

## Fighting Health Insurance Premium Inflation: What the Smaller Company Can Do

If your health plan is fully insured — and at fewer than 1,000 employees statistics show 60% of employers are fully insured — there's an 80% probability that you're overpaying, maybe by a lot but at least by a little.

Why do I say an 80% probability? Pooling the claims for entire segments of people so as to set an average price is how the fully insured plan is priced. The segments that carriers look at are pretty general — age, family status, ZIP code, industry, sex mix, etc.

Experience shows that up to 80% of all claims arise from as few as 10% of the population. Since the price within a given segment needs to be equal, there's a high probability that the healthiest 80% of employer groups are subsidizing the 20% of the sickest groups.

Since insurers spread the premium equally across groups, the healthy 80% overpay to subsidize the unhealthy 20%. There are mechanisms to afford employers the opportunity to regain some of that excess premium. In this article we'll discuss two strategies: one is primarily applicable to companies larger than about 50 employees; the other can be used down to one life.

### Healthcare Cost Increases

Healthcare cost increases are a fact of life in America. The 2006 national healthcare increase was 7.3%, and over the last six years, the growth has been 85%, far outstripping general inflation.

Healthcare costs make the news virtually every day; they will be a factor in the 2008 election, and how we'll respond is still uncertain. The current rate of healthcare inflation is about two - three times the general inflation rate.

And employers, particularly smaller employers, are caught in the middle. One private school we work with spends almost 32% of employee salaries on health insurance! Granted, teachers are poorly paid and the school has a ridiculously rich health plan, but you can see what a problem it presents them.

Large companies have fought the health care cost monster with various tools, chief among them self-funding. This insulates them from paying any more than is appropriate for their group, although it provides no protection against inflation in the underlying health care costs.

The underlying mechanism of self-funding is risk sharing. It's not unfair for the insurance company to charge you an amount that's more than what you'll probably pay when they're taking all the risk. But if you share the risk, you ought to have access to some of the reward too.

That's great for Mega Corp USA, but what's a smaller employer to do?

**Chart 1**  
**Frequency of**  
**Self-Funding**

Employer Size	% Employers Self-funding
0-20	8%
20-100	15%
100-250	23%
250-1000	40%
1000-2500	66%
>2500	71%

Source: Kaiser Family  
Foundation Employer Health  
Benefit Survey, 2002

The answer may be to act more like a large company. Don't assume that the tools that are available for them aren't also available for you. Ask yourself these questions:

- Do I want to pay only for the healthcare my employees actually use?
- Am I profitable and (preferably) growing?
- Are my employee demographics desirable (young, healthy)?
- Will I swap some risk for potential savings
- Can I tolerate swings in cash flow?
- Do I have a better use for the money?

If you answer "yes" to some of all of the above questions, you are a prime candidate for risk sharing. But think carefully about those questions – if you answered "no" to them, you may be ill suited to use the risk-sharing concepts to lower your healthcare costs.

### **Basic Risk Sharing Concepts: More Than 25-50 Employees**

As I said above, the insurance carrier sets an average price for each segment of the population they'll cover. When they look at your group, they take all the factors I mentioned (age, sex, location, etc.), apply them appropriately to your group, average them together, and come up with a rate. It isn't based on your group as a mix of real people; it's based on your group as a representative mix of a bunch of different demographic factors.

But the same is true if you have a company full of granola-crunching, triathlon-running, non-smoking, ideal-weight health fanatics. In fact, if the ages and home ZIP Codes are the same, you'll pay the exact same rate as your competitor whose employees are hamburger-gobbling, smoking, overweight couch potatoes.

If your claims turn out to be much less than the carrier's average group, the carrier wins. If your claims are worse, they lose.

But that's hardly unfair – as we said above, the carrier takes all the risk. No matter how bad your claims are, you're only going to pay the premium you contractually agreed to at the beginning of the plan year. And if you're smaller than 50-100 employees, even a bad claims year won't hurt you: you're fully pooled and will get whatever rate your demographic factors dictate for the renewal.

Since you were unwilling to share the risk, that's the price you pay. But on the other hand, if you do share risk with the carrier, you may be handsomely rewarded.

### **Rewards of Self-funding**

There are many rewards for self-funding.

1. Self-funded plans have lower rates of healthcare inflation than fully insured plans. As Chart 2 shows, cost increases for self-funded plans have risen less than for fully insured plans for eight years running.

