



## Is Self-Insurance for You?

Vol. 56 No. 5

*Health care reform could prompt a move to self-insured health plans to reduce costs.*

5/1/2011

By Joanne Sammer

As health care reform moves forward, employers face important questions about managing their health plans. One question focuses on whether self-insurance makes more or less sense in the age of reform.

At its core, the choice to self-insure a health plan is a business decision. As with any business decision, executives should revisit the self-insurance question regularly to make sure their solution still makes sense and remains the most financially attractive option.

In light of health care reform, fully insured employers—those that purchase a plan from an insurance company—may want to consider self-insurance. Health care reform has introduced new requirements for health insurers that are likely to affect the cost and structure of insured health benefits. For example, the “medical-loss ratio” requirement limits the amount insurance companies can spend on administrative expenses. Self-insured plans are exempt from that rule.

“Changes to minimum medical-loss ratios for insurance companies are likely to make insured coverage more complicated and more expensive,” says Tom Lerche, national health care reform leader with Aon Hewitt in Chicago. “If there is a higher cost to underwrite a fully insured plan and the increases are higher than previous years, more employers are going to look at how feasible self-insurance is.”

Employers that self-insure health plans are directly responsible for paying medical claims rather than paying for conventional health insurance policies. A self-insured employer chooses its plan design and usually hires a third-party administrator to manage the plan. Employers that cannot afford or do not want to be responsible for catastrophic claims purchase stop-loss insurance that covers claims after they reach a certain level. Health care reform’s elimination of annual and lifetime payment caps has made stop-loss coverage more imperative, analysts say.

According to the *Employer Health Benefits 2010 Annual Survey* of 2,046 U.S. employers, 59 percent of their workers are covered by self-insured health plans. Large employers with 1,000 or more employees are far more likely to self-insure, the survey from the Kaiser Family Foundation and the Health Research & Educational Trust shows. However, there seems to be some movement toward greater self-insurance among mid-size plans.

Researchers saw a 10 percentage point increase in employees covered by self-insured plans sponsored by mid-size employers with 200 to 999 employees—from 48 percent in 2009 to 58 percent in 2010. That figure represents a 10-year high for this category of employer. Employers with 199 or fewer employees remain much less likely to self-insure. Just 16 percent of employees in these smaller organizations are covered by self-insured plans, although the percentage has increased since 2008, when it was 12 percent.

### Why Self-Insure?

Historically, self-insured health plans have been attractive to many employers because of the relative freedom these plans provide. Health care reform has not changed that. “The pros and cons of self-insurance are probably much the same as they were before health care reform,” says Kerry Finnegan, a senior partner with global HR consulting firm Mercer in Chicago.

Self-insured employers have greater control of their health plans and more options for controlling costs than do fully insured employers. Self-insured employers can design a plan that meets the needs of their employees without being shoehorned into existing insurance products. Moreover, thanks to the Employee Retirement Income Security Act, self-insured health plans are exempt from state insurance laws covering reserve requirements, state-mandated benefits, premium taxes and so forth.

More recently, employers have begun to leverage the wealth of claims data from their plans to provide wellness and health education programs to employees. "Self-insurance allows employers to control plan design and to collect claims data that they can use to identify the health issues that are driving claims costs in their population," says Helen Darling, president of the National Business Group on Health in Washington, D.C.

"Self-insured employers have a greater ability to use innovative new concepts," agrees George Pantos, executive director of the Healthcare Performance Management Institute, a research and education organization based in Bethesda, Md.

With claims data, self-insured employers can use analytics, metrics and predictive modeling to track costs and the underlying drivers of those costs, then take steps to control them. As long as they comply with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), self-insured employers can have their plan's third-party administrator or a HIPAA-compliant health management services provider identify and reach out to individuals at risk for certain conditions, such as diabetes, stroke or cardiovascular disease, with information and interventions.

