SELF-FUNDING AS A RISK MANAGEMENT FORMULA USED BY COMPANIES FOR FINANCING HEALTH CARE FOR EMPLOYEES – PERSPECTIVE FROM THE US MARKET

Samofinansowanie jako formuła zarządzania ryzykiem stosowana w przedsiębiorstwach w celu finansowania ochrony zdrowia pracowników – perspektywa z rynku amerykańskiego

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STRESZCZENIE

Artykuł przedstawia formułę zarządzania ryzykiem w kontekście samofinansowania ryzyk zdrowotnych przez przedsiębiorstwa (lub grupy przedsiębiorstw). Celem jest zapewnienia finansowania zarówno prewencji jak i skutków zdarzeń o charakterze zdrowotnym wśród pracowników przedsiębiorstwa oraz członków ich gospodarstw domowych. Samofinansowanie stanowi alternatywę dla pracodawców w Stanach Zjednoczonych dla ubezpieczenia komercyjnego.

W poszukiwaniu efektywności przedsiębiorstwa coraz częściej wykorzystują różnego rodzaju formuły zarządzania ryzykiem. Mogą to być np. captivy, TUW-y, kooperatywy, ale również samofinansowanie skutków zdarzeń (odrębny własny fundusz celowy przedsiębiorstwa).

Celem artykułu jest wskazanie różnic pomiędzy zawieraniem umów ubezpieczeń zdrowotnych dla pracowników w komercyjnym zakładzie ubezpieczeń vs. samodzielnym zatrzymaniem ryzyka przez przedsiębiorstwo oraz dlaczego może to być bardziej skuteczna formuła zarządzania ryzykiem.

O zatrzymaniu ryzyka, mówimy wówczas, kiedy przedsiębiorstwo przyjmuje formułę, w której brak umowy ubezpieczenia (a wiec i cesji ryzyka na inny podmiot) lub też ubezpieczenie pełni bardzo ograniczoną rolę.

Zdarza się, że występuje model mieszany (w którym może brać udział ubezpieczyciel komercyjny lub własny captive ubezpieczeniowy zabezpieczony ochroną reasekuratora).

ABSTRACT

Article presents a formula of risk management in the context of self-funding of health risks, which is used by companies (or group of companies). The purpose is to ensure financing of prevention as well as of negative effects on health amongst employees of companies and their household members. Self-funding is an alternative for employers in the USA to commercial medical insurance coverage. In the search for effectiveness, companies more and more apply different kind of risk management formulae. These maybe i.e. captives, mutuals, co-operatives and also self-funding (separate own fund). The purpose of this article is to present differences between concluding contracts with commercial health insurers vs. retain the risks by employer and why this can be more effective formula in risk management.

We speak of a risk retention when a company accepts the formula without a health insurance (therefore no cession of the risks onto another entity) or else when a commercial insurance plays a very limited role. It may happen that there's a mixed model used (in which commercial insure can participate or own captive insurer protected by a reinsurer).

Kluczowe słowa: samo-finansowanie, samo-ubezpieczenie (captive), zatrzymanie ryzyka

Keywords: self-funded, self-insurance, risk retention.

Self-funded health care is a type of a risk retention scheme whereby an employer (a company) provides health and/or disability benefits to employees using the company's own funds. In self-funded health care or disability plan, a company assumes the risk for making payments to cover for employees' costs of health and/or disability benefits.

There are many of those who name retaining risks by a company as a self-insurance, but this is not a correct approach, at least for as long as a company does not use a captive insurer that takes at least part of the risk and for as long as there's no insurance contract as such in place with a company owned captive insurer. Self-"insurance" implies existing of an insurance contract, so the term should not be used in the case of its absence. Self-funded plan is a lot wiser term and choice. Due to rising health care costs, the insurance premium costs have been also on the rise, not only in the USA but also in many other countries world-wide.

Recently published by Aon - Global Medical Trend Rates Report (2019) - explains what are the reasons behind rising costs, which markets are on the forefront of increases and how the costs are managed. It covers budget premiums, factors driving medical cost increases, wellness and cost containment initiatives as well as how to respond to all of these very important challenges. Global average medical inflation was assesses at 7,8% (2019) in comparison to 8,4% (2018)[1]. Due to rising health insurance costs, the US companies start to take actions to better manage costs, such as referring employees to more cost effectively managed operations, direct contracting with vendors, using so call accountable care organizations (ACO) and bundled payments methods.[2]

Self-funded health care is a self-funding scheme (not a self-insurance unless own captive is used).

A company provides health and/or disability benefits to employees using its own funds put aside. This is obviously a very different way to risk manage costs from fully insured health plans where a company concludes insurance contracts with a commercial insurance company to cover the employees and the families.

