



ADMINISTRATIVE BULLETIN

COMMONWEALTH OF PENNSYLVANIA

DEPARTMENT OF PUBLIC WELFARE

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SUBJECT:

Self Insurance Programs

BY:

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SCOPE

County Mental Health/Mental Retardation Programs
Providers of Mental Health/Mental Retardation Services

PURPOSE

To provide guidance in the area of self insurance for providers of MH/MR services funded through the counties.

DISCUSSION

Self-Insurance

The Pennsylvania Code, Title 55, Chapter 4300 Regulations do not specifically list self-insurance programs as an allowable cost, nor do they prohibit self-insurance. Many providers are opting to self-insure, and recent audits have disclosed that this is being done in a variety of ways. Some providers submit inappropriate reimbursement claims for ineligible self-insurance programs.

Self Insurance is Not Insurance

The applicable fiscal regulations, 55 Pa. Code, Chapter 4300, are cost-based (55 Pa. Code § 4300.83(c) and 4300.135) and do not explicitly address self-insurance. Recent audits have identified some Providers as treating the self-insurance set-aside as equivalent to a premium for a commercial insurance policy. Self-insurance, while a permissible way to satisfy workers' compensation laws, (see 34 Pa. Code § 125.1-20), is not equivalent to an insurance policy, because no payment is made to an insurer. Accordingly, eligible costs of a self-insurance program are not the amount of the set-aside, but the actual cost experience of the self-insurance program (claims paid plus administrative expenses).

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Financial Reporting and Payments Section
Bureau of Financial Operations - Telephone (717) 787-3760

Since the Chapter 4300 regulations do not mention self-insurance, the principles for determining the cost of self-insurance must be found elsewhere. The great majority of courts, both federal and state, that have considered self insurance questions have determined that a self-insurance program is not an insurance policy. See, e.g., Stratford School District v. Employees Reinsurance Corporation, 162 F.3d 718,721 (1st Cir. 1998) (“self-insurance” is not “insurance” – “this view has been adopted by a clear majority of courts confronted with the question”); Gulf Oil v. Commissioner of Internal Revenue, 914 F.2d 396, 411 (3rd Cir. 1990) (“Whereas insurance premiums are deductible expenses, amounts entered into self-insurance funds are not”); Wake County Hospital Systems, Inc. v. National Casualty Co., 804 F. Supp. 768, 774 (E.D. N.C. 1992) (“a majority of [state] courts have ruled that self-insurance is not insurance at all,” collecting cases), aff’d, 996 F.2d 1213 (4th Cir. 1993); United National Insurance Co. v. Philadelphia Gas Works, 289 A.2d 179, 181 (Pa. Super. 1972) (a “certificate [of self-insurance] is not an insurance policy”). These cases support the Department of Public Welfare’s (DPW) view as correct.

DPW’s Position

The DPW will allow providers and agencies to self-insure. The 4300 Regulations do not provide specific guidance or acceptable methodology for establishing and maintaining self-insurance programs. However, the regulations are clear that reimbursement must be based on actual costs. (The DPW must ensure that the provided funding is going to meet a client’s needs, and not for excess charges that would be unallowable under the regulations.)

Self-insurance is a means whereby a provider undertakes the risk to protect itself against current and/or anticipated liabilities by providing funds in an amount equivalent to liquidate those liabilities.

Payments/withdrawals made from the restricted self-insurance fund(s) for any purpose other than its intended use for funding employee benefits would not be allowable and would result in appropriate recovery by the county/DPW.

Allowable Costs of Self-Insurance – The costs of self-insurance programs considered allowable for DPW participation are:

1. Actual claims paid in a given fiscal year applicable to that fiscal year, and claims paid attributable to a prior fiscal year during which the provider was under contract to provide MH/MR services, unless the prior-year claims are paid from a reserve that the DPW had participated in accumulating (see Option 2 below).
2. Reinsurance or catastrophic loss insurance.
3. Third-party administrator for the program.
4. Legal fees clearly attributable to the operation of the self-insurance program.
5. Actuarial expenses.
6. Accounting fees clearly attributable to the program.
7. Claims management and other administrative costs charged directly or supported by a documented equitable cost allocation plan.

