinking as to whether or not to change to a self-insured program. Generally, management may not take such direct action towards changing the means of

administering benefit plans one way or another if the plan is contributory. This is true since the employee is paying part of the cost and, therefore, the employee group will be more interested in the benefit plan. The employee's view will depend somewhat on whether or not they are unionized. If they are, there is a possibility that the union might be opposed to such a change unless certain assurances could be made that the administration of the self-insured plan will definitely be on an impartial basis. On the other hand, if the employee group is not unionized, it is possible that it will be easier to change to the self-insured approach since it might be expected that the employees would be more pro-company than a unionized group. Also the company might want to consider the possibility of reducing or eliminating the employees contribution. In the event that the insured or self-insured plan was non-contributory, management might then be more inclined to adopt the self-insured approach since it would have a tendency to exercise a more direct control over the complete insurance program.

Whether or not the plan can be put on a non-contributory basis will depend on a number of circumstances. First of all, if the employee group is organized, it may be management's feeling that the plan should be left on a contributory basis until the request (or demand) for the elimination of employee contributions is actually raised in negotiations. At that time it might be allowed as a concession, however, if it is just given voluntarily at this time, then the bargaining group for the union would be looking for other concessions during the next negotiations.

In the particular insurance plan of Company X the employee group is non-union so that management will consider immediately just what

action they may wish to take with regard to contributions. First and foremost will be the question of whether or not the company can afford this additional cost of $260,000 annually. The answer would appear to be "no". This can be justified by the benefit level of the plan, since it is more generous than many union plans. Another reason for not adopting a non-contributory approach at this time is that by adopting self-insurance the company may find it necessary to establish certain reserves during the first several years of the plan. Once these reserves are set up then perhaps the company will be in a better financial position to allow the non-contributory feature. Also, the self-insured plan being so new, management may want to actually allow the plan to operate for several years before taking such a big cost step from which there is practically no retreat once it is taken. The amount of employee agitation will, of course, have a direct bearing on the non-contributory factor as will the contributory feature of the benefit plans of the local area companies with whom Company X competes in the labor market. If most of them are paying similar wages, and have non-contributory plans, this might affect the future thinking as to when Company X would like to make the plan non-contributory.

EMPLOYEE ACCEPTANCE

This area is tied in somewhat with the question of level of contributions. This is true since the employee group's attitude toward the management of the company will determine to a large extent whether or not self-insurance may be seriously considered.

Major insurance carriers are quick to point out most industrial employers prefer not to be in the insurance business. Their regular

businesses are sufficiently complicated and relationships with employees treacherous enough these days without adding the problems of an insurer.[3]

In addition the insurance industry will also emphasize that the third party feature of the insurance contract had or has notable psychological advantages in the matter of claims administration. The various forms of Accident and Health Insurance tend to raise questions because the benefits are more intricate to compute and, lacking schedules of payments or limits, more questions arise. It is to the advantage of the employer -- and employees are usually better satisfied -- to have an experienced, professional claims service administering benefits.

In reviewing the foregoing statements it should be pointed out that under the self-claim administration approach for an insured plan the insurance carrier is practically out of the program except in name only.

Certainly there is one big advantage in this area and that is that on questionable claims which must be declined for payment, with the carrier underwriting the program it becomes the "goat" so to speak. Hence, any malice born by the employee will usually be directed toward the carrier. On the other hand, if the employee is particularly happy with the amount of benefits received, it is possible that he will feel that the insurance carrier is primarily to be thanked rather than the employer. Perhaps this outlook comes from the little information that is generally made available to the employee group. Information to the effect that usually the employer with the insured plan can have any kind

---

[3]Equitable Life Assurance op. cit.

of coverage he wants, as long as he pays the premium. If he wants to have an insurance allowance in his program of $1,000 for each newborn baby of any employee, this can be written into the group contract so long as the employer can pay the premium. It's the old story of "you get what you pay for" when considering group insurance benefits.

In the survey conducted among self-insured companies, the question was asked as to how employees accepted the program. Ten of the twelve companies responding felt that employee acceptance was very good, while the other two rated acceptance as good. Keep in mind, however, that the survey questionnaire was answered by those individuals who were responsible for administering the program so that there is a high probability that there was no actual measurement of employee attitude toward the program and that the answers given were quite biased. Nevertheless, the fact that self-insured programs are in existence is an indication that solutions have been found to the problem of employee attitude. Again, much will depend on the employees normal attitude toward the employer. If, generally, the employees have a great deal of faith in their management and the decisions made by them, certainly it can be expected that by adopting self-insurance there will be no impairment of this relationship. It should be pointed out, however, that there is a basic danger to the self-insured program that must be met and that is the possibility of favoritism. Under the self-insured program, it is entirely possible that undue pressure may be brought to bear in a particular situation by an executive member of a management. Obviously, if this occurs, there must be a clear understanding as to the policy to be followed. There can be no favoritism shown in the self-insured program

or the program will eventually be discarded because of the employee reaction. Here again is an area in which the insured program has a basic advantage over the self-insured program. This is true since the insurance company as the third party will be consulted on any questionable claim and will render an impartial decision, to which the employer must abide. Once again, however, it should be pointed out that this problem should not be a major stumbling block to the basic question of insurance versus self-insurance. It can be solved if the management of the company will make a conscientious effort to follow the coverage as stated in the employee certificate and in the self-insured master policy. Questionable interpretations should be referred to higher management. Once a precedent setting decision is made, the administrator of the insurance program should be certain that in similar situations the same approach is used for everyone.

