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UBA WisdomStream

Self-Funded Plans: A Solid Option for Small Businesses

Rising costs and changing regulations are making small companies look outside of the box for employee health care options.

UBA United Benefit Advisors
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The Patient Protection and Affordable Care Act (ACA) is now eight years old

When it was enacted, the ACA brought new requirements, including an employer mandate, which has prompted many employers to take a hard look at what they were doing—and paying—for employee benefits.

While cost-sharing and cost-shifting are common strategies to cope with overall costs, small and midsize employers have been taking an even bigger plunge into self-funded health care plans, which used to be considered an alternative funding method that was only feasible for big companies. As the industry has continued to evolve, self-funding, especially among small groups, has been slowly and steadily rising.

In a self-funded plan, the employer—not the insurance company—assumes the risk and cost fluctuations associated with its health care plan. Plan costs can fluctuate by month (or even by week), depending on the claims submitted by the company's employees. By contrast, a fully insured (or group) plan relies on the insurance carrier to assume the risk and plan administration.

The 2017 UBA Health Plan Survey found that 12.8 percent of respondents overall have a self-funded plan (up from 12.5 percent in 2016), while slightly less than two-thirds (60.9 percent) of all large employers' (1,000+ employees) plans are self-funded.

> "[When it comes to] small employers (under 50 or 100 employees, depending on the state where the plan is domiciled), the ACA does not allow an employer to impact the health insurance rates of its employees,"
>
> — KEITH MCNEIL, PARTNER AT ARROW BENEFITS GROUP

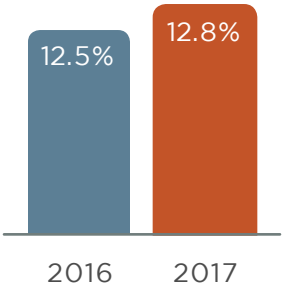
Given this, self-funding may be particularly attractive to small employers with healthy groups since fully insured community-rated plans under the ACA don't give them any credit for a healthy population. Questions in the marketplace about the long-term future of the ACA definitely impact the growth potential of self-funded plans.

According to Jeff Hadden, a Partner at Indianapolis-based LHD Benefit Advisors, the ACA rules and community rating were a main driver for more and more small employers to evaluate self-funding. So, with the long-term future of the ACA being uncertain, the pace of employers with fewer than 50 employees investigating self-funding could be slowed until any changes with the ACA are stabilized.

"However, I believe employers with more than 50 employees will continue to evaluate self-funding or partial self-funding," Hadden said.

2017 SELF-FUNDING STATUS

From the 2017 UBA Health Plan Survey



Overall have a self-funded plan

LESS THAN

2/3

(60.9%)

of all large employers' (1,000+ employees) plans are self-funded

Self-Funding as a Way to Stay Nimble

Employers use partially self-funded plans in order to take advantage of the cost saving options that exist in today's marketplace, McNeil explained.

"That will likely continue, but the BUCAs (Blue Cross, United, Cigna, Aetna)—for all of their being in the news about mergers—will not be able to offer the kind of nimbleness and innovation that a self-funded plan can," he said.

Self-funding, on the other hand, offers more control over the dynamics of the plan.

Ken Liberatore, Vice President of Benefits at Paradigm Group, noted that with a fully insured plan, plans and standard benefit options are filed by the insurance company with the regulatory body, and typically offer limited flexibility.

> As the insurance company is assuming the risk associated with a fully insured plan, employers may be able to adjust copays, deductibles or coinsurance, but only within the guidelines. Small employers may have less flexibility than larger employers in terms of customization.
>
> — KEN LIBERATORE, VICE PRESIDENT OF BENEFITS AT PARADIGM GROUP

But with self-funded plans, an employer has significantly more flexibility in plan design, often only limited by the capabilities of their third-party administrator (TPA).
"Beyond plan design (such as copays and deductibles), employers may be able to select location-specific networks, utilize high performing networks driven by plan design, select a specific PBM (pharmacy benefit manager), customize their prescription drug formulary, and incorporate wellness programs aligned with the underlying plan design," Liberatore said.

