

# Smaller Companies Can Lower Health Insurance Costs with Risk-Sharing

By Jim Edholm

Larger employers are seen as having a health insurance cost advantage over their smaller brethren because they can “self-fund” their insurance. This lowers their fixed costs, and they’re only responsible for reinsurance, administrative costs, and actual claims.

In truth, companies who engage in partial self-funding (so called because of the purchase of the stop loss insurance against catastrophic claims) do profit in most years. Statistically, 80 percent of employers overpay by a little or a lot because 20 percent of employer groups incur about 80 percent of the claims. By sharing risk with the carrier via paying smaller claims with their money instead of insurance company money, these employers lower their effective health care costs.

But smaller companies needn’t be locked out of the risk-sharing game. With an imaginative and knowledgeable broker, companies as small as a handful of employees can structure a risk-sharing arrangement that will lower their fixed costs.

Let’s look at a real-life example. The employer firm is located in Massachusetts, so we’re using Massachusetts’ plans for pricing; however, almost all states have similar plans. For the sake of simplicity, let’s assume that the employer pays 100 percent of the cost. This never happens today, but it makes the concept easier to understand and explain.

The employer shares risk by purchasing a plan that is less attractive than the current plan and paying the increased claims liability via a third-party administrator, which adds about \$60-\$100 per employee per year to the administrative cost. The employer would only undertake this kind of program if he felt that he had a fairly healthy employee group.

In this example, shown in the accompanying table, copay doctor visits are limited to three per person, six per family per year. Excess visits fall under the deductible. For an average family, this would be sufficient to cover normal utilization.

Likewise, the drug plan requires only marginally more out-of-pocket costs for the average



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family. A generic prescription costs \$15, as opposed to the current plan’s \$10 copayment. Tier Two drugs increase from \$25 to \$50 and Tier Three from \$40 to \$50.

The major change in plan design is in the deductible and coinsurance payments. The current plan has a \$1,000 deductible (\$2,000 family), while the new plan jumps to \$1,500/\$3,000. And the coinsurance is much higher — 20 percent after the deductible compared to nothing in the current plan.

But look at the savings! This employer of ten people can save more than \$29,000, about a third of the premium. As mentioned above, because of HIPAA regulations the employer would want to hire a third-party administrator to determine liability.

Most employers would be reluctant to impose such a draconian benefit reduction on their employees — as was this employer. Instead, he opted to tell the employees, “Look, your plan changes are small. Your doctor visit is going up by \$5 and your prescriptions are increasing by somewhere between \$5 and \$25 per refill. But for you there’s no difference in the hospital care — we’ll pay for all the claims in excess of \$1,000.”

Here’s the math. The deductible risk is \$500 for each of the four singles (\$1,500 minus the current \$1,000), total \$2,000 per year. The three duals and three families each represent \$1,000 risk, as the family deductible is capped at two times the single. So that total risk is \$6,000 for the six family groups.

Likewise, the coinsurance risk is \$3,500 for each of four singles (\$14,000 total) and \$7,000 per family, \$42,000 total. That’s \$56,000 coinsurance risk plus the \$6,000 of deductible risk — \$62,000 in all.

What does that mean to the employer? Common sense says that only in the case of surgery or hospitalization is someone likely to use the full \$4,000 of extra risk. There are 23 members in this plan: four singles, three two-person families and 11 people in the three larger families.

Statistics tell us that one in six Americans is hospitalized or has surgery in a given year, so we can expect four people to use the full \$4,000 extra. Therefore, the probability is that the employer will save \$29,000 in premium and spend \$16,000 in medical costs. That’s a net savings of \$13,000, \$12,000 after administrative costs. That’s a net cost reduction of more than 13 percent.

How realistic is this risk assessment? Several of my clients have implemented such a plan; all have saved money compared to their original plan. One client structured a slightly higher risk approach for his population of just over 100 people beginning in 2003. In none of the four years since then did he ever exceed 50% of his theoretical maximum liability.

It can work — you just need to compare the risk and reward factors of your particular population.