Health Plan Funding Options:
An Employer’s Decision Guide
A White Paper by Manning & Napier

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Unless otherwise noted, all figures are based in USD.
Introduction

Health plan costs rank among the highest concerns of U.S. employers, and with good reason, since health care cost increases have outpaced inflation for years. As shown in the chart below, average health plan costs increased dramatically over the past decade1.

![Chart showing average health plan costs from 2003 to 2013](image)

Data obtained from Kaiser/HRET Survey. Analysis performed by the Client Analytics Group of Manning & Napier Advisors, LLC.

Many factors have contributed to these increases, including:

- Unhealthy lifestyles
- Federal and state benefit mandates
- Aging population
- Increased utilization
- Advances in medical technology and prescription medications
- Direct-to-consumer advertising and increased consumer demand

Regardless of the reasons behind the increases, most employers are not able to absorb increases of that magnitude over the long term, particularly in the current economy. Employers pay the vast majority of health plan expenses for their employees, averaging 82% of the cost of single coverage and 71% of the cost of family coverage in 20131. Faced with this necessary cost of attracting and retaining talent, employers have a multitude of decisions to make in designing a health plan that is both valued by employees and sustainable in terms of employer costs.

Among these decisions are:

**Coverage level**
- How much will the plan pay for covered services?
- Will the coverage be different for in-network versus out-of-network providers?

**Employee contribution strategy**
- What share of costs will be passed on to employees?
- Will employees pay flat dollar co-payments or a coinsurance percentage? What about a deductible?

**Vendor selection**
- Which vendors have the necessary tools to help control and analyze costs?

**Funding**
- What is the best way to pay for health plan expenses?

This paper focuses primarily on funding employer health plans and reviews the many intricacies involved in selecting the appropriate funding method, as well as the advantages and disadvantages of different funding methods.

**Funding Options Defined**

The main decision an employer faces on health plan funding is whether to purchase insurance to cover claims and other expenses, or to self-insure the plan.

**Insured**

If a plan is insured, the employer contracts with an insurance company to assume the risk of health plan costs. The employer pays a monthly premium to the insurance company to cover claims and administration costs, and the insurance company bears the full responsibility for paying all incurred claims. Within the fully insured category, health plans can be community-rated or experience-rated.

- Community-rated - For community-rated plans, the employer’s claims experience is pooled with others in the community and insurance company underwriters calculate rates based on experience and administration costs. In New York State, employers with fewer than 50 covered employees are generally community-rated.
- Experience-rated - Many insured health plans are experience-rated, with the premium calculated by the insurance company underwriters based in full or in part on the employer plan’s own claims experience. The
degree to which the plan’s own experience is used in the rate calculation depends on the credibility of the plan. A plan’s credibility is based on several factors, including the number of covered lives and the number of years of claims experience available for the underwriter’s analysis. As the degree of credibility increases, so does the amount of weight given to the employer’s own claims experience. A plan that is 100% credible would be rated entirely on the employer’s own claims experience. If a plan is less than 100% credible, the carrier will blend the group’s actual experience with the carrier’s pooled experience to determine the premium.

Self-insured (or self-funded)
With a self-insured (or self-funded) plan, the employer bears the risk of all costs incurred under the plan for claims and administration. The employer can pay claims either from general assets or through a trust established for funding claims.

The employer typically hires a third party administrator (TPA), or an insurance company on an administrative services only (ASO) basis, who will process claims under the plan and give access to their network of physicians and other health care providers.

Some employers choose to partially self-fund (e.g., carve out prescription drug benefits and self-fund through a pharmacy benefits manager firm, while continuing to insure the medical portion). Options such as partial self-funding, or other hybrid funding options, are not explored in this paper.

Pros and Cons of Insured/Self-Insured Options
There are many variables which would make one type of funding arrangement more appropriate for any given employer. Insured and self-insured plans differ in who bears the risk and who maintains control over the reserves. When moving from insured to self-insured, the risk and control, as well as the advantages and disadvantages that accompany them, are shifted from the insurance company to the employer. The main advantages and disadvantages of each funding arrangement are detailed below.

Insured Pros
On the positive side, an insured funding arrangement means the insurance company bears the risk of unexpectedly high claims. At least for the time period spelled out in the employer’s rate agreement, the monthly premiums will not be affected by high claims. Upon renewal, the insurance company underwriters will include recent claims experience, either good or bad, in determining rates for the next period, but employers do not have to experience the highs and lows of claims variability throughout the year, and they can reasonably budget their expenses.

Insured Cons
One of the downfalls of an insured arrangement is the insurer’s fixed costs that are built into their monthly premiums. This includes costs such as administration, overhead, state premium taxes (average 2% to 4% of premiums), and reserve levels that insurance companies are required to meet. Another point against an insured arrangement is an employer typically has less flexibility in plan design since they are choosing among the insurer’s “off the shelf” products.

