Stepping Out of the Box

How to use self-funded insurance to lower costs and tailor health plans to your employees

From greater flexibility to lower costs, self-funded insurance is attracting the attention of more and more employers.

“Self-funding plans have been gaining popularity as a way for companies and employees to save money in the face of the recession, recent health care reform and increasing health care costs,” says Mark Haegele, director, sales and account management, for HealthLink. “Health care reform adds a number of taxes and restrictions on fully insured companies that those on a partially self-funded basis are typically able to avoid.”

What’s the difference between a self-funded and a fully insured health plan?

With self insurance, or self funding, the employer assumes the financial risk of providing health care insurance. Typically, the company sets up a trust of corporate and employee contributions that are administered in house or subcontracted to a third party. A company can either hire a third-party administrator (TPA) or do the administration itself to save on fees that would normally go to an insurance company. A TPA can also take on fiduciary responsibility with reinsurance to further protect the employer.

When an employer is fully insured, it pays a fixed premium to an insurance carrier that assumes all of the risk.

Why would an employer choose to self-fund?

There are a number of reasons to go with self-funded insurance, and flexibility is one of the biggest selling points. For example, Company A can choose to exclude bariatric surgery on its health plan and Company B can include it, depending on its employees’ specific needs. In Illinois, the state mandates that fully insured businesses must pay for bariatric surgery, so only with self-funding do businesses have the ability to choose.

In another example, under self-funded insurance, an employer can identify disease prevalence and assign benefits to accommodate its employees' specific needs. So, if an employer discovers a higher incidence of asthma and diabetes in its employee population, as a self-funded employer, it can choose to pay 100 percent of all of the services required to manage those illnesses. This keeps employees healthier — and out of the costly ER and hospital — by ensuring they maintain their treatment protocols for that particular illness.

It's about identifying the makeup of the employee population, and designing and building self-insured plans to really support that population's needs; you're not stuck in a box of what you have to provide, based on what the state mandates or on your insurance company's systems.

In addition, you can maximize your interest income on premiums that would otherwise go to an insurance carrier, and you can avoid prepaying for health care coverage, improving your business's cash flow.

Finally, self-funded insurance is only subject to federal law, not conflicting state health insurance regulations and/or benefit mandates and state health insurance premium taxes, which can account for 2 to 3 percent of premium costs.

How common is self-funded insurance and how can a company determine if it is the best option for its needs?

Approximately 50 million employees and their dependents receive benefits through self-insured health plans, which accounts for 33 percent of the 150 million participants in private employment-based plans nationwide, according to the Employee Benefit Research Institute in 2000.

There's a myth that self-funded insurance is not cost effective for employers with fewer than 1,000 employees. However, there are many TPAs that offer partially self-funded programs for companies with as few as 10 employees. In most states, including Missouri and Illinois, health care is a guarantee issue for plans with fewer than 50 lives. This means if you have 50 or fewer employees and you try self-funded insurance but it doesn't work out, health insurance carriers must allow you to have fully funded insurance the following year.

However, if you have between 50 and 100 employees, you need to truly understand your risks because returning to a fully funded plan from a self-funded plan could increase your rates dramatically. Make sure that you have a trustworthy broker and/or lawyer review the plan you're going to participate in before making your decision.

If a company assumes the risk of self funding, how can it protect itself from a catastrophic claim?

You can purchase stop-loss insurance for reimbursement of claims above a specified amount through a TPA. Only the employer is insured, not the employees or health plan participants, which means you can avoid most insurance taxes.

There are two types of stop-loss insurance, which acts as reinsurance:

- Specific stop-loss provides protection against a high claim on any one individual. The rule of thumb is $10,000 if you have 10 employees, $20,000 if you have 20 employees, etc.
- Aggregate stop-loss offers a ceiling on the amount of eligible expenses an employer would pay, in total, during a contract period. The carrier reimburses the employer at the contract's end for aggregate claims.

You also can use TPAs to help decrease your risk. A TPA will have existing affiliations with health care networks to help manage the plan and save the most money. TPAs can also help manage the increased complexity of self-funded insurance.

Self funding is more viable than ever for employer groups with as few as 10 employees. Right off the top, employers save 3 to 5 percent of the total cost of their health plan through insurance companies' risk charge and profit, coupled with the other advantages of plan design flexibility and additional tax avoidance associated with health care reform.