Self-Insurance: You Can Increase Benefits While Minimizing Risk
By Ron E. Peck

In the United States, if you have health insurance, chances are it's through your employer. This is true, even in a post Patient Protection and Affordable Care Act ("PPACA") world, where individuals can choose to purchase individual policies on the so-called "exchange." These two worlds of insurance, meanwhile, do not exist in separate universes. The insurance carriers that offer policies of "traditional" fully funded insurance to employers (policies where the carrier collects a premium and takes on all of the risk – including payment of medical bills), also underwrite the individual policies on the exchange.

It was hoped that a flood of healthy lives would join the exchanges, adding low risk lives and premium dollars to these insurance carrier's risk pools. These new funds could be used to cover the "sickest" enrollees (previously uninsurable but newly insurable thanks to the PPACA), as well as reduce the rising cost of insurance policies purchased by employers.

Unfortunately, the cost of providing coverage via the exchange was far greater than expected. Combined with the steadily rising cost of healthcare itself, and insurance carriers were forced to raise premiums. Because they were limited regarding how much they could raise premiums on the exchange, their employer policies bore the brunt of the rising cost.

Years of such rising costs have forced many businesses to scale back their coverage. One of the quickest ways they have to control the growth in premiums, or cost of coverage, without significantly changing the insurance is to raise an employee's deductible. Enter the so-called "high-deductible" plan. Deductibles have soared in the past decade, according to a survey released by the Kaiser Family Foundation and Health Research & Educational Trust, which reported growth in deductibles seven times as steep as wage growth, over the last five years.

Employers thus face this difficult decision – pay more in premium (for many, 30 percent or more each year) to keep their current plan, shift the burden onto the employees by implementing higher deductibles and co-pays, drop coverage altogether (paying a penalty and having employees purchase their own policies on the exchange), or – self-fund their plan.

Health insurance generally comes in two flavors -- self-funded and traditional fully-funded insurance. Fully-funded insurance, as mentioned already, is the type of coverage most people are accustomed to -- from automobile to homeowners insurance. People are accustomed to having an agent assessing them and the risk they pose, then charging a premium to provide coverage. In that scenario, the actual medical bills are paid by the carrier. The insured pays a fixed cost; the insurer wins if claims are low and loses if claims are high. But what if you want to benefit from promoting health and wellness?

Enter self-funding.

A self-funded health plan is established when an employer -- the primary plan sponsor -- sets aside some of its funds to pay for its employees' medical expenses. Those workers contribute to

the plan instead of paying premiums -- although the similarity of the actions means it's not uncommon to hear employees and employers refer to such contributions as "premiums."

Traditionally, self-funding was for large employers, sophisticated enough to understand the benefits and costs; and armed with a large enough population to easily fund even the costliest claims. This has led to a mistaken belief that there is a "minimum" number of lives needed to self-fund your health plan. Indeed, one of the pillars upon which insurance rests is the idea that a bigger risk pool (meaning, more people enrolled in a plan or with an insurance carrier), means there is more money (premiums or contributions) being "dumped into the bucket" and made available to pay the occasional high dollar "catastrophic" claim. With self-insurance, however, plan sponsors and participants have more direct control over their costs. Indeed – the bigger the plan, the tougher it is to control its health and wellness. If I am self-funding a smaller group of enthusiastic participants, I can more easily implement wellness programs, analyze the claims data, and take active steps to contain costs. Would you rather self-fund a plan for five healthy yoga instructors, or five hundred daredevils? Risk and the health of the population play a role as well. You can't prevent some unforeseen losses from occurring (such as cancer, premature birth, etc.), but size is only one factor when assessing self-insurability.

As smaller employers, who had always purchased insurance in the past, now look to self-funding as an option, it behooves those of us that advise and guide them to understand the ins and outs of self-funding. Here are some reasons why an employer would self-fund.

Plan Control

Self-funding begins with drafting a plan document or summary plan description. This is where the employer chooses what to cover and what to exclude. Within parameters set by federal law, the employer customizes the plan to be generous where their particular workforce needs it, and stingy where benefits aren't needed. For example, if someone owns a yoga studio where the workforce is in tip-top shape, they can go lean on benefits meant to help those who are suffering from morbid obesity.

In addition to customizing the benefits, the employer can customize the partnerships. Fully-funded carriers have selected their provider networks, vendors and other programs that they package and force upon policy holders. A self-funding employer, however, can shop around and select partners to customize their team.

Interest and Cash Flow

When an employer purchases fully-funded insurance, they pay premiums when they are told to pay. That money is gone. It sits in the carrier's account until it's needed to pay claims. While it sits, it's working for the carrier.

With self-funding, the funds are in the employer's hands until they're needed, meaning interest on those assets belongs to the employer. Likewise, the money is in hand and usable where needed, when needed.

Federal Preemption and Lower Taxes

In the United States, we are governed by both federal laws and state laws. However, when you can't comply with a state law without violating a federal law, the state law is moot and federal law preempts the state. The Employee Retirement Income Security Act of 1974 states that a private, self-funded health plan is administered in accordance with its terms and federal rules. As such, these plans are not subject to conflicting state health insurance regulations or benefit mandates. Likewise, such self-funded plans are also not subject to state health insurance premium taxes.

Data

These days, everyone talks about "big data," and leveraging data to predict future needs and expenses. A fully-funded insurance carrier owns the claims data they receive and produce. Employers with self-funded plans, however, can examine the claims data, study trends, allocate resources and form partnerships to address their actual needs.