Self-insured Pros
In a self-insured health plan, an employer will reap the benefits of good claims experience, since their costs are not impacted by the experience of an insurance company’s pool. Thus, any successful efforts an employer makes to control claim costs will not be diluted by poor claims experience of other groups in the pool. Employers who self-fund will have greater flexibility in plan design since they are not limited to the insurance company’s offerings, and they are generally not subject to state benefit mandates. State benefit mandates can add significant cost to health plans, particularly in states with a long list of mandated benefits that insured plans must cover. Some examples of state benefit mandates are dependent age limits that are higher than the age 26 federal mandate, and COBRA continuation coverage requirements that are more generous than the federal requirements. Self-funded plans are still required to comply with federal benefit mandates, such as the health care reform legislation passed in 2010, the Patient Protection and Affordable Care Act (PPACA or ACA).

In addition to the potential for lower claim costs due to fewer plan design mandates, self-funded health plans also offer lower costs in other areas, such as:

• State premium taxes do not apply to self-funded plans (except on stop-loss premiums).
• Administrative fees are typically lower in a self-funded plan.
• Employers have increased cash flow as they maintain their own reserves and have control over investment of these funds.
Another significant advantage of a self-funded health plan is greater availability of claims utilization data. This allows an employer to make more informed decisions regarding plan design based on a better understanding of how claims dollars are being spent. Employers should be aware of the implications of having access to protected health information under the Health Insurance Portability and Accountability Act (HIPAA) and should ensure all HIPAA-required documentation is in place (e.g., policies, procedures, business associate agreements, and staff training). Employers may want to consult with an attorney specializing in HIPAA to ensure compliance.

Self-insured Cons
The employer bears the risk of all costs under a self-insured health plan. While some of this risk can be mitigated by purchasing stop-loss coverage, there is still potential for wide variability in payments throughout the year. Employers who choose to self-insure must be able to meet claim expenses as they arise. Even claims above the stop-loss threshold may be initially funded by the employer until they are reimbursed by the stop-loss carrier.

What Size Firms Use Self-Funding?
As the number of employees increases, the prevalence of self-funding also increases. Since 1999, the percentage of employers self-funding their health plans increased from 44% to 61%, as shown in the chart below1. As health plan costs continue to escalate, more employers are realizing the potential for savings in a self-funded arrangement.

<table>
<thead>
<tr>
<th>Number of Employees</th>
<th>% Self-Funding 2013</th>
<th>% Self-Funding 1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200</td>
<td>16%</td>
<td>13%</td>
</tr>
<tr>
<td>200 to 999</td>
<td>58%</td>
<td>51%</td>
</tr>
<tr>
<td>1,000 to 4,999</td>
<td>79%</td>
<td>62%</td>
</tr>
<tr>
<td>5,000+</td>
<td>94%</td>
<td>62%</td>
</tr>
<tr>
<td>All firms</td>
<td>61%</td>
<td>44%</td>
</tr>
</tbody>
</table>

Data obtained from Kaiser/HRET Survey. Analysis performed by the Client Analytics Group of Manning & Napier Advisors, LLC.

Components of Cost
The largest component of cost in a health plan, either insured or self-insured, is the actual claims expense. Claims typically make up 88% to 92% of total costs, while other expenses account for only 8% to 12%2. In calculating costs (premium rate for an insured plan and premium equivalent rate for a self-insured plan), both insured and self-insured plans begin with actual claims and add expected medical trend to arrive at projected claims for the following year. To account for the full cost of the plan, other expenses need to be factored in, such as administration fees and network access fees charged by the third party administrator, and stop-loss insurance premiums. On the self-insured side, employers avoid some of the insurance company’s added expenses and also maintain control of reserves. Also, self-insured plans are exempt from a new tax on health insurance providers under the ACA3.

<table>
<thead>
<tr>
<th>Cost Component</th>
<th>Insured</th>
<th>Self-Insured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>+ trend</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>= projected claims</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>+ administration</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>(TPA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ network access fees (primary and out of area)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>+ reserves</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>+ pooling charge</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>+ premium taxes</td>
<td>✓</td>
<td>*</td>
</tr>
<tr>
<td>+ insurance company overhead + profit</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>+ stop-loss premiums</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>= Total</td>
<td>Premium</td>
<td>Premium equivalent</td>
</tr>
</tbody>
</table>

*State premium taxes apply only to stop-loss premiums.