ROLE OF THE EMPLOYEE BENEFIT CONSULTANT

An employee benefit consulting firm may be retained by the employer to serve a number of functions. First of all, if management has decided to adopt the self-insurance program ultimately the question will arise as to the adequacy of the benefits under the program as compared with insured programs in the immediate area and in similar industries. The consultant is expected to be well versed on present benefit levels and also with trends in the group insurance field. He can advise the employer of possible benefit shortcomings in his particular program.[4]

Normally the consultant, in being retained by the company to review

---

[4]Interview with Mr. Gayle Mattingly, Edwin Shields Hewitt and Assoc., Libertyville, Ill., Consultants. September, 1959

the group insurance program, will determine first of all from management the company's philosophy towards its employees. Management will be asked to determine its philosophy towards its employee benefit plans so that the consultant and the company can then determine if the plan is succeeding in achieving the desired end.

Some concern should be given to the problem of rising medical costs, hence rising claim experience under the plan of Company X. However, obviously whether the plan is insured or self-insured this problem will arise. There will be a difference however, in how the problem is met, depending on the kind of plan involved. If the plan is self-insured, it will be the duty of the consultant or actuary to determine for the company involved just where the over-all cost of the program is headed dollarwise and how soon it will get there. As a result, the actuary has a duty to his client to explain to him the different avenues that may be used to either lessen or eliminate the effects of inflation on the claim experience of the program. Such might be accomplished by the use of a deductible plan similar to that found in the automobile insurance. On the other hand, if the program is insured, it is the carrier's duty to point out this type of situation and advise just what can be done. It should be kept in mind, however, that the representative of the carrier is in business basically to sell insurance so that there may be a tendency for the carrier to be hesitant in suggesting a direct way of reducing the benefit level to keep the costs in line. The consultant firm can only stay in business by keeping abreast of trends and the latest development in the insurance field.

In addition, these men have the opportunity to contact any number of different insurance companies over a period of time so that they will be up to date with the latest approaches. This is not necessarily true of the representative of the insurance company who will be in the position of advising a large size corporation as to its insurance practices after perhaps only limited experience in the insurance business himself.

It is estimated for a program the size of the one in question, involving about 5,000 insured employees and their dependents, that to retain an actuarial firm or a consulting firm on an annual basis would amount to about $7,000 to $10,000 yearly.[5] It should be emphasized, however, that the service rendered by such a firm may not be duplicated by the insurance carrier in connection with an insured plan since they may not have adequately versed personnel to routinely perform this function for their insured clients.

In the survey of self-insured companies conducted by the writer, the use of actuaries was virtually unheard of. This could be true in view of the age of the plans. Since they had been in effect for well over thirty years, the companies, in all probability, felt that they could project their future costs satisfactorily. This might be especially true since at the time many of those companies established their own self-insured programs, little was known of the actuarial science.

---

[5]Interview with Mr. B. Russell Thomas, Actuary, Wyatt and Company.

CHAPTER IV

LEGAL CONSIDERATIONS

Next consideration should be given to both the legal and the tax status of the self-insured plan. Certainly if there are to be major tax or legal problems to be faced then justification may be given to the continuance of the insured program.

Basically there has been a major advantage to the insured program through the years. Since the birth and growth of the health and welfare program in industry has been primarily in the insured field, federal and state laws have been much more clear cut in their regard to insured plans. This is especially true in states such as California, New York, Rhode Island, and New Jersey which have state laws that govern to some extent the benefits to be paid in the form of weekly Accident and Sickness benefits.

The extreme example of state supervision of health and welfare benefits to any extent is in California which has established a requirement under the California Unemployment Compensation Disability Act that weekly benefits up to a maximum of $65.00 for a period of 26 weeks will be paid to employees working in the state. In addition, basic hospitalization benefits up to $12.00 per day for a period of up to 20 days per disability must be provided by the employer. Requirements such as this may be met under the self-insured program since self-insurance is recognized in California.[1] However there may be a trend beginning toward state regulation of these benefits which could complicate the self-insured approach for Company X in future years.

---

[1] Ibid

It should be pointed out that special state requirements may be better handled by the insured plan. This is true since the carrier will have a number of companies with insured employees in the particular state involved so that it will have to learn the intricacies of the various laws peculiar to that state. It can then better advise its insured patrons than might be true of the lone self-insured company who has to deal with the many ramifications of the laws involved. Once again the caliber of the people available to administer the self-insured plan will be of vital importance in determining how easily this kind of problem can be met.

It should be pointed out that there are several states that do not offer the protection of their own state insurance departments to employees insured under a self-insured program. This may sound like a serious shortcoming but is it? The main function of the state agency is checking into the financial soundness and honesty of insurance companies, and making sure that a group is getting the benefit of prevailing rates.[2]

In looking at the situation of Company X, since they have employees residing in every one of the forty-eight states it will be necessary that the plan if self-insured, conform with the requirements of those states who have passed laws to regulate self-insured plans. This is an area in which the employee benefit consultant firm could be of great help in determining the exact procedure in order to comply with the requirements of the different states. A firm of this kind has its own

---

[2]John Liner, Self-Insurance of Group Welfare Plans, Harvard Business Review, January-February 1956.

legal staff who would be well versed in this area. Obviously, as discussed earlier, this kind of service will be rendered on a fee basis by the consultant. On the other hand, this kind of service is usually a one time cost as once the self-insured plan has been properly filed, the legal staff of Company X should be in a position to file any amendments or changes in the program as may be required in future years.

As a second legal consideration the plan, whether insured or self-insured, must be filed under the Welfare and Pension Plans Disclosure Act passed in 1958 by Congress. Basically the Act requires that all health and welfare plans, pension, stock bonus, profit sharing, etc., must be filed with the Bureau of Labor Standards, United States Department of Labor giving the various provisions and pertinent information concerning the text of the various employee group plans. In addition, financial statements must be filed annually with the Department describing in detail the dollar receipts and disbursements of each plan.

