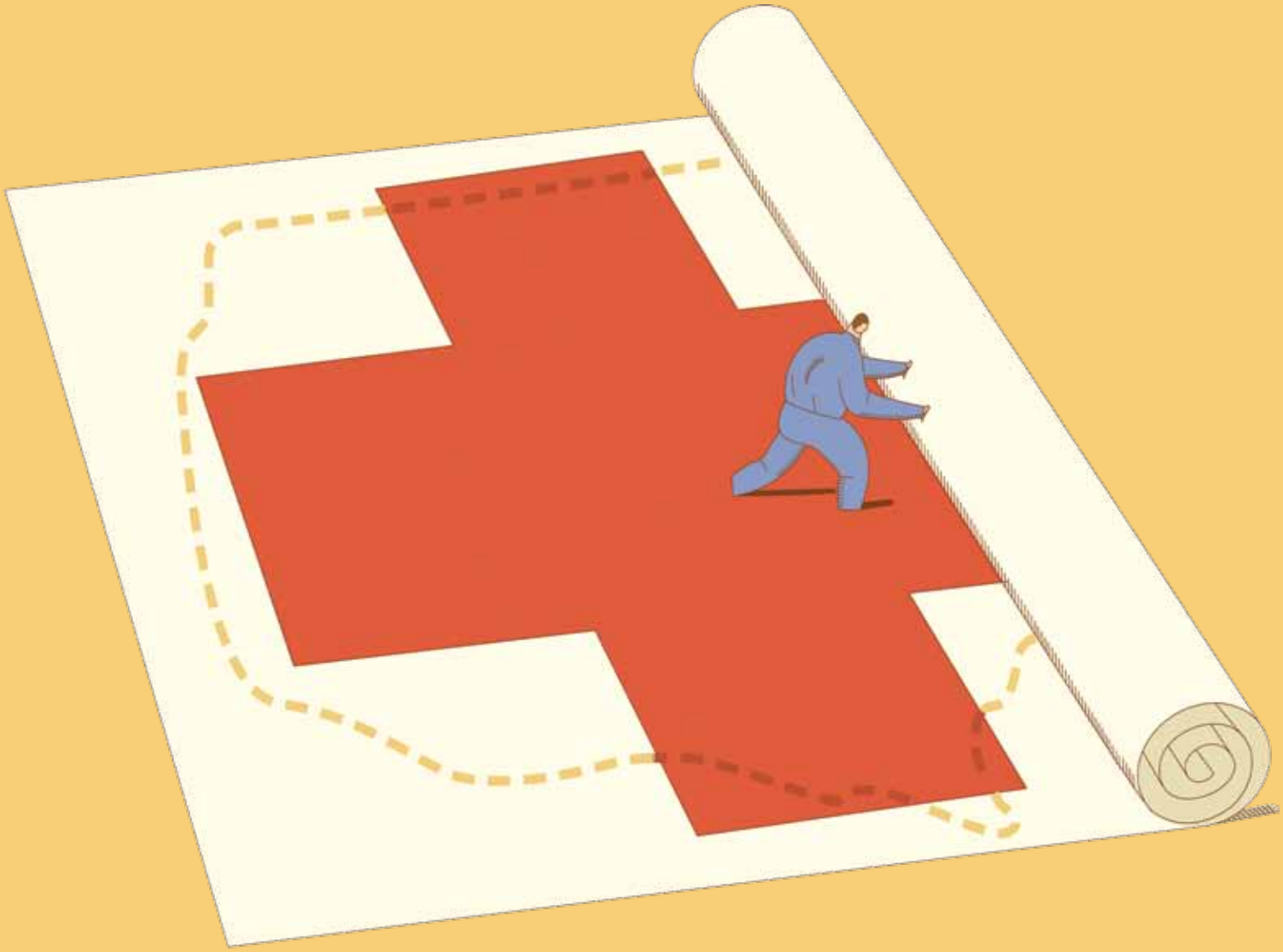
Smart Practices for Self-Funded Employee Health Insurance



BY SHAYNE KAVANAGH

Self-funded health-care coverage is a potentially powerful way for governments to save money. One study, for example, showed a cost reduction of 10 percent compared to commercial insurance.[1] With self-insurance, the local government maintains its own fund to cover the cost of claims, administration of benefits, and reinsurance rather than purchasing a commercial insurance plan to cover these costs. Self-insurance generates savings by eliminating the profit margin of commercial insurers, designing the benefit plan to the employer's exact specifications, and avoiding some legislative mandates and tax implications that apply to commercial insurers, the costs of which are passed on to customers.