There is also the convenience that bundling brings, notes John Hearn, Principal of The Benefit Company.

"The attraction of a fully insured program is that all components are bundled in an easy, streamlined process, and the premiums during the plan year are guaranteed level," he said.

The bundled components within fully insured arrangements (which drive costs) include, but are not limited to, stop loss, pharmacy benefit management, reserve building, case management, and claims paying.

"All else being equal, the simplified process and level premiums are ideal. But at what cost? All else is not equal," Hearn said.

2017 SELF-FUNDING GROWTH

From the 2017 UBA Health Plan Survey

▲ 48%

for employers with 25-49 employees

5.8% OF PLANS

▲ 13.4 %

for employers with 50-99 employees

9.3% OF PLANS

Hearn added that with everything bundled, there is little transparency of charges within the underlying cost of components, and excess costs in multiple areas grow to a meaningful cost difference.

“Three percent matters,” Hearn said. “If you trend your medical plan at eight percent versus five percent over six years, the cumulative variance is worth one half of what you are spending today.”

In short, Hearn says it’s worth scrutinizing the various components to find a best-in-class and transparent option for PBMs, stop loss, claims payment, and case management, among others. “To do so is to avoid death by a thousand cuts,” he said.

McNeil noted an example at his company.

“Arrow Benefits has a self-funded client that uses a BUCA as an ASO (administrative services only) provider,” he said. “They use Vital Incite to perform deep dive data analysis including a Provider Efficiency Report that shows for any given CPT (Current Procedural Terminology) code. The highest cost can be ten or more times the lowest cost. These were approved charges that the plan paid. That is why the BUCAs will not be the answer. They are beholden to their provider contracts at the expense of their clients.”

While self-funding has always been an attractive option for large groups, in recent years it has become desirable to employers of all sizes as a way to avoid various cost and compliance aspects of health care reform.

With health care reform upending the benefits landscape, employers have even more incentive to explore self-funding options because this type of funding offers some relief from the mandates and fees associated with the ACA.

> The rigid community rates leave no room to adjust them based on claims experience. Many employers wish to be innovative and try to do something about that, which means looking at something beyond ACA plans.
>
> — KEITH MCNEIL, PARTNER AT ARROW BENEFITS GROUP

Since 2014, the ACA has required fully insured plans with fewer than 50 lives to adhere to “community rating” rules, which means the cost of insurance will not be based on health factors, according to the Congressional Research Service (CRS). Rates may vary only by age, tobacco use, self-only or family coverage, and region. Beginning in 2016, the community rating rules will apply to fully insured plans with fewer than 100 lives.

Hadden said the community rating and other reform-related changes could have a major impact on future costs for employers in fully insured plans.

“You have to worry about the community rating,” he said. “Even in a very healthy group it may be difficult to capture savings. If groups are self-funded with appropriate levels of protection in place, they have more control over their costs and don’t have to be driven by the community rate.”

PROS OF SELF-FUNDING

- Potential for significant savings (on fixed costs such as administration and insurance costs for catastrophic claims). An employer should realize 5% to 8% lower cost with a self-funded program.
- 5+% reduction in ACA and premium taxes compared to a fully insured plan and the elimination of fully insured plan profit margin
- Greater flexibility in plan design and avoidance of most or all state mandates
- Greater potential for employee and employer engagement
- Ability to evaluate each component of the plan separately
- Vastly increased knowledge of the plan, its claims experience, and component costs (HIPAA protected)
- Ability to install wellness, biometrics, bundled pricing, direct contracting, etc., to reduce claims costs on a direct basis
- Greater ability to save money through use of telemedicine providers (which is becoming an important trend for the future)
- Much greater ability for the HR department to act in a strategic and consultative manner
- Greater ability to create special networks, centers of excellence, and potential medical tourism
- Ability to look at enhanced reference based pricing and value-based insurance design

Using Stop Loss to Manage Risk

By its very definition, a partially self-funded plan takes on risks.

