

Self-Funded Employer Challenge to Stay Self-Funded

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Health care costs cannot continue to rise rapidly without crippling the state's economy and public services. Efforts to manage healthcare costs, a new healthcare payment approach will be required and would demand financial profit margins and business models to be updated from payers, hospitals and healthcare providers. The aim is to create "global payment" plans that assist doctors and hospitals develop an annual budget treatment plan for patient care. Another is to create a regulatory framework for how health care providers can form partnerships, called accountable care organizations, to coordinate care and distribute payments.

If the new health care payment and delivery systems are not designed to improve efficiency and eliminate waste, the risk is the new payment system may lower quality, reduce access to care and cut jobs within community based hospitals within the State's rural marketplace.

Many factors affect an employer's decision to self-fund, particularly the employer's ability to assume the risk involved. Employer size is a key determinant in risk assumptions. Actuarially, the minimum group size for which health benefits are predictable is in the 250 to 1,000 employee range. Employers below the 250 level are not good candidates for self-funding for three main reasons:

1. Smaller cash flow for handling claims
2. Smaller employee base to spread risk
3. Greater vulnerability to being rendered insolvent by a single major claim

In addition to the ability to assume risk, an employer must consider many other factors:

1. Business and benefit related objectives
 - a. Benefits should vary among employee groups (examples: married, single, exempt/non-exempt, full-time, part-time, and survivors)
 - b. Employees should be allowed to choose among different health benefit packages
 - c. Employee attitude should affect plan design
 - d. Mandatory or Voluntary plan designs
 - e. Employers/Employee Cost Share for premiums and/or out of pocket expense
 - f. Promotion of healthy lifestyles and management of chronic disease states
 - g. Annual review of decisions
2. Amount of risk to assume
 - a. Annually Review
 - i. Plan Features
 - ii. Exclusions
 - iii. Benefit Caps/Limitations
 - iv. Cost sharing: Premiums/Contributions, Deductibles, Copays, Coinsurance/Benefit Percentage, Tax-advantaged accounts

- v. Utilization
 - Active
 - Retiree
 - Dependents
 - Continuation of Coverage Participants
 - vi. Wellness
 - vii. Pre-tax benefits
 - viii. Network access
3. How to finance benefits and risks
 - a. Premium/Contributions
 - b. Employer/Employee Cost Share
 - c. General Fund
 4. Who will administer the plan
 5. What benefits will offered
 6. Who will be eligible for benefits
 7. How costs will be controlled