When considering self-insuring, it is important to note any additional programs that an employer may have been receiving as part of their insured premium. As these programs may not be included in the administrative fees charged by a third party administrator, or they may be offered for an additional fee, the employer will need to add these costs into the calculation of the health plan budget and premium equivalent rates. Listed below are a few examples of these programs.

- Case management
- Disease management
- Wellness programs
- Discount programs (e.g., fitness centers)
- Health coaching/nurse advocate service
- Tobacco cessation program
- Claim audits
Stop-Loss Insurance

An employer may choose to purchase stop-loss insurance to protect against catastrophic claims. Stop-loss insurance is available in two forms:

- **Specific stop-loss** – on any individual’s claims exceeding a certain deductible amount in a given year (e.g., $100,000 or $150,000).
- **Aggregate stop-loss** – for the claim costs of the plan as a whole exceeding a certain amount (attachment point) in a given year (e.g., 125% of expected claim costs for the year).

An employer may purchase either specific or aggregate stop-loss, or both. In any case, the employer pays premiums to the stop-loss carrier for this protection, and the stop-loss carrier reimburses the employer for expenses in excess of the specified threshold amounts. Employers will need to evaluate their risk tolerance and strike an appropriate balance between the premium for the stop-loss coverage and the deductible/attachment point that represents a comfortable level of risk.

Stop-loss policies are written as covering claims incurred and paid within a specified time period. Examples of possible options include the following (the first number is the time period for incurring a claim and the second number is the time period for paying a claim):

- **12/15** – Claims must be incurred within the 12 month stop-loss policy period, but could be paid up to 3 months after the policy period ends.
- **15/12** – Claims must be paid within the 12 month policy period, but could have been incurred up to 3 months prior to the start of the policy period.
- **12/12** – Claims must be both incurred and paid within the 12 month policy period.

Employers must also ensure their administrator’s ability and willingness to coordinate claims reporting to the selected stop-loss carrier. Many stop-loss carriers will request to be alerted to claims likely to exceed the deductible once they reach the half-way point (e.g., on a stop-loss policy with a $100,000 deductible, the stop-loss carrier may request to be notified when a claim reaches $50,000 and is expected to continue), or they may need to be alerted to claims with a specific diagnosis, regardless of the dollar amount.

Some stop-loss carriers will be actively involved in managing high cost claims, and early notice facilitates this process and can ultimately lower the overall cost of the claim. Failure to provide timely notice can negatively impact the stop-loss carrier’s ability to manage claims, which will directly impact the employer’s premiums upon renewal. Some administrators will charge an additional fee to coordinate with an outside stop-loss carrier, so employers should confirm the coordination process before finalizing carrier selection and should include coordination details in their contract with the administrator.

Considerations When Deciding to Self-Insure

While self-insuring a health plan has the potential for cost savings over an insured premium, there are several considerations employers need to be mindful of to ensure a successful transition.

**Calculation of premium equivalents and adequate reserves** – Employers may want to work with an actuary or underwriter to calculate projected costs. The administrator or stop-loss provider may be able to assist with these projections. This step is critical to ensure adequate budgeting and calculation of employee contributions.

**Risk tolerance** – Employers will need to be prepared for the variability in costs associated with a self-funded health plan. Claim expenses can vary widely from month to month due to high utilization or a catastrophic claim. Claims can be funded through general assets, or through a trust established for funding claims. In either case, adequate reserves must be available to pay claims as they arise throughout the year.

**Claims data (utilization, benchmarking, prescription pricing)** – Employers will need to select vendors who are able to provide the necessary reporting and data to allow them to make informed decisions regarding plan design changes and to evaluate any cost control measures in place.
Non-discrimination testing – Self-insured plans are subject to non-discrimination testing. (NOTE: This testing was included in the PPACA legislation as a new requirement for insured plans beginning in 2012, but it has been delayed indefinitely.) If the administrator does not provide this service, employers will need to engage another vendor or train internal staff to conduct the testing.

Administrator services – An employer with a self-funded health plan will need to select certain vendors to partner with in the management of the plan. Most employers will hire a third party administrator (TPA), or an insurer on an administrative services only (ASO) basis, to adjudicate claims. At a minimum, the selected administrator should be able to provide the following services and products:

- Accurate and timely processing of claims, including systems for detection of errors, duplicate charges, and fraudulent charges, and a comprehensive auditing and recoupment process.
- Access to a broad network of medical providers, including primary care physicians and a wide range of specialists, to minimize disruption in employee services when transitioning from an insured plan’s network. Provider networks are a key point to consider when evaluating third party administrators. They may differ widely not only in access to providers, but in the discounted rates the administrator negotiates with participating providers. Differences in negotiated rates can have a significant impact on claims expense.
- Quality/cost data to allow members to make informed choices when selecting providers.
- Comprehensive reporting/benchmarking capabilities, including employer ad hoc reporting.
- Ability to coordinate with other vendors (e.g., stop-loss carriers, pharmacy benefit managers, and wellness vendors) chosen by the employer.
- Cost control programs, including case management and disease management.
- An employee web-based tool for communication and education.
- Additional items to consider:
  - Performance guarantees
  - Start-up costs
  - Contract provisions (e.g., processing of run-out claims upon termination and recoupment of claims paid in error)
  - Customer service structure (for both the employer and employees)

