PRACTICE GROUP:
BENEFITS

SEPTEMBER 11, 2017

6 COMMON GAFFES TO AVOID WHEN CONSIDERING A SELF-FUNDED PLAN

Mary Campbell | Vice President, Account Executive

Self-funding is a common method for employers over 100 employees to avoid the costs of a fully insured medical plan. A fully insured plan takes all of the claims risk from an employer group to the insurance company and collects a premium to do so. Self-funding transfers the risk and exposure of claims from the insurance company to the employer.

Typically, an employer would not remain completely exposed to claims and purchase limited coverage to protect against catastrophic losses. This is a method of partial self-funding, but in markets and employers under 10,000 employees, it is still referred to as self-funding.

There are many reasons to self-fund, including savings through cash flow plans that don't have to comply with certain state insurance provisions allowing more control over plan design. Also, insurance companies add margin into their rates for fully insured plans.

Due to pressures of the Affordable Care Act and an increase in taxes on fully insured plans, more employers are now considering self-funding arrangements as an alternative to their current structure.

As an employer considers self-funding, outlined below are six common mistakes to avoid.

1. Viewing self-funding as a short-term solution. Employers should take a long-term view of self-funding. In some circumstances, we might see an employer that has exceeded the claims amount they budgeted for. If they do not have tolerance for the risk of self-insured plans, they will move back to fully insured instead of riding the cycle out. Claims are cyclical and it is important to go into a risk-bearing arrangement knowing this.

While self-funding has many initial benefits, such as savings on taxes, fees, and margins, the self-funded structure is intended as a long-term strategy to provide cash flow advantage and the ability to manage reserves (IBNR).

2. Not planning for fluctuations. A fully insured arrangement is one where an employer pays a premium to a carrier monthly and the carrier assumes all of the risk and claim payments. The only noticeable fluctuation occurs when the employer adds or deletes employees and their dependents from the plan.

continued >

In truth, claims fluctuate monthly. Self-funded plans set budget rates to predict a 12-month cycle accurately, but month-to-month fluctuations should be considered. Some employers who may fluctuate in cash flow on a monthly basis in their normal business might not be as well-suited for the fluctuations in claims.

3. Not understanding reserve liability. Standard accounting practices require that a self-funded plan book its reserves for IBNR claims. This is a critical part of effectively managing a self-funded plan to ensure the money is there at termination to pay incoming claims. Employers that do not understand their liability can find themselves scrambling to pay runout (i.e. period of time after the plan year ends that claims can still be submitted) at contract termination.

4. Not performing periodic claims audit. Not only is this a smart business practice, but it is also an area that the Department of Labor will review under the Employee Retirement Income Security Act of 1974 (ERISA). Since the employer is the plan fiduciary, it is important to protect their employee's interest in the plan. More than just identifying overpayments, an employer can improve the administrative process and identify systemic and ongoing issues. This should improve overall performance of the employer's chosen administrator.

5. Not using plan analytics proactively. If an employer is just receiving the risk scores of employees or gaps in care, then the employer is paying more than needed in claims. Since the employer is now at risk, it is important to focus on claims-reduction measures. Working with a consultant on how to effectively implement a strategy to communicate, engage, and coach employees is essential to mitigate cost.

6. Not understanding the stop-loss contract. Stop-loss is the catastrophic coverage that an employer purchases to stop losses at a certain point. The contracts can be complicated and it is vital that close attention is paid to contract provisions. This can impact cost and satisfaction with a self-funded plan.

For example, some stop-loss contracts do not provide immediate reimbursement of a large claim, meaning the employer pays it up front and then is reimbursed. This can lead to higher than expected claims costs even though you purchased protection against that. Other misconceptions include, whether there is coverage during a period of runout, or who has the ultimate claims determination authority.

Employers have the ultimate responsibility in the determination of claim payment. That means that even if all proper authorities and purposes deny a claim, an employer can still decide to pay the claim.

Aside from the obvious implication of, "if I do it for Jane I have to do it for John," it can also lead to other exposures. If an employer decides to pay a claim outside of the contractual provisions, it will not be covered by the stop-loss. If it is a clinical trial or another large cost item, the stop-loss carrier should be consulted to determine if the claim could be reimbursed. In many cases, it would need to be reviewed by the medical director. A best practice is to not allow exceptions unless you intend to change the contract.

Most importantly, when looking at a self-insured plan, it is important to work with a consultant who can make recommendations meeting the goals of the business and workforce and who understands the intricacies of a self-funded arrangement.