

Self-Funded HMOs

IN GENERAL

The self-funded HMO is similar to a self-funded indemnity plan in that the plan pays: (1) an administrative fee, typically monthly, which is comparable to an ASO fee; (2) fees for services rendered, such as hospital charges, and (3) specialist fees. The hospital charges paid to the HMO are generally paid in a pass-through manner. This means the employer pays only what the HMO was charged by the hospital, which is usually discounted because of the contractual arrangement between the HMO and the hospital. In deciding whether or not to self-fund, the employer should determine the basis of billing:

- Community-rated
- Demographically adjusted.

A capitation and self-funded HMO are identical except for the funding.

Community-rated. Community rated means all persons in the HMO's service area, the community, are charged the same premium to participate in the HMO. There are no differences in the rates charged to an employer to reflect claims experience, utilization, or risk, which vary from employer to employer. Federally-qualified HMOs must be community-rated.

Demographically adjusted. Demographically adjusted means the demographic characteristics of an employer's workforce are used to adjust the rates being charged to an employer. The characteristics most commonly used to adjust rates are age and sex.

Federally Qualified HMOs

It might appear that a federally qualified HMO with its community-rated requirement would not be eligible for the self-funded options. What a federally-qualified HMO might do is to clone itself into two entities.

- Federally qualified
This is funded capitation.
- Nonfederally qualified

This is self-funded. The federally qualified is a mirror of the nonfederally qualified. This organizational technique permits the HMO to work both sides of the street as regards to funding.

EMPLOYER APPEAL

Self-funded HMOs might prove to be an efficient way for employers to slow the rise in their health benefits expenditures. Some of the advantages of the self-funded HMO include the elimination of premium taxes, the ability to enforce subrogation recoveries, and ultimately the ability to modify the standard HMO financial arrangement.

Employers find the self-funded arrangement appealing because it gives them detailed information regarding their costs and an assurance that they are only paying for services used by their own employees. In a self-funded HMO, instead of paying a monthly capitation fee per participant that covers most services, the employer only pays for some capitated services -- usually primary care, and the package may also include prescription drugs, outpatient services, laboratory tests and durable medical equipment.

Typically, other professional services are reimbursed on a discounted fee-for-service basis. Hospital services are generally paid on a pass-through basis where the plan sponsor pays only what the HMO is obligated to pay under its normal contracts. The employer pays a monthly administrative fee, similar to an administrative-services-only fee. This financing arrangement enables sponsors of self-funded HMOs to keep costs down and to retain control over cash flow by controlling treatment patterns and specialist referrals and avoiding paying for health care services that are rarely used.

SELF-FUNDED HMOS IN PRACTICE

Self-funded HMOs provide the employer with several advantages:

- Increased control over plan design
- High cash flow
- Paying only for the services which the plan participants use.

The logic of self-funded HMOs is generally congruent with that of self-funding an indemnity plan; as with an indemnity plan, self-funding of the HMO option is not a good option for all employers.

Not all HMOs offer employers the self-funded option. It has been established that the self-funded option is available for approximately 35% of HMOs.

How It Works

With a self-funded HMO, the employer (in plan) pays two fees:

- Administrative fee
- Provider or HMO access fee.

These fees are made up of various complete costs:

- Claim processing fee.
- Risk pool fee for catastrophic claims
- Managed care drug card program

- Capitated physician's fee

The fixed costs tend to be 40-50% of regular HMO fees.

The Downside

The employer is betting that its plan claims will beat the capitated costs -- not by any means a comfortable bet for some employers. Also, employers must be surprised at the value of busy work connected with the self-funded HMO (actuarial, accounting, administrative, etc.).