

Limitations of a fully insured plan

An employer with a fully insured health care plan sometimes feel that they are losing the battle to control the cost of providing health coverage for their employees.

This employer also may find that the insured plans offers a somewhat inflexible design (including state mandates), not permitting a benefit package that best suits the employee group.

Too, effective cost-containment options are not always available in a fully insured plan.

Finally, insurance plans consume dollars that may be spent on other aspects of the total employee benefits package — to curb employee turnover and attract qualified employees.

“Self funding” may be the answer

With self-funded plans, the employer pays health care claims incurred by employees and dependents, and purchases stop-loss insurance to cover claims that exceed a certain amount.

The employer “funds” the claims from reserves built from saved premium dollars that normally would go to an insurance company for a fully insured plan.

Rather than pay premiums for care that employees and dependents *may* receive, the employer only pays to cover the care that the plan members *actually* receive.

A self-funded plan sounds enticing, but employers must ensure that self-funding is right for them.

Self-funding isn't for everyone

An employer must be willing to exercise discipline over:

- 1) benefit eligibility,
- 2) payment of claims, and
- 3) incurring of expenses

The employer also must understand that self-funding may not reduce cost *every* year ... or reduce cost at all.

There are some potential disadvantages:

- ♦ Risk assumption (anticipated claims level vs. the stop loss level)
- ♦ Provision of services by either in-house staff or outside third-party administrator (TPA).
- ♦ Asset exposure to any liability created by legal action against the self-funded plan.

More caution: When the employer has less than 75 lives, does not have proper staff to manage the plan, or has an unstable employee base, probably the plan should remain fully insured.

When to self-fund?

Self funding should be considered when the employer is willing to:

- trade the *complete security* (and its associated costs) of a fully insured plan for the *possibility* that actual costs will be lower than the cost of a fully insured plan.

— become more actively involved in all aspects of the health care plan.

Advantages to self-funding

Maintaining control of reserves — Dollars are not given up until claim dollars are needed by the TPA to pay claims. (The employer's cash flow is critical. Once claims are processed, the employer must have the funds available to pay claims.)

Cash flow benefit — Cash flow is improved when the employer's dollars, formerly held by the insurance carrier in the form of various reserves, are freed for employer's use.

Return on investment reserves — Reserves remain in the employer's control, not in the insurance carrier's control.

Reduce taxes — Save 2% - 3% with elimination of state premium tax on claim fund dollars.

Lower cost of operation — Savings because the self-funded administration cost generally is lower than the administration fee charged by an insurance carrier.

Carrier profit margin and risk charge eliminated — Savings because these costs do not apply to most self-funded plans.

No costly state-mandated benefits — Self-funded plans are not subject to state mandates. An employer does not have these costs added to the self-funded plan unless the employer elects to adopt benefits mandated for fully insured plans.

Effective claim processing — A TPA's success depends on providing accurate, controllable claims processing for each employer, as well as flexible services to meet the employer's needs.

Control of plan design — The employer has flexibility in the original plan design and may redesign the plan to eliminate plan abuses or to enhance/strengthen the plan where needed.

Cost and utilization controls — The employer has full access to cost and utilization controls through the TPA or stop-loss carrier, rather than being limited by the use of an insurance carrier's in-house programs.

Comparing costs of fully insured and self-funded plans

For a fully insured plan, 100% of premiums fund:

- ◆ Profit
- ◆ Premium tax
- ◆ Commissions, fees, etc.
- ◆ Insurer field expenses
- ◆ Insurer office overhead
- ◆ Claim payment costs
- ◆ Other administrative costs
- ◆ Contingency reserves
- ◆ Rate stabilization reserves
- ◆ Claim reserves

For a self-funded plan, 100% of premiums fund:

- ◆ Claim payment costs*

- ◆ Administrative costs
- ◆ Stop-loss insurance

*Claims are paid from reserves. These reserves are kept in trust-yielding tax-exempt interest or interest-bearing trust account, or book liability on the financial statement.

“Self funded” terms

Specific Stop-Loss Insurance: Limits employer’s liability for an individual claim. Insurance reimburses employer’s expenses when an individual claim reaches a set limit, pre-determined by

- 1) Cash flow
- 2) Risk tolerance
- 3) Claims expense

Aggregate Stop-Loss Insurance: Limits employer’s liability for the total claims. Insurance reimburses employer’s expenses when total claims of group reach a set limit.

Aggregate Attachment Point: Amount of total annual claims paid by employer before Aggregate Stop-Loss begins to reimburse.

Types of excess-loss contracts with a stop-loss carrier or “reinsurer:”

- 1) Incurred and Paid (12/2)
- 2) Run-In Claim Basis (15/12 or 24/12)
- 3) Run-Out Claim Basis (12/15)
- 4) **Paid Basis**