BENEFITS TOOLKIT

Self-insured Health Plans

Provided by CME Benefits Consulting

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Introduction

As health care costs continue to climb, employers are actively looking for ways to mitigate these costs. Some turn to cost-sharing methods, like offering high deductible health plans. Other U.S. employers are making the switch to self-insuring as a way to reduce costs and improve service. Self-insuring is not right for every organization. Employers considering a switch from to a self-insured health plan should analyze the advantages and disadvantages before making the switch.

This toolkit serves as an introductory guide to self-insurance. It provides a general overview of what self-insurance is, how it differs from fully funded health plans and its market trends. It is not intended as legal advice. You should consult a legal professional or plan administrator before making the change to a self-insured health plan.

Background

What Is a Self-insured Health Plan?

A self-insured health plan is one in which the employer assumes the financial risk associated with providing health care benefits to its employees. Rather than paying fixed premiums to an insurance company—which, in turn, assumes the financial risk of paying claims—the employer pays for medical claims out-of-pocket as they are incurred.

A **self-insured plan** is a funding arrangement in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims.

How Do Self-insured Health Plans Differ From Fully Funded Plans?

A **fully insured health plan** is the traditional way to structure an employer-sponsored health plan. With a fully insured health plan:

- The company pays a premium to the insurance carrier.
- The premium rates are typically fixed for a year, based on the number of employees enrolled in the plan each month.
- The monthly premium normally only changes during the year if the number of enrolled employees in the plan changes.
- The insurance carrier collects the premiums and pays the health care claims based on the coverage benefits outlined in the policy purchased.
- The covered persons (that is, employees and dependents) are responsible to pay any deductible amounts or co-payments required for covered services under the policy.

With a self-insured health plan, employers operate their own health plan as opposed to purchasing a fully insured plan from an insurance carrier. One reason that employers choose to self-insure is that it allows them to save the profit margin that an insurance company adds to its premium for a fully insured plan. However, self-insuring can expose the company to much larger risk in the event that more claims than expected must be paid. With a self-insured health plan:

- There are two main costs to consider: fixed costs and variable costs.

- The fixed costs include administrative fees, any stop-loss premiums and any other set fees charged per employee. These costs are generally billed monthly by the third-party administrator (TPA), or carrier handling plan administration, and are charged based on plan enrollment.

- The variable costs include payment of health care claims. These costs vary from month to month based on health care use by covered persons (that is, employees and dependents).

- To limit risk, some employers use stop-loss or excess-loss insurance which reimburses the employer for claims that exceed a predetermined level. This coverage can be purchased to cover catastrophic claims on one covered person (specific coverage) or to cover claims that significantly exceed the expected level for the group of covered persons (aggregate coverage).

Self-insured Health Plans and Stop-loss Insurance

One component that many self-insured plans use is an extra feature called stop-loss insurance. The purpose of stop-loss insurance is to provide financial protection to a self-insured plan sponsor by capping and further defining the plan's financial exposure. A stop-loss contract operates differently from general insurance because it is actually insuring the employer and not the individual employee. It is important to grasp this concept. When a plan is self-insured, the stop-loss contract insures the employer against catastrophic losses under the plan. The medical plan established by the employer accepts the responsibility for paying providers' claims for individuals but limits its risk with stop-loss coverage.

Stop-loss insurance is neither health insurance nor reinsurance. It is more closely comparable to a catastrophic coverage plan that indemnifies a plan sponsor from abnormal claim frequency and severity. Stop-loss claim reimbursements can be made for a variety of benefits, including medical, prescription drug, dental and others. Severe, high-dollar claims such as cancer, organ transplants and dialysis are considered "shock loss" claims, which can give plans the most concern when they consider self-insuring. The protection afforded by a comprehensive stop-loss coverage shows its value in helping to financially manage these catastrophic events.