Consultant/broker services – If an employer is working with a consultant or broker on health plan design and management and selection of vendors, they should be asking questions to determine their ability to assist with successfully managing the plan. In particular, employers should be looking for consultants/brokers with experience in the following areas, or with the ability to assess and select vendors to perform these services on behalf of the employer.

- Evaluation and analysis of third party administrators, pharmacy benefit managers, wellness, and other vendors
- Stop-loss marketing and contract review
- Negotiation of rates and contract provisions with all vendors
- Calculation of premium equivalency rates, claim reserves, and health plan budgets
- Claims data review and analysis
- Predictive modeling of plan design change options
- Strategic planning and recommending plan design changes and cost containment measures
- Designing wellness programs with outcomes-based incentives
- Preparation of plan documents and summary plan descriptions
- Non-discrimination testing

Cost Containment
Since employers bear the full risk of costs under a self-insured plan, cost containment measures are of critical importance. When making the transition to a self-funded health plan, employers will need to confirm with all vendors involved in managing the plan that the appropriate cost containment measures are in place. Listed below are some of the more prevalent programs in use today.

- Case management and utilization review programs have been used by insurance companies for years to ensure appropriate and cost-effective care is being utilized for large, complicated claims, typically involving hospitalization. They are also used to alert the insurance company (or TPA for a self-funded health plan) of the onset of a potentially large claim for budgeting purposes.
- Disease management programs are geared toward individuals with chronic health conditions. The goal of disease management is to educate and reach out to members to keep them in compliance with treatment and avoid high cost claims related to non-compliance. Common conditions covered by disease management
programs include diabetes, hypertension, asthma, high cholesterol, obesity, depression, and lower back pain.

- Wellness programs are designed to reduce costs by improving member health. They typically include incentives for participation, and more recently, incentives for improved health measurements (e.g., body mass index, cholesterol, blood pressure, and smoking cessation).

- Consumerism is a movement by employers away from the traditional model of a health plan paying most – or all – of a member’s expenses and toward the model of increasing personal responsibility for use of health care services. Consumerism attempts to change behavior because behavior accounts for a large portion of health care costs. Studies have found that anywhere from 50% to upwards of 80% of health care costs can be attributed to an individual's lifestyle. High deductible health plans, often coupled with health savings accounts (HSA) or health reimbursement arrangements (HRA), are designed to give employees more responsibility for managing health care dollars and making wise consumer choices in how they spend them.

- Cost/quality data – More and more employers are pushing for pricing transparency from their insurance companies/TPAs in order to give employees access to data to assist them in making wise consumer choices on place of service, and to give them incentives for use of the most cost-effective providers.

- Value-based plan design involves creating incentives to encourage appropriate use of high-value services that ultimately lead to better health and reduced catastrophic claim costs. A common example is lowering – or eliminating – the prescription cost-sharing for certain medications, to encourage compliance with prescription treatment. This is a high-value service since it greatly reduces the likelihood of a catastrophic claim resulting from failure to properly manage a health chronic condition. Another value-based plan design option is the use of tiered provider networks, where the plan pays higher benefit levels to participants who use providers with the best performance on cost and quality measures.

- On-site employee health clinics are growing in prevalence. Employers are realizing cost savings from a greater emphasis on primary care and prevention, and from reduced employee time away from work for preventive care and treatment of minor ailments.

- Plan integration - Employers are turning to integrated management of health and disability plans as they realize the costs of poor employee health and lifestyle choices extend beyond health plan costs, and also impact productivity and absenteeism for all employees, regardless of whether they are covered under the employer’s health plan.

Summary

Of the many decisions an employer faces regarding health plan design, the decision to insure or self-insure is fundamental. There are many considerations to explore before and after choosing the appropriate funding method. Continual cost control efforts are critical once an employer takes on the risk of claims expense under a self-funded arrangement. Equally critical is partnering with the right vendors (third party administrators, consultants, brokers, pharmacy benefit managers, etc.) who will work with the employer and provide the required tools to ensure long-term success. Self-funding alone is not enough to change the trend of cost increases. However, if it is undertaken with appropriate planning and budgeting, and is coupled with a smart plan design that engages employees as wise consumers, it can be a powerful tool in an employer’s struggle to control health care costs.