This is a major attraction for employers looking to take aggressive steps to rein in health care costs. Moreover, any savings that a self-insured employer realizes directly affects its bottom line. By contrast, a fully insured employer must wait until it renews its agreement with its insurance carrier to see if lower costs and fewer claims will reduce premiums.

### Self-Insurance for All?

Self-insurance remains most prevalent among large employers. Far fewer small companies self-insure. Small companies may forgo self-insurance for sound business reasons. However, at least some merely assume that self-insurance is not a viable option for them. "The conventional wisdom is that you need at least 250 employees to self-insure health benefits," says George Pantos, executive director of the Healthcare Performance Management Institute. However, "even employers with fewer than 25 employees have been able to self-insure."

Other observers agree. "If the right protections are built into the program, there is no reason why almost any company should not be self-funded," says Bill Lavis, a partner with Sitzmann Morris & Lavis Inc.

To begin evaluating the self-insurance option, take a hard look at costs. This means making an apples-to-apples comparison of the costs of self-insured and fully insured plans. While the cost of a fully insured plan is relatively straightforward, calculating the projected cost of self-insurance is not so simple. In general, any such calculation should factor in the following elements:

- Projected claims minus any investment returns on reserve funds.
- The cost of any vendors hired to manage the plan, including third-party administrators.
- The cost of any stop-loss insurance the company purchases.

Once you have completed that calculation, consider a less concrete factor—the risks associated with self-insurance. Claims can still be higher than expected and can come in peaks and valleys that do not necessarily reflect the company's cash flow. That is true even with a stop-loss insurance policy in place. By contrast, a fully insured plan comes with a set premium that is easily budgeted and planned for.

Another consideration is whether to purchase a stop-loss policy and, if so, what kind and with what terms. In general, stop-loss coverage provides aggregate or specific coverage. Aggregate coverage begins when claims for all employees in the plan reach a certain level. Specific coverage begins when claims for an individual employee reach a specified dollar amount. With health care reform's elimination of annual and lifetime payment caps, stop-loss insurance—especially for specific coverage—has become more essential.

Look at the overall stability of your workforce and average turnover rates. Low turnover can make self-insurance

a more viable option for many smaller companies. “You are better able to forecast your future claims, and you can do a better analysis of whether you are a good candidate for self-insurance,” says Mike Ferguson, chief operating officer of the Self-Insurance Institute of America Inc. “If you have a workforce that is constantly in and out, it is very difficult to conduct an effective actuarial analysis that tells you what you can expect going forward.”

The key to the self-insurance decision is how the cost of self-insurance compares to the cost of a fully insured plan. If a company has a lot of turnover, that comparison can be difficult.

—Joanne Sammer

All employer health plans, whether self-insured or fully insured, have to meet new federal mandates:

- Dependent coverage for children up to age 26.
- No pre-existing condition limitations.
- No lifetime limits on coverage.

Self-insurance may help employers contain the costs associated with these mandates.

“Self-insured companies that actively manage their costs are in a better position to control costs now that the mandates have taken effect,” Darling says. “Self-insurance gives the employer the most freedom to define the benefits and the health plan appropriate for their workforce. Most employers would not consider going back to an insured plan. Things could change to make self-insured plans less attractive, but so far it hasn’t happened.”

### Reeling from Reform

Most analysts expect that the federal mandates implemented in 2010 will increase employer health care costs. “The mandates are going to cause rates to increase by maybe 3 percent to 5 percent at the outset,” says Bill Lavis, a partner with Sitzmann Morris & Lavis Inc., an insurance advisory company in Oakland, Calif. “That means that all efforts to try to control costs just got 3 percent more difficult.” He notes that health care reform has diverted employers’ focus away from identifying and addressing what is driving claims costs and toward compliance and other issues.

At self-insured employer SuperMedia Inc., a Dallas-based advertising agency with 5,000 employees, executives anticipated a 2 percent to 3 percent increase this year above their normal health care costs, after factoring in the additional cost of the new federal mandates and other changes.