In the event of an insured plan, the insurance carrier serving Company X may be of help to the company in filing. However, Company X itself must learn the intricate details of the Act so it can determine which of its various plans must be so registered. As a result the legal and accounting department of the company involved will be in a position to comply with this Act as well as the carrier who is interested in only the insurance aspect of the registration. Under the Act whether the plan is insured or self-insured it must be registered.

LEGAL STATUS OF PROGRAM

Of real importance in the self-insurance question is the legal agreement to be used for the over all administration of the program. In addition Company X, of course, must be certain that its dollar contribution to the program is deductible for Federal tax purposes. This can be accomplished by having the plan approved by the U. S. Treasury Department.

In determining the agreement to be used a preliminary question must be answered. First of all will the plan, if self-insured, be contributory for employees? If employee contributions will be involved, Company X may want to take extra precautions in safeguarding their funds.

It has already been established as far as Company X is concerned that in all probability the plan, if self-insured, would remain on a contributory basis for the employees. This was true in view of the very generous nature of the benefits and the sizable portion of the cost of the program that is presently paid through the employee contributions.

Since employee contributions would be involved this would appear to be good reason for the establishment of an employee Trust. A Trust is normally used as a means of protecting a large amount of money which is available for an indefinite period and which is usually to be invested in common stocks and bonds for both appreciation and interest. The Trust would be approved by the U. S. Treasury Department and would be administered by a group of Trustees who may or may not be employees of the company. In addition it would help insure the tax

deductibility of the company's contribution to the self-insured plan. Of prime importance, however, the Trust would be a separate legal entity from the corporation itself.

Nevertheless, since there would be employee contributions accounting for approximately 25% of the premium or cost of the self-insured program, it is recommended that the Trust device be adopted. The Trust would tend to reassure the employees regarding the security of their money that was paid into the program and would also tend to promote the idea of the financial stability of the fund. This is especially true since Company X would be required to file certain annual reports with the U. S. Treasury Department. The Trust would be administered by a group of Trustees who would be concerned with the income and expense of the Trust Fund. Through the use of Trustees there might be less possibility of the self-insured program being subjected to pressure from the upper management of Company X. Since there would be a possibility of no reserves, in view of the size and comparative safety of the risk, the company contribution to the Trust would be made to equal the expected claim experience for the month.

Eventually if the plan should ever reach a non-contributory status, as far as employees are concerned, then it would be possible to eliminate the Trust completely and simply use a company account from which to make the payments. At that time the employees would be more receptive to this approach since none of their money would be involved.

Another basic legal area in the self-insurance question is whether or not the self-insured plan is subject to regulation under

state insurance laws. This question is appropriate since many state insurance departments provide that any person who engages in the "insurance business" or who "transacts business" shall be licensed and regulated as an insurance company. According to Harold von B. Cleveland, Associate Counsel, John Hancock Mutual Life Insurance Company, no court has yet decided this question with respect to any form of self-insured plans.

Attorney Generals have ruled on the question in the following states: Florida, New York, and Wisconsin. The consensus of opinion of the states was that if the plans were jointly administered by union and management, they would not be subject to regulation. However, no information was given as to the status of the plan if it was solely administered by the company.

DEVELOPING CERTIFICATES AND THE MASTER POLICY

In the health and welfare program whether insured or self-insured it is necessary to develop an official master policy which outlines the basic benefits to be paid, defines who is eligible for these benefits, and how the program terminates for those participating. The master policy does not attempt to include all details concerning the hundreds of minor rulings that are termed administrative rulings. Rulings of this nature will be of great help to those administering the plan to be certain that they are consistent in the decisions made and also to eliminate the possibility of any form of discrimination. The pattern of the wording in the master policy can be very similar to that used in the insured master policy by the company. It should be developed by the Legal Department of Company X. Here is another expense which would be

non-recurring since once the policy is developed there is little need to change it until the benefit or eligibility provisions might be changed. A copy of this master contract will be filed with the two State Insurance departments that require it. They are Illinois and New York.

The insurance certificates to be developed are the formal documents given to the insured employees as evidence that they do have certain protection against certain specific hazards. Although certificates of this kind are rarely read by the employee group because of the difficulty in understanding the legal language, they are the basis on which the employee may protest any unfairness that he feels he may have received under the program. In addition the certificates are legal contracts between the company and the employee so that he can use the wording in it as the basis for a lawsuit in the event he may not be treated fairly. Should there be any problems in developing the wording in the certificate, there are law firms available that have experience in this kind of work and will be glad to prepare the proper wording for a fee.

In connection with this certificate, it is interesting to note that it is treasured by the employee group although they may not understand its wording to any extent.

LAWSUIT PROBLEMS

This area is concerned with the questionable claim that is turned down for payment either because of ineligibility or some other factor which prevents the claim from being paid. Assuming that the size of

the claim was large enough there would be a good chance that the distraught employee or former employee might seek legal assistance in obtaining payment. This would be especially true if he did not agree with the decision of those administering the program. Under the insured program the insurance carrier would step in as a buffer between the employee and the company. As a result the employee would find it necessary to bring suit against the carrier who would then be in the position of defending himself against the suit. Hence Company X would be kept out of the matter and from a community relations point of view might find this to their advantage. Here is one of the areas in which there is no substitute in the self-insured program. This is true since there is no intermediary so that it is necessary that Company X defend itself against the suit. As a result it is possible that unfavorable publicity could result and the Company might be given the reputation of trying to avoid payment of certain claims. This could be very costly from the point of view of employee relations.

Conversely, however, if the self-insured program is administered as fairly as possible and the basic master policy and certificates have been properly written, the probability of any lawsuits occurring is very remote. Generally speaking this type of problem is more prevalent in either life insurance or accidental death programs where the benefits involved are much larger. There is a possibility of it occurring in the conventional health and welfare program, especially if the illness involved was a lengthy one resulting in very sizable expenses and there was disagreement as to benefits under the plan. During the past ten years Company X has never been faced with such a suit. On the

other hand, since the present level of benefits has been in effect less than two years, perhaps this is not a long enough period to be certain of the probability of such lawsuits occurring.