2. Reduced premium taxes. About 2-3% of your health costs are for your state's premium tax. With self-funding, only the stop loss insurance incurs a premium tax.
3. Cost management efforts like wellness plans reduce costs for you, not for the insurance company.
4. You can "tweak" your design to offset wasteful use of the healthcare system by your employees.
5. In the first year there is a cash flow advantage created by the fact that it takes one-two months for a claim to be paid after it's incurred. So you'll only pay 10-10.5 months' of claims, but you'll save 12 months' of premium.
6. Use of money gained via only paying for one's own claims.
7. In the first 2-3 months your claims will be very small. We suggest you set the premium savings aside as a reserve against "incurred but unreported" claims. Until paid out, you earn interest on those reserves
8. States mandate specific benefits (oral contraceptives, in vitro fertilization, substance abuse, etc) that self-funded plan can choose to limit. Self-funded plans are subject to ERISA, not state laws.
9. You can offer identical benefits across state lines.

**Chart 2**  
**Historical Cost**  
**Increases — Self-**  
**funding vs. Fully**  
**Insured**

Year	Fully Insured	Self-funded
1998	9.4%	4.5%
1999	6.1%	4.5%
2000	9.7%	6.7%
2001	12.4%	9.3%
2002	13.5%	12.3%
2003	15.6%	12.4%
2004	11.4%	11.1%
2005	9.3%	9.1%

Source: Kaiser/HRET Employer Health Benefits 2005 Survey

### **Self-funding Explained**

The traditional way of sharing risk is via partial self-funding. In such traditional plans there are three components:

1. You pay an administrator to adjudicate your employees' health claims.
2. You pay the claims your employees actually incur. The total amount of those claims is set by your stop loss insurance policies... see the next point.
3. You pay an insurance premium to limit your losses from extraordinary events. The policies will set a premium/employee and will show the maximum claims you'll pay before they step in and start paying claims.
  - a. The first policy is a specific stop loss policy, which pays any individual's claims for a particular illness or injury beyond some stop loss point, for example, \$25,000.
  - b. The second is an "aggregate stop loss" policy, which limits the claims you pay for all claims that are smaller than the specific stop loss point.

Your broker will help you get cost estimates for all of those factors. If the total of those quotes compares favorably with your fully insured renewal premium, you may be able to profit handsomely from self-funding.

The largest number will be the claims amounts, and there will be two figures referred to in the quote – “expected” claims and “maximum” claims. The “expected” claims level represents your actuarially expected claims and the “maximum” claims level is the point at which the insurance company will step in and absorb all further claims during the year.

The second largest cost will be the insurance premium to protect you against extraordinary losses, called stop loss policies. There will be two policies, an aggregate stop loss, which will cost very little, and a specific stop loss, which will be much more expensive.

The smallest cost will be the administrative cost, but it’s second only in importance to the claims themselves. The administrator that processes your claims can – if they’re good – help control plan utilization by your employees, and can work with your broker to guide you to a cost effective plan design.

### **Claims and the Administrator**

There used to be a saying in self-funding that “the claims will be what the claims will be.” Don’t believe it. It’s the excuse poor administrators use to justify their mismanagement of health plans they administrator.

Granted, no administrator can keep Harry in the plant from getting cancer, but the right administrator can help minimize claims and claims cost by doing some of the following:

1. Providing employee tools to help them evaluate alternative treatments, offer wellness programs, make drug option comparisons, etc.
2. Help control the costs of chronic and other serious diseases, whose costs can vary dramatically depending on the management techniques used. Asthma, chronic obstructive pulmonary disease, diabetes, coronary artery disease, pain, end stage renal disease, heart failure, oncology, neonatology are all examples.
3. Case management. When the dreaded disease does strike, a good administrator can improve the outcome for the employee/patient and can reduce the cost to the plan by providing expert advice and treatment guidance.

There’s another old saying (that I just made up): “Good plan administration isn’t cheap, and cheap plan administration isn’t good.” Never underestimate the importance of the administrator. Administration costs will seldom exceed 10-15% of the total plan costs; saving 15% on administrative costs will reduce the total plan expenses by 3%, but a good administrator can reduce costs by 5-8%.

### **Stop Loss Costs**

After claims, the next largest factor is the cost of stop loss protection. The stop loss carrier initially makes an actuarial determination of your likely claims level. It’s based on the same kinds of things that your fully-insured carrier looks at — industry, family mix, age mix, location, etc.

Later that number is modified based on your actual claims experience — the healthier your group and the better your claims results, the lower that number is. Based on their estimate of your claims, they'll offer you, typically, two kinds of stop loss policies.