Stop-loss insurance provides protections in two forms:

1. Specific stop-loss—Also referred to as individual stop-loss, it protects a plan against individual catastrophic claim occurrences. This type of stop-loss coverage shifts responsibility for a claim to the insurer once it exceeds a certain dollar amount for a specific claim.
    - Example: An employer with a specific stop-loss attachment point of $25,000 would be responsible for the first $25,000 in claims for each individual plan participant each year. The stop-loss carrier would pay any claims exceeding $25,000 in a calendar year for a particular participant.
2. Aggregate stop-loss—Limits a self-insured plan's financial exposure for the entire plan year (or policy year) and protects against abnormal claim frequency across the entire group of individuals. This type of stop-loss coverage protects the employer against high total-health-plan claims.

- **Example:** Aggregate stop-loss insurance with an attachment point of $500,000 would begin paying for claims after the plan's overall claims exceeded $500,000. Any amounts paid by a specific stop-loss policy for the same plan would not count toward the aggregate attachment point.

Advantages of Self-insurance

The primary reasons employers cite for self-insuring are:

- **Reduced insurance overhead costs**—Carriers assess a risk charge for insured policies (approximately 2 percent annually), but self-insurance removes this charge.
- **Reduced state premium taxes—**Self-insured programs, unlike insured policies, are not subject to state premium taxes. The premium tax savings is about 2-3 percent of the premium dollar value.
- **Avoidance of state-mandated benefits—**Although both insured and self-insured plans are governed by federal law (predominantly ERISA), self-insured plans are exempt from state insurance laws. State benefit mandates can add to the cost of insured employer benefit programs. For multi-state employers, self-funding can help create national consistency by elimination of the need for state-by-state compliance.
- **Employer control—**Employers who want to revise covered benefits and the levels of coverage are free from state regulations that mandate coverage and the carrier negotiation typically required with changes in insured coverage. By self-funding, employers are able to design their own customized health benefit packages.
- **Employers see improved cash flow since they do not have to prepay for coverage—**Claims are paid as they become due. There is also a cash flow advantage in the year of adoption when "run-out" claims are being covered by the prior insurance policy. Employers pay for claims rather than premiums and earn interest income on any unclaimed reserves.
- **Choice of claim administrator—**An insured policy can be administered only by the insurance carrier. A self-insured plan can be administered by the company, an insurance company or independent TPA, which gives the employer greater choice and flexibility. When selecting a TPA, employers should consider whether the TPA efficiently handles claims, has contacts with stop-loss carriers, has a strong reputation, cost management skills and negotiating clout, has medical expertise on staff, and provides excellent customer service and claims administration.

Note: Talk to an attorney for self-insured health plan specifics related to your state. This guide is intended for informational use only and uses general statements.

Disadvantages of Self-funding

While self-funding can have its advantages, it can be a lengthy process for employers, and it can sometimes be a long time before they see results. This section outlines other potential disadvantages to self-funding.

- Greater risk—The main risks of self-insuring involve situations where claims are higher than anticipated. While stop-loss coverage will protect employers from paying excessive claims in a given year, the cost of that coverage will likely increase, and it may be more difficult to get rates from other stop-loss providers. Claims that are higher than expected in a self-insured plan may also make it more difficult for employers to go back to a fully insured plan in the future. And, an employer's assets may be exposed to liability as a result of any legal action taken against the plan. Legal matters in regards to self-insured plans can be complex.
- Higher administrative costs—For organizations that choose to run their self-insured plans internally, the administrative costs involved can be significant. However, using TPAs to operate the plans will still likely involve lower administrative costs than those associated with fully insured plans.

Self-insurance: A Rising Trend

According to the Kaiser Family Foundation and the Health Research and Educational Trust's Employer Health Benefits 2018 Annual Survey, 61 percent of covered workers are in a self-insured health plan. Of these covered workers, 13 percent are workers in small firms and 81 percent are in large firms. Generally speaking, as the number of workers in a firm increases, the percentage of covered workers in a self-insured plan increases. Experts believe this is because large firms can spread the risk of costly, large claims or unexpectedly high expenses over a larger pool of workers and dependents. These trends are on par with what the market has seen in the past few years.