CHAPTER V

SUMMARY, RECOMMENDATIONS, AND CONCLUSIONS

SUMMARY

A review of the self-insured plan and the insured plan for Company X establishes many factors which must be considered in making a decision for the problem under study.

During 1958 a total of $127,500 was retained by the insurance carrier for administrative, legal, and reserve requirements. This was true even though Company X was responsible for most of the administrative details of the program.

Could Company X have performed the duties now assumed by the carrier at a cost of substantially less than $127,500 in 1958? In the years following 1958 could Company X self-insure its program at an annual cost of less than $50,000? It should be emphasized again that the cost for 1958 was not typical of what might be considered the cost for a normal insurance year. This was largely due to the fact that benefits were changed substantially in 1958 which required an unusually large contribution to the Reserve for Outstanding and Unreported Claims. A normal contribution to the Reserve would be less than $10,000 per year as compared to the $62,000 contributed for 1958. This Reserve was established by the carrier to pay the outstanding and unreported claims as of a given date.

In the self-insured plan this liability would still be in evidence. Should Company X adopt and later terminate its self-insured plan, it would have a direct financial obligation to pay all valid outstanding and

unreported claims. Although this liability would exist, an actual cash reserve would not be set up by Company X. This would be true as long as the Company is in a sound financial condition, with adequate cash to meet this obligation. This liability should be noted on the Company's balance sheet at the end of the year. It will tend to be about the same dollar amount from year to year unless the benefits are liberalized, there is an increase in the number of insured employees, or the present inflationary trend continues in medical expenses. As a result, the payment of $62,000 in 1958 to the reserve, because of more liberal benefits would not have been made in the self-insured program. Hence this amount would have been available for other uses.

Next, attention should be given to the retention by the carrier of $65,500 for 1958. Undoubtedly some of this expense would have to be continued whether the program was insured or not, but just how much could be saved? There are four basic items that make up the carrier's retention. First of all is the broker's commission of $6,000 (on a ten year average basis or $18,000 for 1958 only). This expense would not be found in the self-insured program. Next, a self-insured program would result in a saving of $17,500 in state premium taxes which were paid in 1958 by the carrier on this business. Presently self-insured plans are not subject to this tax, although there is an excellent possibility that they may be in the near future. Contribution to Surplus of approximately $18,000 is the actual profit for the carrier. This amount could be saved since there would be no equivalent expense in the self-insured program.

Last but not least, there is the carrier's retention of $12,000 for acquisition costs and contribution to the Contingency Reserve. The following expenses were incurred in 1958 under the insured program, and also shown are estimated expenses for 1959.

TABLE 4

ESTIMATED SAVINGS UNDER SELF-INSURANCE

Expense Of Insured Plan	1958	1959
Reserve for Outstanding and Unreported Claims	$62,000	$ -
Broker's Commission	18,000	5,000
Contribution to Surplus	18,000	18,000
Acquisition Costs and Contingency Reserve	12,000	12,000
Premium Taxes	17,500	17,500
Total Retention and Reserves	$127,500	$52,500
Less Estimated Expenses if Self-Insured	20,000	10,000
Net Estimated Savings Before Reserve Allocation	$107,500	$42,500

Under the self-insured program there would be certain immediate expenses to be considered. Typical expenses would be for the services of a benefit consultant, printing of booklets and certificates, and legal advice when meeting state insurance department requirements throughout the country. The first year cost for these items is estimated not to exceed $20,000 and in subsequent years no more than $10,000 annually. These figures are based on using the services of a benefit consultant the first year for aid in filing with state insurance departments and giving other needed legal assistance. Also, he would review the terminology to be used

by Company X in its certificates. It is estimated this service would cost about $7,500 the first year. Thereafter the fee would be considerably less, unless actuarial information might be needed on occasion. The consultant's annual fee after the first year should not be more than $2,500. Next, there would be an annual charge for auditing of the self-insured program. It would be expected that $2,500 would be the maximum charge the first year by the outside public accounting firm retained for this purpose. After the first year, $2,000 should be adequate to cover all expenses in connection with the required audit procedures.

The expense of the self-insured plan for 1958 should include $7,500 for the printing of employee booklets, certificates, and claim forms. Most of this expense would not recur annually. As a result, after the first year the expense in this area should be well under the $3,000 apportioned for this item. The remaining $2,500 in 1958 and in future years would be available for contingencies such as unexpected legal or actuarial expense. Following is an itemization of the expected expense of the self-insured program at Company X in 1958, and also in 1959, a more typical year.

TABLE 5

ESTIMATE OF SELF-INSURANCE EXPENSE

	1958	1959
Consultant Fee	$ 7,500	$ 2,500
Auditing Fee	2,500	2,000
Communication Material	7,500	3,000
Miscellaneous	2,500	2,500
Total	$20,000	$10,000

In addition there would be another important cost in the self-insured plan as an offset against the original $127,500 expense of the carrier for 1958. The question of the Contingency Reserve must be settled. Should there be such a reserve? If so, how much? What are the minimum immediate requirements? The company might consider Stop Loss Insurance to cover extraordinary losses. If Stop Loss Insurance is to be used, what is the premium per year for the coverage? A decision in this area is necessary if a true comparison is to be made of the insured versus the self-insured plan.

The next consideration relates to the administrative problems to be met? As far as the actual processing and payment of claims, the procedure would be much the same as is now used by the company under the self-claims administration program so there should be no problem in this area. The preparation of certificates and employee booklets should be relatively easy. The same type of communication program was needed in developing a pension plan for employees in Company X and in that situation the company developed the material very effectively.

