Self-funding Interest Rises

How future and historical self-funding benefits combine to draw employers

The historical benefits of self-funded health insurance — lower costs, more flexibility and control — are even more appealing when added to the ability to avoid many Patient Protection and Affordable Care Act (PPACA) rules and expected premium increases.

As a result, there's growing interest in self-funding. A March study by Munich Health North America of 326 executives from health plans, HMOs and insurance brokerages, found 82 percent of respondents saw more interest in self-funding, with nearly one-third seeing significant interest. The survey also found nearly 70 percent of insurance organizations plan to increase selffunding offerings during the next year.

"The PPACA has shed a light on selffunding because it created several new reasons why self-funding or partial selffunding is attractive," says Mark Haegele, director, sales and account management, at HealthLink.

What historical self-funding benefits remain relevant today?

Historically, self-funded employers avoid the risk charge — typically 2 to 4 percent of the total premium — that all insurers build into premiums. Self-funded plans also avoid costs from insurer profit; premium taxes, usually 1 to 3 percent, depending on the state; and the insurance company's fixed operating costs. A fully insured plan can include fixed operating costs that are 40 to 50 percent higher than a partially self-funded plan with a third party administrator.

Plan flexibility and control is the other overarching benefit of self-funding or partially self-funding. You don't need to follow state coverage mandates for areas like autism, bariatric surgery and infertility treatments. Employers can customize plans based on member population needs.

Smaller, self-funded employers also receive detailed member data, resulting in the ability to make informed decisions. With the help of consultants and brokers, they can manage their population as much or as little as they want.

Why is health data more critical now?

The health care system is moving from a fee-for-service to a performance-based model, so transparency and information are more critical. If you expect members to make good purchasing choices, then employers and their members must know what services cost. This transparency is one of the staples of a self-funded plan. Employers know what services members partake in, the plan risk factors, what care those with chronic illnesses receive, etc.

What is drawing employers to self-funding because of the PPACA?

A number of pieces from the PPACA aren't required under self-funding, including the:

- $8 billion insurer tax, currently calculated to be passed onto employers as a 4- to 6-percentage point increase in premiums.
- Medical loss ratio requirements, which force profitable insurance companies to reduce administrative expenses and ultimately lower service levels.
- Community rating rules that group small employers by geography, age, family composition and tobacco use. Thus, healthy, younger insurance groups will pay more — estimated to be 60 to 140 percent — while older, less healthy member groups pay less.
- Minimum essential benefits, where insurance companies are required to limit annual deductibles.

How are PPACA-driven premium increases already factoring in?

Although the PPACA's community rating rules, insurance tax and minimum essential benefits don't begin until Jan. 1, 2014, the repercussions have started. Some carriers are including extra 2013 premium increases. For example, rather than a 4 percent premium increase now, insurers might try to get employers to accept a 20 percent increase this year. In addition, despite state pushback, many insurance companies are considering offering an early renewal — changing the plan effective date from Jan. 1, 2014 to Dec. 1, 2013, for instance — to let employers temporarily avoid increases. However, those with a selffunded plan never have to worry about these costs.