In the past, local governments have not self-insured as often as private firms,[2] but this could change as health-care cost pressures continue to mount. The purpose of this article is to review smart practices for running a self-insured employee health plan. For governments that already have a self-insured plan, these practices can be implemented to make sure it remains sustainable. For those that are considering self-insurance, these practices can form the basis of a plan's design.

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FUNDING THE PLAN

Just as a private insurer charges premiums to cover the cost of health insurance, a local government must devise a system of internal charges. Under commercial insurance, the market effectively "enforces discipline" on a health plan because commercial insurers will charge the government commensurately with the cost of providing services. Under self-insurance, a government must discipline itself — if internal charges are insufficient, the plan will not be sustainable.

Funding Smart Practice No. 1: Make sure the costs for the amounts needed to cover the use of benefits and to fund the desired reserve levels are transparent. Foremost, charges should be set at a level sufficient to cover the cost of medical services, administering the health plan, and purchasing reinsurance, or "stop loss" coverage. Local governments can calculate a range of likely costs and then set charges high enough to cover it. Local governments can engage an actuary or work with other external experts to help set rates. Outside advice is needed because in addition to accounting for the plan's own experience, rates should also cover external factors like medical cost inflation or changes in the market for medical services. An outside firm that helps the local government run the plan could even "bill" rates to the government, mimicking a premium payment and enforcing the discipline that commercial insurance would impose. Charges should also be sufficient to make progress toward accumulating the desired reserves for the plan, protecting it against unforeseen circumstances.

Funding Smart Practice No. 2: Align participant contributions with the cost of the plan. Employees should contribute to the funding of the plan, and the size of the contribution should be related to the plan's overall cost. This means that local governments should adopt a policy stipulating that employee contributions will change with the cost of the plan, giving employees a stake in cost management. This policy will also help the employer maintain regular updates to the contribution structure and avoid a situation wherein contributions remain stagnant while costs increase.

Funding Smart Practice No. 3: Allocate costs to departments. It's a good idea to allocate the employer's share of the plan to departments based on the number of employees they have participating in the health plan. This allows governments to make personnel decisions based on true cost of personnel.

CONTAINING THE COST OF THE PLAN

One of the big advantages of self-insurance is that it gives the employer more latitude in designing the plan, compared to commercial insurance. As a result, it's often easier to apply cost-containment measures.

Cost Containment Smart Practice No. 1: Develop a cost-effective wellness plan. Wellness plans have the potential to generate substantial savings. One large study showed more than $3 in savings for every $1 spent on wellness over a three-year period.[3] However, the design of a wellness plan makes a huge difference in the amount savings, or if savings are generated at all.[4] Self-insured governments typically have much better access to claims data than their commercially

insured peers, and these data can be used to align wellness offerings with the conditions that are driving costs up. Biometric evaluation and surveys can complement claims data by providing more forward-looking information on the conditions that should be of greatest concern; for example, data on high blood pressure, cholesterol, glucose, and triglycerides can suggest the biggest risks to employee health, which in turn suggests potential areas of focus for wellness.

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Cost Containment Smart Practice No. 2: Provide more cost-effective ways to access care. A trip to the doctor's office can be expensive, not only in terms of the payout to the doctor but also in lost work time and, in the case of services that require 24/7 coverage, the cost of substitute labor. Governments should consider creating an on-site clinic to provide medical services on (or near) the workplace. In addition to creating more rapid access for employees, the employer benefits from an on-site clinic by eliminating the profit margin a commercial provider would charge and by gaining ways to negotiate charges with the medical service provider that staffs the clinic. Staffing needs vary from nurse practitioners and physician assistants to a full medical staff, depending on how the clinic is expected to be used. The services offered may range from immunizations and limited acute care to physicals, lab work, behavioral health services, and even pharmacy services. Research shows that on-site clinics save between $1.60 and $4 for every dollar invested.[5] Keep in mind, however, that employees will require incentives to use the clinic, like waiving co-pays for using the clinic instead of a commercial provider.