Company X might have more success in handling the excessive charge problem than the insurance company itself. The reason for this is that in either circumstance someone will have to contact the physician or surgeon to determine in detail the circumstances. This would be necessary so that a final decision can be made as to whether or not the charge could be considered as excessive. Since most physicians would be centrally located in the area of the main plant, it is possible that the simple act of the company investigating the fee charged might in itself tend to deter the physician from using excessive fees in the

future. This could be true since his local reputation might be harmed if it became known that his fees were excessive. However, the carrier would definitely be in a better position to contact physicians located away from the vicinity of the home plant.

Internal control area presents no problem since the necessary checks can be made by the internal audit group within the company or the public accounting firm that audits the company's records.

Perhaps one of the major issues in the self-insurance question concerns employee acceptance of the program. Fortunately in Company X employer-employee relations are very good. Since the employee group has a basic faith in the management of the company, there is no reason to believe that they will not accept a self-insured program.

An occasional problem might arise in connection with a specific claim which is submitted by an employee and, for one reason or another, is declined payment. There may be a tendency for the employee to hold some malice toward Company X under a self-insured program rather than toward the insurance carrier if the plan was insured. However, considering the few times that this kind of problem arises, especially if Company X administers the plan in a fair and equitable manner, the odds will be reduced considerably that such claims will cause too great a problem.

Last, but certainly not least, are the legal requirements which must be considered. The writer has found this area difficult to pursue, since it varies by state and is a highly specialized field. Certainly it can be answered best by specialists in the legal profession. There is very little written in this area. Most authors do emphasize that a

careful investigation should be made of the legal considerations of a self-insured program. Based on the information which was available however, there appeared to be no stumbling block either as to cost or legal requirements for adopting a self-insured health care program.

The major benefits of the self-insured program have been summarized above. Now the major advantages of retaining the insured plan will be reviewed.

First is the peace of mind that the group has when the large reserves of the carrier are behind the company when catastrophe strikes. Certainly Company X is not in a position to establish the financial reserves that are available under the insured program.

Secondly the carrier offers the various services through the specialists it employs without any additional cost to the insured. Assistance is available in preparing employee booklets, certificates, circulars, and other means of communicating the program to employees. There is no additional cost for actuarial service performed. Projected costs of the program in future years are a regular part of the carrier's service based on its nation-wide claims experience.

Assistance in claims administration is an important advantage of the insured plan. Advice of expert claim representatives is available when necessary in settling claims problems. Unhappy claimants look to the carrier as the culprit in the case. This protection is important when distraught physicians are unhappy with a particular coverage or claim with which one of their patients is concerned.

Nation-wide claims investigating services as provided by a large carrier can be a real asset when the insured group is located throughout

the United States and Canada. The personal contact of a trained claims-man can be much more beneficial in settling claims problems than by writing letters which might be necessary under the self-insured program.

Excessive fees charged by physicians is another service in which the carrier can protect the insured company from continued abuse by bringing pressure on the practitioner involved. The carrier would assume full responsibility when dealing with a physician so that Company X would not become involved.

Last but not least is the legal aid under the group insurance program. Defense under claim law suits, awareness of state insurance statute requirements, interpretation of federal laws pertaining to group insurance, ways of providing coverage for employees in Canada are all areas the insured must handle under the self-insured plan. The insurance carrier, because of its broader experience is aware of these technical problems and how they can be met most efficiently.

These areas are the major ones in which the insurance carrier can perform a definite service. The basic questions as to which plan Company X should use resolves itself to the answers for the following questions. Are the services performed by the carrier worth $65,500 to Company X in 1958? Could the program have been administered as effectively by Company X and result in considerable savings? Would the insured have had to make the $62,000 contribution to the Company's own reserve accounts as the carrier did?

RECOMMENDATIONS

In reviewing the pros and cons of these important questions it is the author's opinion that Company X should adopt self-insurance. There

are a number of reasons why this decision has been made.

If claim experience in any particular year is poor so that it is necessary for the carrier to draw upon the insured's Contingency Reserve, then the premium for the following year will be raised so that the carrier can recoup the additional expense of the previous year. If under the insured program Company X pays all expenses, plus maintaining adequate reserves with the carrier, why can't the Company do this for itself if all other factors are favorable?

The second reason for favoring self-insurance for Company X is because the size of the insured group is large enough to reduce to almost zero the possibility of a catastrophic year which could easily affect a small group because of the lack of numbers.[1] This is especially true since the kind of insurance in question is for non-occupational illnesses and injuries only.

Third, the carrier is receiving funds for which there is a very understandable purpose, but it is questionable from the point of view of Company X whether the contribution will ever benefit the insured company itself. Specifically reference is made to the Contingency Reserve contribution. In the 22 year history of the group health care insurance program at Company X, there has never been a need for the Contingency Reserve since its claim experience has not been excessive in terms of the premiums paid. In addition, assuming that Company X was to retain its insured program, there would appear to be little doubt that this would be done with the same insurance carrier since the

---

[1]Interview with Roger Patrick, Actuary, Edwin Shields Hewitt and Associates. March 16, 1960

necessary reserves have already been established. If it was to change insurance carriers it would be necessary to build these reserves up again. If the same carrier is retained on an expected permanent basis then the contribution of over $200,000[2] made to the Reserve for Outstanding Claims will always remain in the carrier's possession. This would be true, of course, only in the event that the contract was never terminated and Company X's life was infinite in length. However, if the company was to self-insure then the carrier would use a substantial portion of this reserve to pay outstanding and unreported claims that would be received after the official termination of the insured contract.