SuperMedia’s leaders dealt with this by changing the plan design. “We had to manage that, frankly, by restructuring offerings and changing the contribution level to increase what employees pay while maintaining competitive benefits plans,” says Georgia Scaife, executive vice president of human resources and employee administration. “The amount of the increase depends on the employee’s family situation. Some employees with dependents saw increases of 20 percent.

“When we implemented the new rates, employees were not happy but I did not get the outcry that I anticipated,” says Scaife. She credits extensive communication.

Like leaders at many self-insured employers, SuperMedia’s executives have taken other steps to manage health care costs. For several years, they have been consolidating health benefits plans to reduce administrative costs; the company has gone from having 100 plans for active employees to having eight.

At the same time, Scaife strives to create a culture where employees are accountable for managing their own health and medical conditions. The company has a robust wellness program that provides health risk assessments, health monitoring and coaching. The message is that if employees care for themselves, they can reduce their own costs—and company costs. “We are seeing employees make far more educated choices around their benefits offerings and what makes sense for them and their families,” Scaife says.

Despite rising health care costs, the company has no plans to stop offering health benefits. “We have a brand around who we are, and we are not planning to get out of the benefits business,” Scaife says. “We want to be a company that is competitive and can offer a competitive pay and benefits package to attract the best talent.” To make that point,

the company provides employees with comparisons between SuperMedia's benefits offerings and those of its competitors.

## A Strategic View

Employers that opt for self-insurance would do well to develop a strategy to manage their health plans and capture savings that result from reduced plan costs. But what is the best way to achieve that goal and provide competitive coverage to employees?

In 2010—the first year of health care reform—employers were preoccupied with compliance issues surrounding mandates and understanding the long-term implications of the law. “The focus was on compliance, not strategy,” Lerche notes. Employers face fewer compliance requirements in this second year of health care reform because some of the major changes originally scheduled to take hold in 2011 were postponed.

For instance, administrators of fully insured plans will not be required to perform nondiscrimination testing this year to ensure that their plans do not favor highly compensated participants. The nondiscrimination rules already apply to self-insured plans, but the Internal Revenue Service (IRS) delayed their application to fully insured plans until further guidance is issued. The IRS also announced that employers will not be required to report the cost of group health benefits on Forms W-2 in 2011.

Therefore, 2011 represents a window of opportunity to assess strategy and change programs. Come 2014, states will have to establish health care exchanges that have the potential to alter the landscape, as insurance companies in the exchanges compete for customers that do not have employer-provided plans. “If you wait until 2014, it will be too late,” Lerche says.

Employers can use this relative lull to focus on updating or creating a health care strategy that is right for them, Lerche says. “They need to understand the demographics of the workforce and identify what disease states are prevalent in the population so they can design a strategy that will result in a lower long-term medical cost trend,” he explains.

Start strategy discussions with a report on current wellness and health management efforts. Include the percentage of employees completing a health risk appraisal or undergoing annual biometric testing. From there, look at whether employees are actively improving their health by completing courses on smoking cessation, for example, and whether the company has an effective process for measuring changes in employee behavior. Finally, create a culture of health and send the message that getting healthy is critical to the company's mission.

An organization's leaders need to give priority to developing a healthy culture. “Getting to a lower cost trend often has nothing to do with plan design and everything to do with employee behavior,” Lerche says. “If the strategic goal is to have greater employee accountability, employees must be fully engaged and not just participating in wellness, disease management and case management programs.”

## What's Ahead

Significant external changes—such as the newly enacted federal mandates, along with other elements of health care reform and the advent of the health care exchanges in 2014—should encourage HR professionals to revisit the self-insurance question, if only to confirm that their current plans still make good business sense.

“We are in a waiting period between now and 2014 when health insurance exchanges come into play,” says Mike Ferguson, chief operating officer of the Self-Insurance Institute of America Inc., a nonprofit trade group based in Washington, D.C. “Although few employers are likely to make public statements, no doubt they have had internal discussions and conducted analyses to determine their options and what they will do in 2014.”

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