To be effective, a clinic must have a certain number of potential patients — approximately 800 to 1,000.[6] But this does not mean that on-site clinics aren't an option for smaller employers; multiple employers can share a clinic. For example, the City of Mesquite, Texas, joined with the Mesquite School District to offer a full-service clinic.

Another strategy for improving employees' access to health care is telemedicine. This isn't as comprehensive a solution as an on-site clinic, but it can create significant savings. A telemedicine appointment can cost approximately half as much as a typical office visit.[7]

Cost Containment Smart Practice No.3: Introduce "consumerism" into health plans. Conventional health plans don't give participants accurate price signals. For example, a participant whose co-pay is $50 for an office visit has no incentive to choose a doctor who charges $135 for over one who charges $175. "Consumerism" aims to more closely align the costs plan participants face with the actual total charges the plan experiences. At minimum, this could mean charging plan participants more for emergency room visits than for going to an urgent care facility, since emergency room visits cost more.

A fuller realization of the consumerism ideal is a high-deductible health plan (HDHP). Simply put, the high deductible (often up to $5,000) theoretically leads employees to be more discerning about which health providers to use, and perhaps even to scrutinize provider invoices more closely. Research has shown that HDHPs do result in lower patient spending, but there is a cloud with this silver lining: Instead of choosing more wisely, plan participants often choose to receive less care.[8] Participants may need help making more informed choices. The City of Farmers Branch, Texas, for example, started using a health-care concierge service to help employees navigate health-care choices. The City of Holland, Michigan, gives cash gift cards for choosing lower-cost providers for certain pricey procedures such as colonoscopies. Value-based insurance design, discussed below, can also steer employees toward the most cost-effective services, rather than just encouraging them to spend less.

Cost Containment Smart Practice No. 4: Implement a value-based insurance design (VBID). The premise of VBID is that high-cost and chronic cases account for the bulk of an employer's overall costs.[9] These patients usually agree to follow the course of treatment recommended by the provider.[10] Therefore, containing costs requires that providers recommend cost-effective treatments and that the patient then follow through on their agreement with the provider. Hence, eliminating or lowering co-payments for high-value treatments eliminates an important barrier that keeps patients from maintaining their treatment regimen.

To illustrate, it is far better to subsidize an employee's $2-a-day drug cost for a high-value drug for a heart condition than to pay for $100,000 heart bypass surgery later.[11]

In the most basic approach to VBID, the employer simply lowers or eliminates co-payments for drugs or treatments that are proven to have high value relative to other treatment regimens. An elaboration on this basic model is to have more individualized cost-sharing arrangements, depending on a plan participant's specific condition. For example, a plan participant with heart problems may have no co-payments for a drug with proven value for heart conditions, while another participant, who doesn't have a heart problem, would have to make copayments if they sought to use the drug for another condition, where value hasn't been demonstrated. The crux of the idea is to adjust the out-of-pocket costs for health services based on how clinically beneficial a service is to a particular patient.

The City of Asheville, North Carolina, runs a highly successful disease management program that conforms to VBID principles. Disorders covered by the program include diabetes, asthma, depression, hypertension, and high cholesterol. The city has seen positive results from these programs, saving about $4 for every $1 invested.[12]

Cost Control Smart Practice No. 5: Focus on pharmaceuticals. Because pharmaceuticals are a potentially expensive and complicated aspect of medical treatment, self-insured employers can benefit from engaging a pharmacy benefit management (PBM) company to manage this aspect of the plan. For example, a PBM could focus on managing/avoiding custom formularies and mitigating the use of drug company coupons (which create incentives to purchase high-cost drugs that employees might otherwise avoid). The downside is that adding a PBM could increase the government's administrative overhead.