Hearn notes that only the very large employers assume all of the risk associated with self-funding—the majority purchase some form of stop loss insurance (also referred to as reinsurance).

"Stop loss insurance is purchased in two forms," he said. "Individual specific stop loss and aggregate stop loss. It is very important that an employer purchase the appropriate level of individual stop loss and even more important that they purchase a quality stop loss contract. Evaluating the quality of a stop loss contract is perhaps the most important advantage an advisor can provide his or her client."

In discussing the basic differences between self-funded and fully insured plans, Liberatore notes that fully insured plans have the employer transferring risk to the insurance company. With fully insured plans, there is a fixed premium for each person (employees and dependents) while the insurance company assumes the cost of administration and claims as they emerge during the plan year and continue after the plan year.

"However, in a self-funded plan," he said, "the employer pays the TPA a fixed administration fee per person enrolled in the plan and [there is] risk in several forms. Medical and pharmacy claims (being variable costs of the plan) will fluctuate throughout the year and could present as significant swings above and below the expected threshold."

Larger employers expect to see less fluctuation, but that risk remains, he says. Individual large claims also pose risk to an employer, as these are often unexpected and potentially ongoing.

This is when implementation of appropriate levels of stop loss coverage can protect the employer from some (but not all) risk exposure, Liberatore says. "With risk often comes the potential for reward. If claim activity is better that expected, the employer wins."

McNeil offers an example of how risk can be minimized by the levels of stop loss insurance purchased.

"For example," he noted, "the plan might purchase a deductible of $35,000 or less to $500,000 or more. The employer can then use risk management techniques to compare the premium for the stop loss coverage to the level of risk. The employer must determine how much risk its cash flow will allow."

Hearn says the level of stop loss is a question of risk tolerant. "If an employer is risk tolerant, they buy less stop loss coverage and pay a lower premium. If they are risk averse, they pay a higher premium for more stop loss insurance."

He also says that actuarial decision support tools are used to help select the correct level of stop loss for employers who are unsure.

CONS OF SELF-FUNDING

- Chance for higher costs due to unpredictable claims experience
- HMO plans replaced by potentially less economically-efficient EPO plans (such as an HMO on a PPO chassis)
- More employer engagement required to optimize effectiveness
- Self-funded plans can be more complicated at the employer level (but generally not for employees)
- Less predictable cash flow, and IBNR run-out issues (such as reserve calculations)
- Asset exposure to fund claims
- Internal Revenue Code §105(h) discrimination testing that applies to self-funded plans only
- Wellness and biometrics (if instituted) might cause employee morale issues if not handled correctly
- More technical expertise required on the part of the advisor/ consultant

Doing Wellness Right

Wellness programs can be extremely important in making a self-funded program more successful. However, according to Hadden, it is important that the wellness program be customized to address the short- and long-term goals of a self-funded employer.

"It is quite possible that a wellness program could add costs in the short term as most programs promote preventive care costs that may not have been incurred had a program not been implemented," he noted. "It's a well-known fact that a surprisingly limited number of individuals incur a majority of costs in a group health plan."

Hadden says it's important to implement programs that identify medical conditions early, because this can lower the ultimate costs of treating those conditions. In the best-case scenario, a well-developed wellness program can actually help individuals maintain or lower clinical risk factors and help avoid associated medical claims.

McNeil noted that there is potential to have a big impact by using data analytics to find the "ticking time bombs" in your group, and provide targeted vendors to help those with chronic conditions.

His perspective is that part of the solution for lowering health care costs is education and getting the employees to act as part of the solution when it comes to finding lower cost care and other ways to save money.

> Wellness might help with that somewhat by showing the employees that the employer does care about them. That could be the springboard to creating employee engagement in being part of the solution.
>
> — KEITH MCNEIL, PARTNER AT ARROW BENEFITS GROUP

Particularly because it's difficult to prove the ROI of wellness programs, Hearn says that employee engagement of the right population is crucial. "The most effective population health management programs "cut the hole in the ice where the fish are," he added.