The fourth reason the writer favors self-insurance in Company X's situation is the financial savings that could have taken place had self-insurance been in effect in 1958. Company X could have saved as much as $107,500, depending on whether or not it elected to set up a Contingency Reserve. For example, if no reserve was to be established under the self-insured plan, the savings in 1958 would have been the carrier's retention and reserves ($127,500) less the expected additional cost of administering the self-insured program ($20,000). Obviously this difference of $107,500 would be the maximum savings for 1958. It should be emphasized again that 1958 was not a typical cost year for the insured program for two reasons; first the liberalization in benefits necessitating additional reserves. Secondly the change in claims procedure midway in the year which directly affected the retention by the carrier for that year. In future years the

---

[2]This contribution was built up over a number of years with the growth in benefits, medical costs and number of employees.

carrier estimates its retention will be about $52,500 annually assuming no increase in the number of insured employees, benefit levels, or claim losses. In future years then, it is this $52,500 figure that should be used in estimating any proposed savings in the self-insured over the insured program. After 1958, assuming no contribution to a contingency reserve, the expected additional cost to Company X by self-insuring would be $10,000 which would be comparable to the $52,500 retention charge by the carrier. As a result the maximum savings per year to Company X would be no more than $42,500 and could be less if any contribution to reserves was needed or if Stop Loss Insurance was purchased each year. If Company X elected to establish a Contingency Reserve over a two or three year period of approximately 5% of projected claim experience, a total of $50,000, obviously this contribution would reduce the savings for those years. Naturally this reserve could be invested so that the interest income would either increase the amount of the reserve or be used to reduce the annual contribution for losses.

If Company X has serious concern over abnormal claim experience, this could be covered by Stop Loss Insurance. Stop Loss Insurance could be used instead of maintaining a contingency reserve. However, with the expectation of predictable claim experience, this avenue might be more appropriate for a company with a considerably smaller insured group than Company X.

If the funds employed by Company X in its own operation are returning a 10% or 15% return then perhaps a reserve should not be used and instead the funds left for the regular operating use of Company X.

Stop Loss Insurance could be purchased at a moderate premium to allay any fears by Company X of abnormal claim losses.

The author's last reason for favoring self-insurance is that Company X is now performing many of the functions of a self-insurer. This is true since they review and pay all claims, use their own bank account and their own bank. This experience helps to assure that they will be able to handle the administrative problems with success. In addition, Company X already has its own staff of four full time physicians who would be available to answer technical medical questions. These questions were formerly answered by the insurance carrier.

The major consideration yet to be made in the adoption of self-insurance is in the legal area. Legal requirements are often too complicated to be answered completely by a layman. Expert legal advice is available to assist Company X, and the fact that the twelve companies surveyed were able to self-insure satisfactorily indicates that the various legal requirements can be satisfied without too much difficulty.

CONCLUSIONS

This paper is also intended to identify the various areas that should be studied by any company interested in the possibilities of self-insurance.

It is important for the reader to understand that few generalizations can be drawn from this paper to apply directly to other company situations. Certainly the pre-requisites of self-insurance, as explained in Chapter I, can be practically applied to all companies considering the question. When reviewing such areas as reserves, premium

retention, benefit levels, claims administration, and available technical knowledge, each company must consider these factors in the light of its own situation. There is no substitute for a thorough comparison between the insured and self-insured plans. A company would be ill-advised to switch to a self-insured plan if there were not substantial savings available to it. It is also essential that the company meet the prerequisites for self-insurance. An insured program will still continue to be the wisest solution for many such companies. For others, however, self-insurance may merit more than a passing glance.

APPENDICES

Appendix		Page
A	Initial Letter Accompanying Questionnaire	92
B	Copy of Questionnaire	93
C	List of Companies Participating in Survey	95
D	Survey Results	96
E	Transmittal Letter Accompanying Results	107

APPENDIX A

INITIAL LETTER ACCOMPANYING QUESTIONNAIRE

1304 Hickory Street
Waukegan, Illinois
June 29, 1959

ABC Company
1273 Oriole Drive
Baltimore, Maryland

Gentlemen:

Your company has been referred to me as one which has chosen to self-insure its employee group insurance program.

As a graduate student at Marquette University, I am gathering background information in connection with my Master's Thesis: "Self-Insurance of an Employee Health Care Program in a Specific Corporate Situation."

Will you please assist me by completing the enclosed questionnaire. Anticipating that you may wish to retain one for your files, I have enclosed two copies of the questionnaire. To complete the picture, will you please accompany your reply with copies of any of your insurance booklets which you may have published for employee use?

Thank you for your assistance.

Sincerely,

R. A. Dietmeyer

P. S. Should you wish a summary of this questionnaire study, please note this on your reply.

APPENDIX B

QUESTIONNAIRE
Page 1

Administrative Considerations

1. Number of claims processed for 1958 under each coverage;

   a. Weekly Accident and Sickness Benefit

   b. Hospital Benefit

   c. Surgical Benefit

   d. Medical Expense Benefit

2. When you adoped self-insurance, did you liberalize the benefits under the program?

3. How do you determine excessive medical charges by physicians?

4. How do you handle investigations of surgical claims representing excessive charges?

5. Can an employee continue his coverage after separation from the company by retirement or resignation?

6. Are all claims, or a sampling of claims, routinely audited by a group outside the insurance department? If so, is this an internal audit group within your own company or a public accounting firm?

7. How would you rate employee acceptance of your self-insurance program? (check one please)

   ( ) Very good

   ( ) Good

   ( ) Fair

   ( ) Poor

8. In adopting self-insurance, did your company use the service of an outside employee benefit consultant firm in determining the feasibility of such a program? If so, what service did they perform?