Cost Control Smart Practice No. 6: Conduct a dependent eligibility audit.[13] Approximately 8 percent of dependents who participate in health-care plans are ineligible for coverage — for example, children who have gotten too old or former spouses.[14] The City of Corpus Christi, Texas, learned that 9 percent of dependents participating in its plan were ineligible for coverage. Governments should periodically audit plan participants and remove those who aren't eligible participants, thereby cutting costs.

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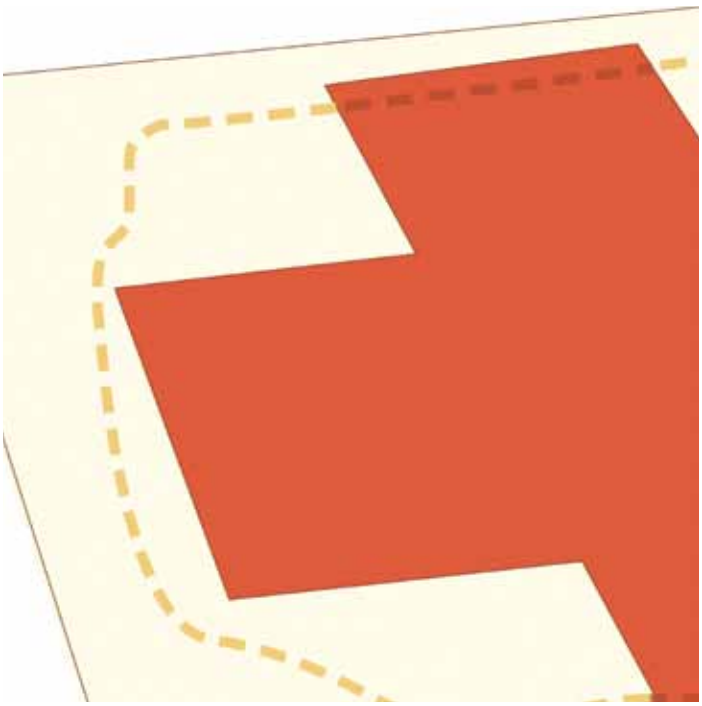
PLAN GOVERNANCE

Part of enforcing discipline on a self-insured plan is having a decision-making structure in place to help make hard choices. Many governments use special committees for this purpose.

Plan Governance Smart Practice No. 1: Include employees on a committee. An important barrier to making hard choices is concern about the negative impact of plan changes on employees in the short term — although employees have a clear interest in the plan's long-term viability. By including them in plan decision, the government makes hard choices something that is done with the employees rather than done to them. Some governments have bodies made up mostly or exclusively of employee representatives to make recommendations about the plan or even to participate directly in decision making. For example, in the City of Renton, Washington, the committee makes recommendations for potential changes to benefits based on a cost-benefit analysis. The committee also helps select the city's stop-loss insurance provider.



Plan Governance Smart Practice No. 2: Consider including expert citizens on a committee. Citizens sometimes have expert knowledge that could be helpful in managing the plan. Furthermore, including citizens in the decision-making process could confer greater legitimacy to the decisions the committee reaches. The City of Chandler, Arizona, takes applications from interested citizens.

Know Your State's Rules

Your state may have special requirements for how a self-funded plan must operate, including funding and reporting requirements. Governments that are considering self-insurance should be aware of these regulations.

MONITORING THE PLAN

Self-insuring means that local governments can get more access to detailed information about how benefits are used. These data should be used to look for opportunities for better managing the plan.

Monitoring Smart Practice No. 1: Engage a partner that will help monitor the plan. Governments often engage third-party firms to help manage the plan. Being able to provide information for monitoring the plan is an important consideration in choosing a firm.