"There is no doubt that employers (and employees under an HSA) who have skin in the game view Population Health Management differently. For instance, employers who are self-funded and paying their own claims are far more likely to offer and incentivize telemedicine, clinics, data analytics, case management, and price/quality transparency solutions. I've said often, 'If it's free, I'll take two,' and we have to get all stakeholders focused on maintaining costs."

CONS OF Self-FUNDING

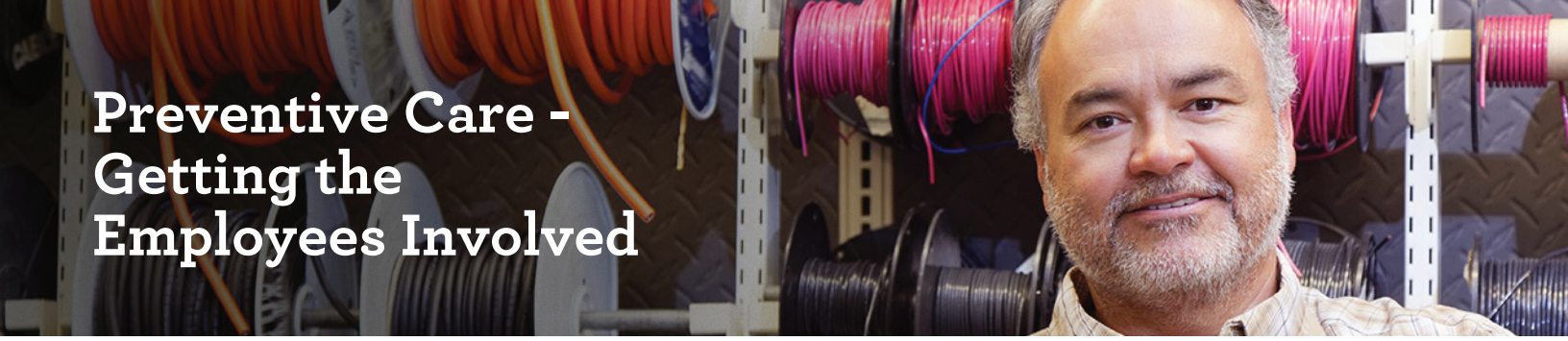
The employer or plan sponsor insures the members, not the insurance company or stop loss carrier. (This makes tying the plan document to the stop loss carrier's exclusion critical.)

Insurance carrier or health plan tools and resources for wellness, etc., might not be available if self-funded (some of the tools might be available if that provider's PPO network is rented)

Somewhat increased reporting requirements (ACA tracking, state compliance on-going work, etc.)

Stop loss coverage can be more price sensitive to ongoing claims than a fully insured program

Potential to purchase the wrong type of contract that could expose an employer to unintended or unforeseen costs



Preventive Care - Getting the Employees Involved

Obtaining stop loss insurance, conducting risk assessments, and instituting wellness programs are all crucial elements of switching to self-funding. So are developing processes for claim funds, cash flow, updating documents, and bill reconciliation—that's where an experienced benefit advisor can help. But don't forget about the employees, their engagement, and their preventive care.

McNeil recommends finding a way to motivate employees to see their primary care physician and to have an ongoing relationship with him or her.

"Using your plan design, you can incentivize members to have checkups—such as lower premiums or lower deductibles if they do," he said. He also recommends educating employees and making sure they know the plan is self-funded. "Tell them that everything that they do [in terms of preventive care and working with a primary-care physician] helps the company bottom line, which means more money for salary and bonuses."

According to Hearn, the first priority is to focus on employer culture.

"The employees have to know and believe their company is doing something FOR the employees, versus TO the employees," he said. "Once the culture is established, premium differential and gift cards are useful in creating engagement. An important point is to ensure, through the use of data analytics, that the right employees are engaging in the wellness initiative."

Once employees are engaged and on board, small businesses are poised to make a smooth transition to a funding strategy that will allow them to create a flexible and cost-effective health care plan.

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