What Types of Self-insured Plans Are Workers Enrolled in?

When it comes to the different types of self-insured health plans workers are enrolled in, the trends are fairly stable between 2008 and 2018 for health maintenance organizations (HMOs) and preferred provider organizations (PPOs). However, the trend significantly increased for high deductible health plans with a savings option (HDHP/SO).

- Percentage of covered workers enrolled in a PPO:
    - 2008: 64 percent
    - 2018: 67 percent
- Percentage of covered workers enrolled in a HDHP/SP:
    - 2008: 35 percent
    - 2018: 65 percent
- Percentage of covered workers enrolled in an HMO:
    - 2008: 40 percent
    - 2018: 39 percent

Do the Average Premium Contributions Differ Between Self-insured and Fully Funded Plans?

In 2018, covered workers in firms that were partially or completely self-funded contributed about 25 percent of their total premium cost, while covered workers enrolled in fully insured plans contributed about 36 percent of the cost. For single coverage in 2018, there was no difference in average premium contribution between workers enrolled in self-insured plans and workers enrolled in fully insured plans.

Making the Decision: Considerations

When deciding if self-funding is right for your organization, make sure that you consider the following best practices to ensure that your self-funding strategy is appropriate and effective.

1. Evaluate Stop-loss Coverage. Most self-insured employers purchase stop-loss insurance on their self-insured health care benefit plans to reduce the risk of large individual claims or high claims for the entire plan. The employer self-insures claims up to the stop-loss attachment point, which is the dollar amount above which claims will be reimbursed by the stop-loss carrier. Obtain stop-loss quotes at several different levels.
2. Understand the volume and nature of your employee health claims for the past five years. Knowing facts such as whether your workforce is mostly young or old, whether the majority of claims were due to chronic illnesses or one-time incidents, and the total dollar amount of claims will help you budget for claims in the future. Self-funding should be viewed as a long-term strategy in which good and bad years average out in the employer's favor.
3. Analyze cash flow. Self-insured plans work best for companies that have a strong cash flow or reserves. Understand what your cash needs are so you have money available to make timely claim payments.
4. Decide whether it makes sense to administer the plan internally or through a TPA. If you decide that it is best for your organization to use a TPA, make sure you factor TPA fees into your decision to self-insure. Obtain several different TPA quotes. Your TPA should offer a strong plan for monitoring the plan.
5. Make coverage goals. Decide on such things as eligibility, benefit coverage, exclusions, cost-sharing, policy limits and retiree benefits. Weigh the self-insured plan advantages of flexibility and lower average cost versus the increased risk and administrative responsibilities.

Summary

Self-insuring health benefits can provide many advantages for employers. However, it is important for employers to do their due diligence before deciding if self-insurance may be the right choice.

There are certain attributes that an employer must have in order to successfully manage their health benefits, including the following:

- Risk tolerance
- A steady employee population
- Stable claims experience
- Employee involvement in cost-savings strategies

Because the employer assumes the financial risk of providing health care benefits, a company can either save or lose money depending on the level of claims incurred by its employees. The most important step you can take to assure that you make the best decision is to have an experienced professional assist you. Your CME Benefits Consulting representative has experience with self-insurance programs, and can answer your questions and assist you with your decision to self-insure your company health plan.

CME Benefits Consulting welcomes the opportunity to help your organization examine its plan designs and make recommendations for improvement.

Self-insured vs. Fully Insured

Self-insured		Fully-insured
The employer does not pay premiums; instead, it pays fixed costs (administrative fees and stop-loss premiums) and variable costs (employee health care claims).	**PAYMENTS**	The employer pays monthly premiums to an insurance carrier.
The employer assumes the risk.	**ASSUMPTION OF RISK**	The insurance company assumes the risk.
Employers have more control and freedom in their plan designs.	**PLAN DESIGN**	Employers are more limited by insurers' plan design options.
The Employee Retirement Income Security Act of 1974 (ERISA) pre-empts state regulations.	**COMPLIANCE PAYMENTS**	The plan must comply with state regulations.