Sharing Is Not Caring

A fully-funded insurance carrier sets premiums based not only on what they anticipate you will cost them, but they add a buffer to cover other employers' employees, to soften the pain of underestimating how much one of those other policyholders will cost. In other words, all policyholders are contributing towards their own expenses and the expenses of others. As such, the steps an employer takes to make their own population healthy don't much impact the bottom line unless all other policyholder employers do the same thing.

With self-funding, the employer pays only the claims of their own population -- so steps taken to reduce the cost directly impact the employer's bottom line. Employees of self-funded companies generally have lower single and family premiums than those with fully-funded insurance.

Overall, these benefits result in net savings for the self-funded plan over a three- to five-year span, compared to a comparable fully-funded insurance policy. Yet there are risks. Among them: the threat of catastrophic claims, inability to fund claims and new fiduciary responsibilities to the members of the plan.

Ordinarily, a self-funded benefit plan will obtain a policy of insurance meant to financially protect the plan. This form of "reinsurance" is called stop-loss. Like most insurance, stop-loss includes its own policy, and a deductible. In a nutshell, a self-funded plan may be forced to pay a substantial amount of money, to treat a participant's costly illness or injury. Any amount that the plan pays in excess of the stop-loss deductible is – after having been paid by the self-funded plan to the medical services provider(s) – submitted to the stop-loss insurance carrier for reimbursement. To illustrate, imagine your self-funded plan has a stop-loss policy, and a deductible of $100,000.00. One of your plan participants is diagnosed with a rare disease; it's treatable, but the cure costs $250,000.00. Your plan pays the $250,000.00 to the doctor. That $250,000.00 exceeds the $100,000.00 deductible by $150,000.00, so you submit a claim for $150,000.00 reimbursement to the stop-loss carrier..

Finally, self-funded health plans operate within the scope of Federal law, and in some cases, State insurance laws as well. As such, there are many protections in place, to secure patient information and ensure proper administration of the plan. For instance, the Health Insurance

Portability and Accountability Act ("HIPAA") ensures that participant's health information (Protected Health Information or "PHI") is kept secure. Further, a self-funded employer is -- or appoints -- a plan administrator. That administrator is a fiduciary of the plan and its members. Applicable law dictates the fiduciary must act prudently, protect the plan and apply its terms judiciously. Failure to comply with these terms, mismanaging plan assets or otherwise doing something not in the plan's best interest could expose the plan sponsor to claims of fiduciary breach, resulting in steep penalties. Fortunately, there are third party organizations that will step in, aid in decision making and act as a fiduciary as it relates to those decisions. This indemnifies the self-funded plan administrator. Such plan administrators serve as a fiduciary decision maker for the plan, and most (if not all) sensitive information is limited to that entity. Additionally, most plans hire an insurance carrier to provide administrative services, or a third party administrator ("TPA") to process the claims. In other words, the self-funded employer is hiring an objective third party to receive medical bills, process claims, and pay the bills with the employer's money – without sharing PHI with the employer. When deciding what to cover, where to focus efforts, etc. (things employers can do to contain costs that they can't do with traditional insurance), the employers will generally look at data freed of personal information. In other words, as an employer, I may see that half my staff is pre-diabetic, and decide that a weight loss benefit is called for. I don't see any individual employee's information; I view the plan as a whole.

Self-funding has its risks, but also presents numerous rewards. As the price of health care continues to increase, many employers who previously had been too risk-averse are second-guessing their decision -- and self-funding.

My company, for example, made the decision to self-fund our health plan nearly a decade ago. Although self-funding is an obvious choice for employers with more than 1,000 lives that can spread the risk among their employees, employers with 100 or fewer workers are at greater risk. If one catastrophic claim is submitted, and the company lacks the population or assets to absorb the hit, the results can be devastating. Yet my company – with fewer than 100 lives at the time -- made the leap.

Over the time we have been self-funding, our contributions dropped drastically from the premiums we had been paying -- by nearly 30 percent in two years. Since then, they haven't increased by more than a few percentage points annually and we have yet to submit a single stop-loss claim.

Our ability to customize and control our plan certainly has helped. We've drafted terms into plan documents empowering participants to notify the plan administrator anytime a costly procedure is being sought. We also reward participants for collaborating with the plan sponsor to identify the most effective yet cost efficient options.

Our health plan already has saved thousands of dollars this year, and awarded employees thousands in incentives as well. A plan member recently sought to obtain surgery with an anticipated fee of $60,000 for the facility, and another $10,000 for the surgeon. After research, we determined the fee was on the high end of the spectrum.

We communicated with some area hospitals and found one facility that would take $20,000 cash up front for everything involved -- with the procedure being performed by the same surgeon. We saved more than 70 percent and a portion of that saving was given to the participant as a reward.

Self-funding isn't for everyone. But for employers willing to get hands-on about their health care, the savings could be monumental -- enough, in fact, to save the employer-based health benefits industry.

Many employers who previously had purchased fully-funded insurance are contemplating dropping their coverage, paying a penalty (per the Affordable Care Act) and allowing their employees to secure individual insurance on the exchanges. That cuts agents out of the mix, and they lose business. Agents who rely solely upon fully-funded insurance, therefore risk losing many of their employer clients.

Agents who educate themselves about self-funding and its benefits can steer their employer clients away from the scenario described above. Agents can use self-funding as a means to keep their employer clients as clients, purchasers of insurance.

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