Monitoring Smart Practice No. 2: Look for trends that increase costs. Monitoring should be focused on a limited number of high-impact topics, such as:

- *Impending large claims.* Reviewing claims warns the government that large expenditures are imminent.
- *Medical conditions that drive cost.* If particular conditions are driving up costs, it may be possible to focus wellness and/or VBID disease management on those conditions. For instance, chronic conditions like diabetes or hypertension are often major contributors to the rising cost of a plan.
- *High-growth areas.* If a cost area is growing rapidly, the employer can intervene before the costs become too high, perhaps by offering an appropriate service through an on-site clinic.
- *Value of services.* Some providers may have demonstrably better value than others. For example, a hospital with low rate of infection is a better value than a hospital where the rate is higher. The plan could be adjusted to encourage participants to use high-value providers.
- *Pharmacy trends.* Given the high cost of pharmaceuticals, it is wise to measure trends like the underuse of lower-cost generics or the overuse of opioids.
- *Sufficient use of preventative services.* One of the unintended consequences of trying to better align participant incentives with plan costs (e.g., with health-care consumerism) is that a flawed design can create incentives to underutilize preventative services, leading to higher long-term costs. Underutilization of these services might prompt investigation of strategies to increase use by changing financial incentives or making the services more accessible (via an on-site clinic, for example).

Monitoring Smart Practice No.3: Establish a regular monitoring schedule. Staff who are close to the plan (e.g., the human resources and finance departments) should monitor trends monthly, and an outside expert (e.g., broker, consultant, third-party administrator) should conduct a more formal review, along with members of the governing committee(s), at least quarterly. When the governing committee is aware of the trends that drive cost, it will be make more effective decisions.

STOP-LOSS COVERAGE

Stop-loss coverage caps the amount of money an employer has to pay out, protecting the plan against catastrophic claims by shifting the risk of low-probability, high-consequence events to a third-party insurer.

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Stop-Loss Smart Practice No.1: Consider both aggregate and individual stop loss. Organizations can purchase stop-loss coverage to protect against a high claim by any individual participant, which is referred to as individual stop loss. Aggregate stop loss provides a ceiling on the dollar amount an employer would be required to pay across all plan participants for the duration of the insurance contract period. Each type provides

coverage against extremely poor plan performance, but in different ways, so employers often purchase both.

Stop-Loss Smart Practice No. 2: Find the optimal "attachment point" with a risk analysis. In insurance parlance, the "attachment point" is the point at which stop-loss insurance becomes effective. For example, if a stop-loss policy has an attachment point of $1 million, the insurance pays out after the employer has paid $1 million in claims. The relationship between the attachment point and the price of the insurance policy is not linear; rather, it is more like the relationship shown in Exhibit 1. At the ends of the curve, the employer doesn't get a good deal. At very high attachment points, the employer assumes more risk for very modest decreases in cost, while at the low attachment points, the employer receives modest increases in coverage for much greater increases in cost. The best attachment point varies for each government, but will be a function of the government's appetite for risk, tolerance for uncertainty, and capacity to absorb higher-than-average claims years through reserves.

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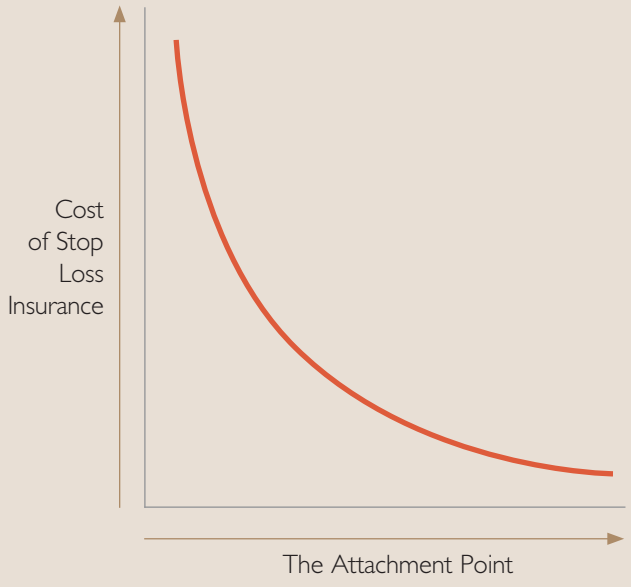
Exhibit 1: The Relationship between the Attachment Point and the Price of the Insurance Policy



Stop-Loss Smart Practice No. 3: Beware of treating stop-loss coverage as a commodity. Stop-loss coverage is sometimes treated as a commodity — the employer simply picks the policy that appears to offer the best combination of price and attachment point. However, stop-loss policies with the same attachment point may not be equal. The terms and conditions of the policy could result in less protection than the government thought it was getting. For example, during a renewal or re-bid, insurance providers could use information on existing large claims to exclude the services that are the subject of the claim (a practice known as a "laser").