June 29, 1959

QUESTIONNAIRE

Page 2

General

1. What part of your group insurance program is self-insured? (please check)

   ( ) Weekly Accident and Sickness

   ( ) Hospitalization

   ( ) Surgery

   ( ) Medical Expense

2. Number of employees insured.

3. Number of dependent family units insured.

4. Why did you adopt self-insurance?

5. Do you retain an actuarial firm to assist you in determining future costs?

Financial Considerations

1. What dollar savings do you estimate in premium taxes and insurance broker's commissions for 1958? (Please separate).

2. Have you established a Reserve For Outstanding and Unreported Claims? If so, what percent is it of your 1958 claim experience?

3. Have you established a Contingency Reserve as a safeguard against a year of adverse claim experience?

4. What percent of annual claim experience is now in this reserve? How many years has it taken to reach the amount you now have in this reserve?

5. Are the funds in this reserve invested? If so, what percent return did you receive on the fund last year?

6. If a contingency reserve has not been established, do you have either stop-loss or excess-loss insurance coverage?

7. What was the net cost of this insurance coverage for 1958? (Please show figure as percent of 1958 claim experience).

8. What do you estimate as your dollar savings over-all in contrast to insuring your program for 1958?

APPENDIX C

COMPANIES PARTICIPATING IN SURVEY

Bulova Watch Company, Inc.
Flushing, New York

Champion Paper and Fibre Company
Hamilton, Ohio

Consolidated Water Power and Paper Company
Wisconsin Rapids, Wisconsin

Elgin National Watch Company
Elgin, Illinois

Goodyear Tire and Rubber Company
Akron, Ohio

S. C. Johnson and Sons
Racine, Wisconsin

Nekoosa-Edwards Paper Company
Port Edwards, Wisconsin

H. C. Prange Company
Sheboygan, Wisconsin

A. E. Staley Manufacturing Company
Decatur, Illinois

Tappan Stove Company
Mansfield, Ohio

Western Printing and Lithographing Company
Racine, Wisconsin

Textile Employee Benefit Association
Wyomissing, Pennsylvania

APPENDIX D

SURVEY RESULTS

I

QUESTION: What part of your group insurance program is self-insured?

Weekly benefits
Hospitalization
Surgery
Medical Expense

ANSWER:

1. Weekly benefits only
2. " " "
3. All four coverages
4. Partially on all except weekly benefits
5. All four coverages
6. All four coverages
7. Weekly benefits and Hospitalization
8. All but medical expense
9. Weekly benefits
10. All four coverages
11. All four coverages
12. Weekly benefits

II

QUESTION: Number of employees and dependent family units insured under your program?

ANSWER:

1. 1631 employees
   1000 dependents

2. 824 employees
   680 family units

3. 17,000 employees
   29,000 wives and children

4. 1450 employees
   no dependents

5. 3976 employees
   3315 dependent units

6. 3300 employees
   2500 family units

7. 961 employees
   no dependents

8. 1937 employees
   1567 dependent units

9. 1800 employees
   no dependents

10. 2366 employees
    4253 dependents

11. 10,000 employees
    number of dependent units not available

12. 2500 employees
    no dependents

III

QUESTION: Why did you adopt self-insurance?

ANSWER:

1. Decision made in 1918 when plan was established.
2. In order to establish more personal contact with employees.
3. Group insurance not available in 1909 when self-insured plan was adopted.
4. To provide coverage of small bills for employees only.
5. Always were self-insured.
6. Organized as self-insured in 1917.
7. Less costly.
8. Have been on this basis since 1921.
9. No answer.
10. Less costly and better employee relations.
11. No insurance coverage available in 1917.
12. No insurance coverage available in 1913.

IV

QUESTION: Do you retain an actuarial firm to assist you in determining future costs?

ANSWER: Answered "No" except for companies coded 5, 8 and 9 in the survey.

V

QUESTION: What dollar savings do you estimate in premium tax and broker's commissions for 1958?

ANSWER: Answered "unknown" by all companies participating in the survey.

VI

QUESTION: Have you established a Reserve for Outstanding and Unreported Claims? If so, what percent is it of your 1958 claim experience?

ANSWER:

1. No
2. No
3. Included with Contingency Reserve.
4. No
5. Included with Contingency Reserve.
6. No answer
7. No
8. Yes, equal to approximately one month's claim experience.
9. Included with Contingency Reserve.
10. No
11. No
12. No

VII

QUESTION: Have you established a Contingency Reserve as a safeguard against a year of adverse claim experience? What percent is it of your annual claim experience and how many years were needed to set it up?

ANSWER:

1. Yes, equal to 300%, established over 41 years ago.
2. Yes, equal to 189%, established over 16 years ago.
3. Yes, equal to 75%.
4. No
5. Yes, percentage not given. Established over 43 year period.
6. Not answered
7. Yes, equal to 225%.
8. Yes, equal to 100%, established over a 38 year period.
9. Yes, varies per experience, although continually increasing.
10. Yes, 50.75%, established over a 9 year period.
11. No
12. No

VIII

QUESTION: If a Contingency Reserve has not been established, do you have either stop-loss or excess-loss insurance?

ANSWER: "No" by all companies participating.

IX

QUESTION: What do you estimate as your dollar savings over-all in contrast to insuring your program for 1958?

ANSWER:

1. Unknown
2. Unknown
3. Unknown
4. $1445
5. Possibly $50,000
6. No answer
7. $15,000
8. Unknown
9. 15% - no dollar figure given
10. $30,000 to $50,000
11. No
12. No

X

QUESTION: Are the funds in this Reserve invested? If so, what percent return did you receive on the fund last year?

