BY DOUG RAMSTHEL | *VICE PRESIDENT*
BURNHAM BENEFITS INSURANCE SERVICES

Self-Funding Employer Health Benefits in the Midst of Dealing with Health Care Reform

Anxiety surrounding health care reform compliance has driven a fresh batch of employers toward exploring self-funding. It is a viable choice for those concerned about increasing health care costs and expanding health care coverage requirements.

Employers opt for self-funded insurance plans with two things in mind: control and potential savings. Self-funding offers them more focused control over their plan's design, components, administration—even regulation, since there are fewer state insurance laws with which to comply. This explains why more than 72 percent of firms with 500+ employees and 55 percent of firms with 200 to 500 employees were self-funded in 2010.

Advantages of Self-Funding Under Health Care Reform

Clearly there is real founded concern about the financial costs of the health care reform legislation (PPACA) due to richer benefits and coverage requirements. Self-funding is an effective cost control strategy for avoiding: (1.) Benefit requirements—self-funded plans are not included in requirements imposed on fully-insured plans such as essential health benefits, comprehensive coverage for health benefits package, annual limitations on deductibles, and guaranteed issue of coverage. (2.) Administrative requirements—jurisdiction of state ombudsmen, application of state law to prevent fraud and abuse, and administrative simplification rules will not apply to self-insured plans. Not having to comply with these requirements will reduce costs.

Health care reform also imposes significant taxation on carriers beginning Dec. 31, 2013 that will undoubtedly be passed onto employers in the form of higher premiums if fully insured. It is expected employers will save money when they are required to enroll all their eligible employees or potentially face a monetary penalty. Currently any given employer group health plan has about 25 percent or more of eligible employees waiving off their plan.

Claims data demonstrates those likely to waive coverage have significantly lower claims than those who enroll in their employer's plan. The most cost-effective way to pay for these low claimants is to pay only for their claims costs, and an administrative fee; versus a fully-insured premium based on the higher claims employees who have already enrolled in the plan. A self-funded arrangement is the most cost-effective platform to provide coverage for healthier than average employees, as low claims equate to low costs. With fully-insured premiums being built on decades of actuarial data from current insured (excludes the healthier employees who are waiving), it could take years for a fully-insured carrier to recognize this influx of healthier employees in their rate development and premiums they offer to employers in the market.

The ABCs of Self-Funding

When contemplating a self-insured arrangement, it is important to make a realistic assessment of employee health and insurance utilization patterns. Factors like average age and employee health determine which option is likely to provide the optimum cost benefit.

It is not surprising that larger companies are more likely to appreciate the self-funding option, sometimes called an administrative services only (ASO) plan. Ideal candidates for self-insurance have at least 100 employees as larger numbers provide better predictability of future claims costs.

Another way to achieve solidity of costs in a self insured plan is through individual stop-loss (ISL) coverage. Companies with ISL coverage are only on the hook for an individual's claims up to a maximum dollar amount, after which their insurance steps in to assume the balance. Aggregate stop-loss (ASL) coverage provides similar insurance for a poor claims year for the entire group, further reducing the variability of costs.

With the more detailed claims information available under a self-funded plan, an employer becomes more empowered to focus on solutions including targeted wellness programs. So many wellness programs are rolled out without being targeted to employee's specific health issues, rendering them ineffective. Targeted wellness programs based on an employer's claims data can really help to reduce claims costs.

Building a Better Health Plan

In exchange for greater control, self-funded insurance plans demand more effort on the part of the employer, who also becomes the plan sponsor. There are legal obligations that must be complied, such as meeting plan documentation requirements, funding bank accounts, and creating an appeals process, to name a few.

Like any package deal, things begin to look different when they are unbundled. When a company replaces a health package with individually selected components, it exposes itself to a variety of unexpected risks. In an arena where mistakes can be very costly, it pays to assemble the components of an ASO plan with the guidance of benefits experts who can point out the pitfalls and identify the best ways to save.

There is an element of risk versus reward in any health insurance plan. While self-funded insurance carries an inherent level of risk, it can be controlled with the purchase of appropriate stop-loss insurance. Those companies willing to put their money on the table are eligible for hefty payouts in the form of realized savings. With significant savings up for grabs in this tough health insurance environment, it makes sense that a growing number of companies are deciding it is worth the calculated risk. CDHC $