THIRD-PARTY SUPPORT WITH MANAGING THE PLAN

Local governments should form partnerships with third parties (often, but not always, private firms) that can support the plan's objectives. Companies that provide commercial health insurance (e.g., Anthem, Blue Cross) can also provide support for a self-insured plan by adjudicating claims and making available a network for medical service providers. Firms that play this role are broadly known as "third-party administrators" or "TPAs." Brokers and benefits consultants can perform analysis and offer guidance on how to best manage the plan. They are independent of the TPA's interests and may have a broader perspective on the market for medical benefits. Third-parties should be strong partners in helping the government implement smart practices like those described in this article — so the lowest cost provider is not always the best option.

Third-Party Smart Practice No. 1: Get a TPA with strong purchasing power for health services. One of the most important features of a TPA is the purchasing power it can bring to bear on behalf of the government. If the TPA can negotiate better pricing with health-service providers, the government will benefit. Benefits consultants can be used to help evaluate TPAs for the strength of their networks and the discounts they can provide on medical services, and how these strengths compare to the administrative fees the TPA charges.

Third-Party Smart Practice No. 2: Insist on claims processing performance guarantees for a lower error rate. The TPA's performance influences how employees perceive the quality of the benefit. For example, a plan might start covering chiropractic services, but if the TPA doesn't adjust its system promptly and correctly to accept claims for the new service, and claims are rejected, the plan's reputation will suffer. Governments can therefore require performance guarantees and even have audit rights over in place with their TPAs.

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Third-Party Smart Practice No. 3: Get a TPA that can help with cost containment. The best TPAs can help the government implement many of the cost-containment techniques described earlier in this article. For example, designing a cost-effective wellness and disease-management program is much easier with the expert support of a qualified TPA.

Third-Party Smart Practice No. 4: Get a TPA that can support plan monitoring. Third-party partners should also be able to help with monitoring the trends described earlier in this article. In fact, the TPA should be an integral participant in the quarterly monitoring meetings. The third party best positioned to do this varies. Some TPAs can provide this support, while in other cases, a broker or benefits consultant might be best.

PLAN RESERVE

A reserve provides a hedge against the risk that a self-funded plan is subject to. The big question for all employers offering a self-funded plan is "How much is enough?"

Reserve Smart Practice No. 1: Make sure the reserve is sufficient to cover incurred-but-not-reported (IBNR) claims. IBNR typically has two parts. The first is claims that have happened but have not been reported. There can be a significant lag time between a coverable event and when it is reported to the plan. The second part is claims that are known but not completely settled. Both of these numbers can be estimated based on prior experience or, in the absence of that, the experience of similar sized organizations that are self-insured. A TPA, broker, or consultant could also help estimate this number — or the government might need the assistance of an actuary. IBNR is important because if the local government were to discontinue the plan, it would want to have sufficient reserves to pay off remaining claims. Some states also require reporting or verification of plan liquidity and viability.

Reserve Smart Practice No. 2: Make sure the reserve will cover claim cost variability that is greater than planned revenue inflow. Governments need to be prepared for costs that are higher than the internal charges were designed to cover. At the same time, reserves shouldn't be greater than the amount that would be covered by aggregate stop-loss insurance. In practice, this can be a complicated calculation, and many governments use a dollar amount that's equal to two or three months' worth of claims as a rule of thumb (in addition to the amount required for IBNR).

PUTTING IT ALL TOGETHER: INTERNAL CHARGES, RESERVES, AND STOP LOSS

Exhibit 2 shows how internal charges, reserves, and stop loss work together to create a sustainable plan funding strategy. The chart shows the total cost of a self-insured plan as a normal distribution, or bell curve. The actual cost of the plan varies from year to year, but it is more likely to be closer to its historical average than to deviate greatly (adjusting for medical inflation, which is substantial).

