

benefit basics

navigating health plan funding options

As the average annual premium for employer-sponsored health plans continues to rise, many employers and plan sponsors may explore self-insured and hybrid models as alternatives to fully insured plans. Racquel Maye, EA, FSA, founder of HR Transformation Consulting Group, discusses the basics of each model and identifies some of the benefits and disadvantages.

Fully Insured Plans

In a fully insured plan, the employer pays a fixed premium to an insurance carrier, which covers anticipated claims, administrative expenses and the carrier's profit margin. The insurance company assumes the financial risk of covering employees' health care claims. Advantages include the following.

- **Cost predictability:** The fixed premium remains constant regardless of actual claims, thereby aiding effective budgeting and financial planning.
- **Risk mitigation:** The insurance carrier absorbs the risk of higher-than-expected claims, protecting the employer from unexpected financial burdens.

Disadvantages may include the following.

- **Higher costs over time:** Fixed premiums include the carrier's profit margin and administrative fees, which may result in higher overall costs compared with other models, especially if claims are consistently lower than expected.
- **Limited flexibility:** Plan sponsors have little control over plan design and cannot customize benefits to meet the specific needs of their workforce since plans are standardized by the carrier.
- **Reduced transparency:** Employers typically have limited access to claims data, making it difficult to analyze trends or implement targeted wellness programs.
- **State-mandated benefits:** Fully insured plans are subject to state regulations and mandated benefits, which is especially challenging for multistate employers.

Self-Insured Plans

With a self-insured plan, the plan sponsor assumes the financial risk of providing health care coverage, directly funding employee medical claims as they occur, and the administrative services are often outsourced to a third-party administrator (TPA). The insurance carrier's margin is typically absent in self-insured models, providing potential cost savings, but plans no longer have the financial buffer that a fully insured plan offers.

Advantages of this model include the following.

- **Flexibility:** Employers have greater flexibility in plan design since they don't have to adhere to the standard plan offered by the insurer.
- **Potential cost savings:** Without paying for the insurance carrier's profit margin or state-mandated benefits, plan sponsors may experience lower overall costs. If claims are lower than expected, the employer retains the unused funds.
- **Access to data:** Self-insured plans can more easily get detailed claims data, enabling better insights into employee health trends and opportunities to implement wellness initiatives that target specific health issues impacting the population.
- **Uniform benefits:** Self-insured plans are governed by the Employee Retirement Income Security Act (ERISA) and can establish one set of benefits because ERISA preempts state insurance laws.

However, disadvantages to be considered include the following.

- **Financial variability:** The plan sponsor bears the risk of fluctuating claims, which



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can lead to unpredictable costs and potential financial strain, especially in years with high claims.

- **Regulatory complexity:** While not subject to state insurance regulations, self-insured plans must comply with federal regulations such as ERISA.
- **Cash flow strain:** Employers need to have sufficient reserves to cover high-cost claims, which could create financial strain, especially for smaller organizations.
- **Administrative burden:** Managing a self-insured plan involves significant administrative responsibilities, often requiring a TPA to handle claims processing and compliance, which adds costs.

Level-Funded Arrangements

A hybrid model, known as a level-funded arrangement, combines elements of both fully insured and self-insured plans. In this setup, the employer pays a fixed premium to the insurance carrier. If actual claims are lower than expected, a portion of the surplus is returned to the employer; if claims are higher, the carrier absorbs the excess costs. Like self-insured plans, these plans are subject to ERISA.

Consider the following advantages of this model.

- **Balanced risk and reward:** This arrangement offers cost predictability while providing an opportunity for employers to benefit from lower-than-expected claims.
- **Incentive for cost management:** Both the employer and insurance carrier are motivated to manage health care costs effectively to achieve potential savings. The carrier's profit potential also is limited by the surplus-sharing structure, which motivates the carrier to set premiums more closely aligned with expectations for claims experience.
- **Simplified administration:** Administrative responsibilities are largely handled by the insurance carrier, reducing the employer's workload compared with a self-insured plan.
- **Predictable budgeting:** Fixed premiums give the plan greater predictability for budgeting health care expenses.

Disadvantages include the following.

- **Limited savings potential:** Although employers may receive a portion of the surplus when claims are lower than expected, the carrier retains a significant share.
- **Shared incentives may be uneven:** While the carrier is incentivized to set premiums close to expected claims,

the surplus-sharing structure may still prioritize the carrier's profit margins over maximizing cost recovery for the plan sponsor.

- **Complexity in surplus calculations:** Determining the surplus and how much is returned to the employer may lack transparency, leading to potential disputes or misunderstandings.
- **Restricted flexibility:** Employers have less control over plan design compared with self-insured plans.
- **Limited access to data:** Employers may not have the same level of detailed claims data as with a fully self-insured plan.