8. Cost of obtaining a letter of credit or surety bond to satisfy the requirement of the governing body (see Option 3 below).
9. Independent fiduciary fees and cost of establishing the reserve fund (applicable only to Option 2 below).

Any excess earnings, rebates, interest, or dividends resulting from self-insurance activities will be used to reduce allowable costs within the counties' contracts.

The county or counties that contract with the provider that is establishing or maintaining a self-insurance program must be kept informed relative to the status of the program. Furthermore, 55 Pa Code § 4300.139(b), requires full disclosure on the part of the private providers for all aspects of financial activity. If this does not occur, the county and the DPW have the right to disallow any costs for DPW participation.

To become self-insured, providers are generally required to establish a reserve fund or equivalent. The provider has three (3) options for meeting this requirement.

1. Provider Designated/Administered – The provider/agency will set aside provider-accumulated assets, in an amount equal to the requirements determined from actuarially established computations by the appropriate regulatory agency, on an annual basis (Labor and Industry in the case of Worker's Compensation). Contributions to this reserve are not an allowable cost for DPW/county funding. Use of funds in a reserve account that was established in this manner is restricted, only to the extent that the regulatory required balance be maintained at all times.
2. Independent Fiduciary Administered – The provider/agency establishes a fund with a recognized independent fiduciary such as a bank, trust company, or a private benefit administrator. In this case, payments to the independent fiduciary may be allowable, subject to the following limitations:
 - Written Agreement – The provider and fiduciary must enter into a written agreement that includes the appropriate legal responsibilities and obligations required by state law.
 - Control of Fund – The fiduciary must have legal title to the fund, and be responsible for proper administration and control. The fiduciary cannot be related to the provider, either through ownership or control. The home office of a chain organization or a religious order, of which the provider is an affiliate, cannot be the fiduciary. In addition, investments that may be made by the fiduciary from the fund are limited to those approved under state law governing the use of such fund.
 - Payments by Fiduciary – The agreement must provide that withdrawals be for approved claims related to the losses for which the provider seeks to indemnify itself and other allowable expenses as defined later in this section. Any rebates, dividends, etc., to the provider from the fund will be used to reduce allowable costs. Furthermore, evidence of a practice of payments from the fund for purposes unrelated to the proper administration of the fund may result in a withdrawal of recognition of the self-insurance fund. This includes loans to the provider and other payments to or for the provider. In such instances, payments into the fund will be not considered an allowable cost.
 - Premium Costs – Premiums charged by the independent fiduciary are allowable costs, as long as they are not in excess of the cost of available comparable commercial insurance premiums. In addition, supplemental premiums that are assessed to build reserves against contemplated losses are allowable costs if, when added to the regular premium, the total premium costs do not exceed a commercial insurance premium of normal comparable coverage.

- Termination – The agreement must state that upon termination from the self-insurance program, the provider must obtain a determination of the adequacy of the fund balance as of the date of termination from an independent actuary, insurance company, or broker. Any reserves that are deemed excessive must be offset against the provider's allowable costs in the provider's final cost report. If the reserve fund is deemed inadequate, additional contributions to the fund, subsequent to the date of termination, are not allowable.
- Reporting – The agreement must require that a financial statement be forwarded to the provider or pool members by the fiduciary no later than 60 days after the end of each annual insurance reporting period.
- Income Earned – Any income earned by the fund must become part of the fund and used to establish adequate fund levels.

Option 2 is available only if a reserve fund is required by the regulating body, as in the case of Worker's Compensation.

3. Credit Line – Obtain a letter of credit or surety bond that meets the requirements of the regulating body.