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Self-Funded Health Insurance Plans: What You Need to Know

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Insured Health Plans vs. Self-Funded Plans

Are you considering self funding your health plan? Do you wonder how a self funded plan differs from an insured plan? This guide provides you with a simple explanation that we hope you find helpful.

With insured health plans, a company pays a premium to an insurance company for a predetermined plan design made available by the insurance company. The premium is a fixed rate, generally guaranteed for a 12 month period that is calculated based on the demographics and health risks of the employees and dependents enrolled in the plan.

The insurance company uses the premium to pay claims, to cover administrative costs such as booklets and insurance cards, customer service together with any claims management services, and to set aside reserves for future claims. State laws mandate that insurance companies maintain reserves to cover future claims liabilities and to preserve the financial strength of the insurer. Insurance companies invest the reserves and they are another source of income for the insurance company.

Self-funded plans came into being many years ago as large companies began to realize that they could accurately project the health expenses for their large group of employees and had the staff available to manage their own health plan. Thus, it made financial sense for them to keep the money they were paying in premium, hire someone to pay the claims directly for employees and buy reinsurance to cover only the catastrophic losses. This also meant the employer retained the income from the reserves rather than the insurance company. And so self-funded insurance plans were born.

How Self-Funded Plans Work

With self-funded plans, an employer usually hires a Third Party Administrator (TPA) to handle the administration of the plan. This includes details such as processing claims, issuing ID cards and booklets, pre-treatment review, etc. The TPA generally also lines up the appropriate preferred provider network (PPO) as well as the appropriate reinsurance coverage. The TPA will charge a fee for providing these services and there will be a premium to pay for the reinsurance coverage.

Generally, the claims cost will represent 75-80% of the total cost of the plan and the fees for the administrative services, the premium for the reinsurance will represent 20-25% of the total cost of the plan. It is essential for the employer to understand the cost breakdown of their plan and the discounts associated with the PPO being recommended by the TPA.

Companies with self-funded health plans have a lot of flexibility crafting health plans because they are designing it themselves rather than choosing an offered

plan from an insurance company. This allows the employer flexibility to set co-pays, deductibles and other out-of-pocket expenses for the employee.

An employee will see little difference in the way a self-funded plan works as compared to an insured health plan. They are still given an ID card to take to the doctor and a benefit booklet that explains the coverage provided by the plan. The doctor submits their claim to the TPA who processes the claim and pays according to the plan design.

Because self-funded plans are generally not subject to state laws, employers are not required to set aside reserves for future claims. However, while not required, prudent financial management of the plan suggests the employer do so anyway. Self-funded plans are subject to ERISA which regulates and governs self-funded plans. ERISA is highly complex with many regulatory requirements and care must be taken that all aspects of the self insured plan are in compliance with ERISA.

Catastrophic Claims

Most employers using self-funded health insurance plans will buy stop-loss insurance to cover catastrophic claims. Stop-loss insurance (also called reinsurance) is generally purchased to cover large claims for individuals (specific coverage) and to cover excessive claims for the entire group (aggregate coverage). For example, a company's specific stop-loss insurance coverage may kick in once an individual has reached $50,000 in covered claims. This is referred to as the "attachment point." The company pays the initial $50,000 in claims and the reinsurance will cover any claims above this threshold. In addition, aggregate coverage acts as an umbrella over the entire group. It provides a ceiling on the amount the company will have to pay for claims for the entire group. Both specific and aggregate stop loss insurance cover only claims incurred and paid during the period described in the contract. It is absolutely essential that you understand these time periods as set out in the contract because claims incurred and/or paid outside of these time periods will not be covered leaving the full burden for paying these claims on the employer.

A cautionary note about specific stop-loss insurance: if there is an individual with a large on-going claim, the reinsurance company may choose to "laser" that individual. This means that the reinsurance company could single out the individual with the large claim and raise the attachment point to a much higher level. Using our example from above, the attachment point for the group might remain at $50,000. However, the attachment point for the individual with the large claim may be increased to $300,000. As you can see, this represents a significant increase in risk and cash flow requirements for the employer. Employers with this dilemma face the unpleasant decision of paying the extra claim costs for the individual, trying to find another reinsurance provider offering a lower attachment point or try to get back on an insured health plan (not likely). If the company is unable to find another reinsurance plan and can't find an

insured health plan, this could be financially devastating to the employer. As you can see, understanding the risk and cash flow fluctuations associated with a self funded plan is essential before moving to this type of funding.

Are Self-Funded Health Insurance Plans Worth the Risk?
For employers that can handle the risk, both financially and emotionally, self-funded health plans can be a very viable option for providing health coverage to employees. Flexibility, cost savings and improved plan management can all be realized with this funding model.

A word of caution, moving from an insured plan to a self insured plan requires more than simply comparing the cost. You need to understand the risk associated with the cost of each plan as well. If you rush into a self-funded plan without properly analyzing your risk, the results could be financially devastating to your business.

Benefits of Self-Funded Plans
There many advantages and benefits for companies that choose to use self-funded plans.

- The employer has greater flexibility to create and customize a plan specifically tailored to the needs of both the employees and the employer.
- The return on investment from successful wellness initiatives accrue 100% to the plan. Healthy employees with fewer medical claims will have a direct, positive impact on the overall cost of the health plan. In an insured plan, the benefits generally accrue to the insurance company and they may or may not share the savings with the employer.
- Rates are based primarily on the experience of the self funded group rather than on the experience of a pool of groups as is generally the case with an insured plan. In addition, costs are primarily impacted only by cost trends in the locale where the group receives their health care rather than the conservative global trend adjustments used by insurance companies.
- Detailed claims data will be available so the claims and usage trends can be more effectively analyzed and managed.

Are You a Candidate for Self-Funded Health Insurance?

Not every company is a good fit for self-funded health insurance. Consider:

<u>Company Size</u>
Self-funded plans typically work best for employers with at least 100 employees because the more employees you have, the easier it is to project claims expense and trends.

Sufficient Cash Flow

Self funding requires discipline in managing the finances of the plan as well as the ability to withstand significant cash flow and risk swings. If your company cash flow is tight and/or you have a low tolerance for risk, you are not a great candidate for self-funding.

Risk Tolerance

Employers considering self-funded health plans must be comfortable accepting and managing risk. Self-funded plans can look great on paper for the first year, but if a major catastrophic event happens, an employer needs to be able to handle excessive claims. Employers should weigh the risk factors down the road before jumping into a self-funded plan.

Curious to see if you might be a good fit for a self-funded health plan? Group Services helps companies analyze whether self-funded plans are right for them by doing a thorough comparative analysis between insured and self-funded health plans. Call today to learn more: 800.925.8846.

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