Making a Switch

With self-insured or level-funded arrangements, premiums and costs are more directly tied to a plan sponsor's own claims experience rather than a community-wide rate used with fully insured plans. However, if the employer is a large enough group, a fully insured employer will be experience rated. The potential for savings in these models is enticing, especially for organizations that are confident in the health of their workforce. The risks associated with fluctuating claims and the possibility of large, unexpected medical expenses are important factors to consider. Without the risk-spreading benefit of community rating, a single high-cost claim could significantly impact a plan sponsor's financial health.

Shifting away from a community-rated fully insured plan requires balancing the potential for savings with the need for financial protection against large claims. This is where stop-loss insurance and other cost-management strategies become crucial.

Ultimately, the decision to leave a community-rated fully insured plan must be made with a clear understanding of the risks and rewards, as well as a strategic plan for managing health care costs and protecting against potential downsides. It is essential to consider the three primary cost components the employer should be prepared to cover in the long term:

1. **Claims:** The expenses incurred from employees' medical services.
2. **Administrative expenses:** Costs associated with managing the health plan, including claims processing and compliance.
3. **Risk protection costs:** This is paid as either (1) the profit margin retained by the insurance provider in the

case of a fully insured plan or (2) stop-loss insurance premiums, as explained later in this article, applicable for self-insured plans.

The Role of Stop-Loss Insurance

Stop-loss insurance is a key consideration for employers transitioning to a self-insured model. This type of coverage is designed to protect plan sponsors from the financial strain of catastrophic claims by setting a limit on how much the employer is responsible for paying.

There are two primary types of stop-loss insurance.

- **Specific stop-loss:** Protects against individual high-cost claims. For example, if one employee incurs a large medical bill, the policy kicks in once the cost exceeds a predetermined threshold (e.g., \$50,000).
- **Aggregate stop-loss:** Protects against the total amount of claims exceeding a certain percentage of expected costs across the entire group of covered employees.

Stop-loss insurance can protect an organization against the crippling effects of a single high-cost claim, but it adds an expense to the employer's health care budget.

The Importance of Cost Control

If active steps are not taken to control expenses—such as promoting wellness programs, encouraging preventive care and educating employees on cost-effective health care choices—the likelihood of higher-than-expected claims increases, reducing the savings potential for both self-funded and level-funded arrangements. Employees who do not receive guidance on managing chronic conditions or choosing in-network providers may overutilize expensive medical services, driving up the overall claims experience.

Though the insurance carrier in a level-funded arrangement may absorb the excess costs in the short term, it will eventually raise premiums to compensate for the higher claims experience. As a result, any potential savings from a surplus will be overshadowed by rising premiums over time, eroding the key feature of the level-funded model—the opportunity to recoup a portion of the surplus if claims are lower than expected.

Tips for Employers Considering a Switch

Before making the leap from a fully insured plan to a self-insured or level-funded arrangement, plan sponsors must carefully assess their readiness for this significant change.

Here are some critical tips for organizations considering a switch.

1. **Conduct a financial risk assessment:** Understand your organization's risk tolerance by conducting a financial analysis of your cash reserves and claims history.
2. **Obtain leadership buy-in:** Leadership buy-in ensures that decision makers are committed to supporting the organization through the potential fluctuations in claims costs and the added complexities of managing the plan.
3. **Evaluate stop-loss coverage options:** If self-insured, make sure you understand the types of stop-loss insurance available and whether they adequately protect your organization from catastrophic claims.
4. **Partner with a knowledgeable broker or consultant:** A broker experienced in self-insured and hybrid models can guide you through the transition, help you evaluate plan options and ensure compliance with health care regulations.
5. **Engage employees early:** Communicate with employees about potential changes to their health plans. Employee buy-in is essential for the success of any health plan, so provide clear information about how the new plan will work and any benefits it offers.
6. **Plan for compliance:** Self-insured plans come with additional regulatory requirements, such as compliance with ERISA. Ensure that you have the necessary resources to manage these responsibilities when switching to a self-insured plan.

By following these guidelines, plan sponsors can make a more informed decision and set themselves up for success when switching to a new health plan model.

Conclusion

Selecting the appropriate health plan funding arrangement is a complex decision that requires careful consideration of an organization's financial stability, risk tolerance and employee needs. While fully insured plans provide cost predictability and risk mitigation, self-insured and level-funded models offer potential savings but come with the responsibility of managing health care costs. Ultimately, the key to success in any health plan funding arrangement lies in proactive management, employee engagement and a commitment to cost-saving strategies.