The first is “specific stop loss,” which limits the costs of any one “shock claim,” to some pre-agreed limit, for example, \$25,000. Then there is “aggregate stop loss,” which covers the combined cost of all the sub-\$25,000 claims to some annual limit.

Here you are at the mercy of your broker and the administrator to help you make the right selection. The contractual provisions are varied and beyond the scope of this article to address in depth, but here are the considerations you should evaluate:

1. Does the stop loss contract define diseases the same way your plan does? If not, treatments your plan obligates you to cover may not be insured by the stop loss policy, and you'll lose your protection.
2. Are there limitations on benefits payable, either annual limits or lifetime limits?
3. When does the stop loss plan reimburse your cost of eligible claims? Immediately or on a deferred basis?
4. Are there any “lasers” that give higher stop loss limits for people with serious conditions?
5. What are the “terminal liability” limitations, i.e., the protection offered you if you terminate the plan?
6. Is the stop loss contract set at a “Goldilocks Level” (neither too high nor too low)?
7. What are the terminal protections, if any? That is, should you decide not to self-fund at the end of this contract year, you'll still owe for any claims incurred during the contract year that aren't reported until after the end of the contract year. Will your contract provide any protections for those claims?

### **Risks of Self-Funding**

There are risks, of course, with self-funding. Besides the risk of choosing a broker who's unfamiliar with how best to structure a plan or the risk of an administrator that simply pays claims instead of adjudicating them, there's the risk of a bad year.

I mentioned above the “maximum claims” number that the carrier projects. Many first-time self-funders look at that and get frightened. You'll see that number every year, so you should understand it.

The stop loss carrier first generates the expected claims of your group. Most employers find that their claims fall within a 2-5% range of that expected number. But the stop-loss carrier has to define the point at which they'll begin paying claims, so they take the expected claims number, and they add a corridor — typically 20-25% — to that expected claims level, and that becomes the “maximum claims” level.

Fewer than 5% of employers ever hit their maximum in a given year. So don't be frightened of that number... it's an unlikely number. Make your decision based on the

expected claims number, and you'll have a much better approximation of what your plan costs will be.

How unlikely is it? Well, consider that the premium you pay for aggregate protection costs about 9-14% of the protection you pay for specific stop loss. That tells me that the carrier thinks it's seven to 11 times as likely that someone will have a very serious illness as it is that your group will go over its maximum claims level. Many larger firms don't even purchase aggregate stop loss protection.

But you *will* have bad years.

Every fourth to fifth year a lot of folks will get sick, or a handful will have very large claims, and you'll pay more that year than you were expecting. Moreover, when that happens, your renewal numbers will be ugly. If you had lots and lots of smaller claims, your aggregate stop loss point will jump substantially, and if you had several serious illnesses your specific premiums will increase, too.

But think about this — unless you have two bad years back-to-back, the increase in the aggregate stop loss point means nothing. It's only an increase in *potential* loss, not an increase in out-of-pocket expenses.

On the other hand, what happens when you're fully insured? First, you will pay for slightly bad years even in the years your claims are good. Second, when you have that same bad year, your premiums for the following year will increase even above the "normal" increase.

So when fully insured you're punished in the good years by overpaying, and you're punished after the bad years by overpaying even more the next year, despite the probability that claims won't be high two years in a row.

The risk of self-funding seems small, when compared to the guaranteed overpayment of fully insuring.

### **Solutions for the Very Small Account**

What I've described above works for accounts beginning at 25-50 lives and going up from there. But what about the company that is smaller than that level? The approach above won't work; the carriers to execute it just aren't generally available.

But you can do something very similar by creating a Health Reimbursement Arrangement (HRA). Assume your current deductible or hospital copay is \$500. Find a carrier that offers a fairly deep deductible, say \$2,000. That premium will be cheaper than the \$500 plan by 10-12%, even with a doctor copay that covers the small doctor claims. That should save you about \$400/year for each single employee and \$1000 for a family.

Then create a plan whereby you reimburse the employee for all deductible above \$500. Local Third Party Administrators will gladly administer such a plan for about \$5/employee/month, \$60/year. Typically, 60% or more of claims are smaller than \$1,000 but usually account for about 5-7% of total dollars, less when doctor claims are taken out of the equation.

This approach is a do-it-yourself approach to self funding, using the larger deductible plans available from most carriers. While it's not self-funding in the true sense of the word, it is still risk-sharing, the heart of self-funding.