Internal charges are usually set to cover some amount that is greater than the average costs, shown as a line in Exhibit 2. After all, setting charges right at the average would leave a 50 percent chance of coming up short during the year. Reserves serve as a backup in case plan costs exceed the amount that internal charges cover. Reserves that are used in one year will likely be replenished in successive years, as plan costs will probably be less than estimated internal charges in subsequent years. The line where internal charges are set can be moved, based on how much money is currently in the reserve and appetite for risk. For example, if reserves are low, tthe

line in Exhibit 2 could be moved to the right to increase the odds that: 1) internal charges will be sufficient to cover the plan's cost, and; 1) charges will exceed the amount needed to pay for that year's service costs, allowing reserves to be built back up. Finally, stop-loss insurance covers extreme cases beyond reserves; it is not cost-effective for a government to accumulate reserves large enough to cover the most extreme cases.

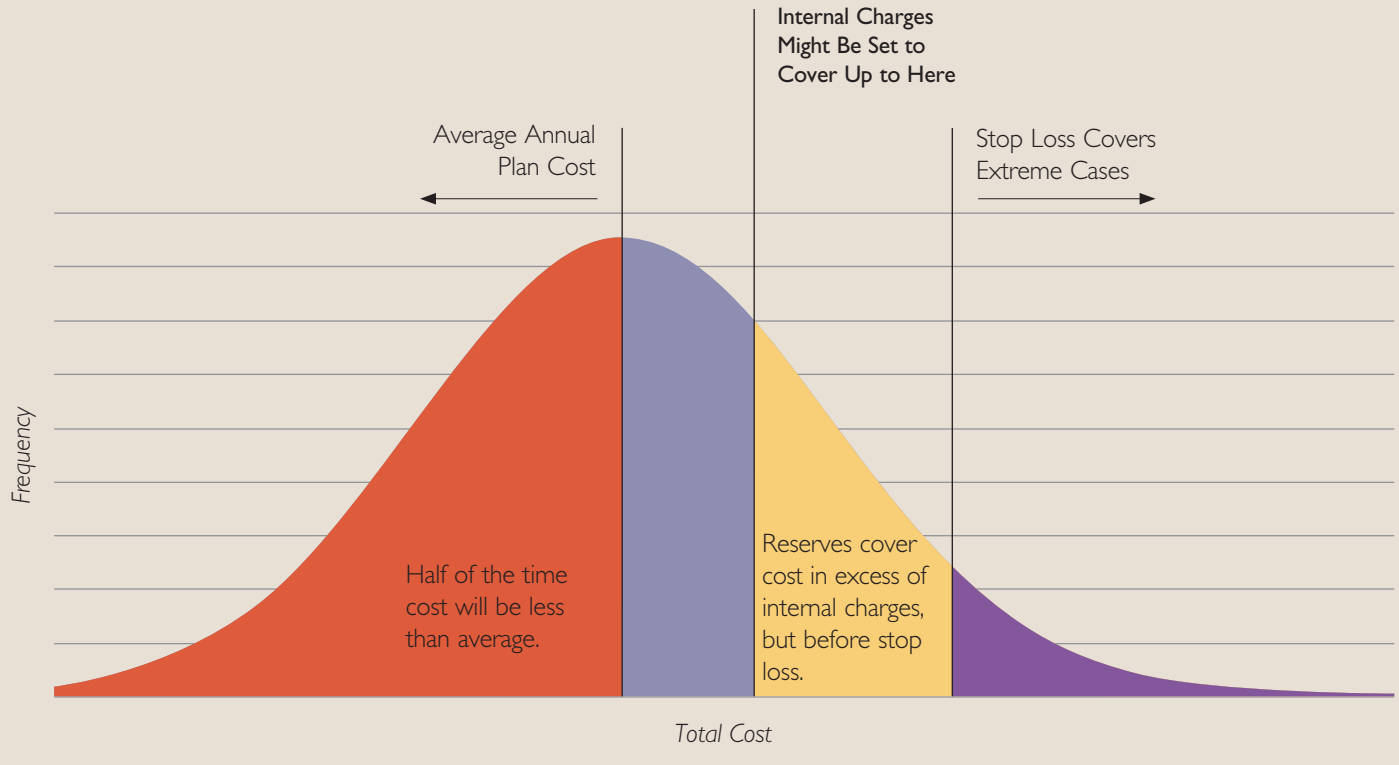
CONCLUSIONS

Self-funded health insurance is a promising way for governments to have more control over the cost of employee health benefits. However, managing a self-funded plan requires discipline in setting charges and reserves at the right level and adjusting how the plan is operated in response to information about plan performance. Verifying the plan against the smart practices outlined in this article can ensure that self-insurance remains a smart choice for your organization.

Notes

1. The Kaiser Family Foundation and the Health Research & Educational Trust Employee Health Benefits Survey 2010.
2. GFOA's 2011 report, "Containing Health Care Costs," showed that approximately 40 percent of member governments are self-insured, compared to 59 percent of all private firms.
3. ROI figures include soft-dollar savings such as productivity gains and reduced absenteeism. See Katherine Baicker, David Cutler, and Zirui Song, "Workplace Wellness Programs Can Generate Savings," *Health Affairs*, February 2010.
4. For example, wellness programs are usually more effective at helping people improve blood cholesterol, blood pressure, and blood glucose, but less effective at weight loss. Steve Aldana, "5 Workplace Wellness Statistics Every Employer Should Know," WellSteps, January 10, 2018.