ANSWER:

1. Yes, 3.7%
2. Yes, 3%
3. Yes, 3%
4. No fund
5. Yes, 4%
6. No answer
7. Yes, 4.1%
8. Yes, Federal Reserve Notes at 2½%
9. Yes, 4½%
10. Yes, 3%
11. Not applicable
12. Not applicable

XI

QUESTION: Number of claims processed for 1958 under each coverage:

a. Weekly Accident and Sickness

b. Hospital Benefits

c. Surgical Benefits

d. Medical Expense Benefits

ANSWER:

1. a. 22 per week
   b. 55 per month
   c. 67 per month
   d. no answer

2. a. 70

3. a. 102
   b. 5502
   c. 1310
   d. 45,209

4. a. 30
   b. 10
   c. 150
   d. 300

5. No figures available

6. a. 830
   b. 485
   c. 236
   d. 488

7. a. 202
   b. 128

8. No breakdown available

9. a. 488

10. a. 1908
    b. no figures available
    c. " " "
    d. " " "

11. a. 2230
    b. 5127
    c. 4364
    d. 2498

12. a. 479

XII

QUESTION: When you adopted self-insurance did you liberalize the benefits under the program?

ANSWER:
1. Self-insured since beginning
2. No answer
3. Self-insurance only, amended annually
4. No
5. Not applicable
6. Not applicable
7. No
8. Not applicable
9. No answer
10. Yes
11. Yes
12. Not applicable

XIII

QUESTION: How do you determine excessive medical charges by physicians and how do you handle the investigation of excessive charges?

ANSWER:
1. Not applicable
2. Not applicable
3. Use past experience as criterion-Board of Trustees determine reasonable fees with advice from disinterested doctors.
4. No real recourse
5. We set our own maximum allowance
6. Through our medical director and the local chapter of the American Medical Association
7. Not applicable
8. Never have had the problem
9. No answer
10. Past experience plus advice of company physician
11. No answer
12. Not applicable

XIV

QUESTION: Can an employee continue his coverage after separation from the company by retirement or resignation (excluding weekly benefits, of course)?

ANSWER:
1. No
2. Retirement only
3. Retirement and lay-off only
4. No
5. Retirement only
6. Retirement only
7. No
8. Retirees coverage now being set up
9. No
10. Retirement only
11. Retirement only
12. Not applicable

XV

QUESTION: Are all claims or a sampling of claims routinely audited by a group outside the insurance department? If so, is this an internal audit group within your company or a public accounting firm?

ANSWER:
1. No
2. Internal auditing group
3. Both
4. Records are sample audited annually
5. Public accounting firm
6. Internal audit group
7. Public accounting firm
8. Public accounting firm
9. No
10. Yes, by Association Board of Directors
11. Sampling by internal audit
12. Public accounting firm

XVI

QUESTION: How would you rate employee acceptance of your program?
Very good
Good
Fair
Poor

ANSWER: Question answered as "very good" by all companies with the exception of companies with codes 1 and 11 who answered "good."

XVII

QUESTION: In adopting self-insurance, did your company use the service of an outside benefit consultant for determining the feasibility of such a program? If so, what service did they perform?

ANSWER: Question answered "no" by all companies except code 9 who indicated that the consultant performed an actuarial service in first setting up the plan.

APPENDIX E

TRANSMITTAL LETTER ACCOMPANYING MAILING OF SURVEY RESULTS

1304 Hickory Street
Waukegan, Illinois
July 15, 1959

ABC Company, Inc.
17 North Madison Street
Walpole, Massachusetts

Gentlemen:

Recently you were kind enough to complete a questionnaire sent to you in connection with background material needed for my Master's Thesis.

Your fine cooperation is certainly appreciated and the information you supplied was very helpful. Eleven other companies who have also self-insured either all or part of their employee medical expense program also completed a questionnaire. As a result I am happy to enclose a summary of the answers that were given me in addition to the names of the companies that participated.

Your answers have been identified as Code Number _____. The answers supplied by the other companies have been identified by their code number only.

Thank you again for your participation.

Sincerely yours,

RAD-hs

BIBLIOGRAPHY

BOOKS

Ilse, Louise W., Phd., Group Insurance and Employee Retirement Plans, Prentice-Hall, New York City, 1953.

Mehr, Robert I. and Cammack, Emerson, Principles of Insurance, Richard D. Irwin, Chicago, Illinois, 1954.

ARTICLES AND PERIODICALS

Liner, John, "Self-Insurance of Group Welfare Plans", Harvard Business Review, January-February, 1956.

Palmer, David V., The Use of Excess Insurance, American Management Association, Report No. 7, Current Trends in Corporate Insurance, 1958.

REPORTS

Becker, Kennard W., Stop Loss Coverage, a report to the National Conference of Health and Welfare Plans, Trustees and Administrators, October, 1958.

Faggen, Harold A., Self-Insurance, a report to the National Conference of Health and Welfare Plans, Trustees and Administrators, October, 1958.

Foust, George C., Jr., Long Term Disability Coverage and Self-Insurance, a report to the Health Insurance Association of Chicago, 1958.

OTHER SOURCES

Edwin Shields Hewitt and Associates, Self-Administered Plans, a report prepared for a client, August, 1954. Personal Interviews with Gayle Mattingly, Consultant, and Roger Patrick, Actuary, 1959.

Equitable Life Assurance Society, Personal Interviews with Bernard McGuirk, Senior Auditor, and John Schenning, Service Manager.

Liggett, Darwin S., Mutual Life Insurance Company, a speech before the 1959 National Conference of Health and Welfare Plans, Trustees and Administrators, Los Angeles, California.

BIBLIOGRAPHY (CONTINUED)

OTHER SOURCES (CONTINUED)

Segal, Martin E., Insurance Versus Self-Insurance of the Employee Benefits Program, a speech given before the Fall Insurance Conference, American Management Association, November, 1958.

Smith, J. Henry, Advantages of an Insured Over a Self-Insured Plan, Group Competition Manual, Equitable Life Assurance Society, June, 1956.

Travelers Insurance Company, Personal Interview with Russell Mowry, Assistant District Manager, February, 1959.

Wyatt Company, Chicago, Illinois, Interview with B. Russell Thomas, Actuary, February, 1959.