5. Xuguang Tao, David Chenoweth, Amy S. Alfriend, et al, "Monitoring Worksite Clinic Performance Using a Cost Benefit Tool," *Journal of Occupational and Environmental Medicine*, Volume 51, Number 10, October 2009. ROI figures often include soft-dollar savings like less sick time used and higher productivity. Xuguang and colleagues cite the most modest ROI figures; consulting groups and industry advocates cite higher figures. Differences likely stem from differences in how ROI are

Exhibit 2: How Internal Charges, Reserves, and Stop Loss Work Together to Create a Sustainable Funding Strategy



calculated (e.g., which benefits of clinics are included in calculation and how they are monetized) and the structure of the clinics being evaluated.

6. "Employers Implement On-Site Health Clinics to Manage Costs," Hewitt Associates LLC, August 2008.
7. Terena Bell, "Can Telemedicine Be Both Cost Efficient and High Quality," *US News and World Report*, February 27, 2018.
8. Rajender Agarwal, Olena Mazurenko, and Nir Menachemi, "High-Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use Of Needed Preventive Services," *Health Affairs* Vol. 36, No 10.
9. Samuel H. Fleet, "Self-Funding: Taking Control of an Employer's Health Benefits Destiny Under the Patient Protection and Affordable Care Act," *Compensation & Benefits Review* 43: 30, 2011.
10. A. Mark Fendrick, "Value-Based Insurance Design Landscape Digest," Center for Value-Based Insurance Design at University of Michigan, July 2009.
11. Example taken from "Value-Based Insurance Design Landscape Digest."
12. These programs are collectively known as "The Asheville Project." They were extensively studied and written about in the *Journal of the American Pharmacists Association*. ROI figures include soft-dollar savings (e.g., productivity enhancements, less time off work).
13. Information from this section is from: Mark Mack, "Controlling Health Care Costs with Dependent Eligibility Audits," *Government Finance Review*, June 2015.
14. Research focused on the health-care firms HMS, ConSova, and the Society for Human Resource Management. See the following: ConSova Resource Center — Dependent Eligibility Audit Case Studies, January 1, 2010; Gary Claxton, 2014 Employer Health Benefits Survey, September 1, 2014; Healthcare 411, U.S. Department of Health and Human Services Medical Expenditure Panel Survey; "Modest health benefit cost growth continues as consumerism kicks into high gear," Mercer, November 19, 2014; Stephen Miller, "Health Care Savings with Dependent Eligibility Audits, Society for Human Resources Management, April 19, 2009; and Understanding Dependent Eligibility Audits, HMS, October 1, 2013).

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