In self-funded health care, a company assumes the direct risk of all required payments that will need to be made in the future for the benefit needed (either by employees, their family members or from providers of medical services). The terms of eligibility and scope of covered benefits are set forth in a plan document, which includes provisions similar to those found in a typical group health insurance policy. Such plans create rights and obligations under the Employee Retirement Income Security Act of 1974 ("ERISA").

Companies with relatively young and healthy employees are free to out of the regular health insurance market to avoid the minimum coverage standards as prescribed in Obama's care, which is a move that could drive up costs for

[1] Aon report: https://www.aon.com/getmedia/0c375f10-3b16-4d2d-a452-4ae86968525b/2019-Global-Medical-Trend-Report.pdf.aspx
As accessed on 20.03.2019

[2] Aon Global medical trend rates report: https://www.aon.com/getmedia/0c375f10-3b16-4d2d-a452-4ae86968525b/2019-Global-Medical-Trend-Report.pdf.aspx – page 4. As accessed on March 20th, 2019

employees of other companies that adopted rules made for commercial insurers. This raised concerns that if too many of the self-funded plans exist, they will erode a good premium base for commercial insurers that deliver cover under Obama's care. On the other hand, Congress did not want to change the rules for the companies and employees that have been satisfied with self-fund plans for a long before Obama's care and did not want to follow the Affordable Care Act.

Many companies seek to mitigate the financial risks connected with self-funding costs of benefits by purchasing stop loss insurance from insurers. These policies (stop-loss policies) typically provide excess of loss cover for risk retentions both, on a specific single claim cost of an individual i.e. USD 25 K to 100 K per employee and on aggregate costs basis (aggregate cost of X millions of USD in a given year).

An important legal aspect of self-funded group health plans lies in the requirement that a company remains liable for funding of a plan regardless of whether it purchases a stop loss insurance.

This means that a pool of funds accumulated in the company's own bank account needs to be managed in a way to be able to cover for all the necessary medical and/or disability payouts. However, it is a company that has a contractual relationship with plan participants and beneficiaries. The stop loss policy exists solely between an employer and a stop loss insurer, which means there no direct contractual liability between a stop loss insurer and individual employees covered under the health plan.

This feature provides the critical distinction between fully insured plans (subject to State law insurance regulations) and self-funded health plans, which exist under the provisions of Section 514 of ERISA, which exempts self-funded health plans from State insurance regulations [3].

Aggregate stop-loss policy has a finite price that can be compared to a health plan's guaranteed but fully insured cost (if a company were to purchase it). If an aggregate stop-loss policy cost does not exceed the health plans' fully insured guaranteed cost, plus expected health costs, which is expected to come from employees' claims in a year time, then the self-funding may be a viable option. Aggregate stop loss can be also meant as an umbrella policy that caps a company's liability within a specified limit and time period.

Companies usually do not self-administer their self-funded group health plans. Many, if not most, conclude contracts with third parties for the management of employees' claims handling and payments. Third party administrators (TPA's) provide services that guarantee access to the preferred (selected by a paying company) provider networks, prescription drugs (card programs), as well as the contacts to (aggregate) stop-loss insurance market.

Insurance companies also offer similar services that can be described as "administrative services only" or "ASO", which is a type of a claims management contract. Under "ASO's" arrangements, insurance companies provides TPA services while assuming no risk for any claims payment (for the risks retained by an employer). The question remains however, what would motivate such an insurer to handle medical expenses cost efficiently, when it is not on the risk for the majority of them? Such insurers would probably exercise the same level of care or less control (could care less than about own claims) and could also become less pro-active, since they would only "administer" claims or in fact do processing only!. Whether this is a good solution – "ASO" managed by an insurer – is something that needs to be verified by an employer. There're views on the market that state "ASO should deliver claims data". Well, insurers should also be able

[3] Employee Retirement Insurance Securities Act:
https://legcounsel.house.gov/Comps/Employee%20Retirement%20Income%20Security%20Act%20Of%201974.pdf
As accessed on March 20th, 2019

to deliver claims data. Why would "ASO" managed by an insurer deliver more than the same insurer when not acting as "ASO".

The TPA can play the same role (of "ASO") in the case of self-insurance health risks when captive insurers are used.

The biggest advantage of self-funded plans may lie in the transparency of claims data. Self-funded companies, which contract a TPA receive a monthly report detailing type of medical claims and pharmacy costs. Knowing this information may become critical in controlling costs, preventing fraud and also changing the buying patterns. However, are the monthly, quarterly or year reports really analyzed in depth and used for those purposes. Who is doing the analyses, how often, what are the outcomes of such analyses?

Other advantage is plans' flexibility (self-funded health plans are not subject to insurance regulations). In self-funded plans employer does not need to choose between plans designed by insurers. Employer decides on a scope of cover of its own plan. There are no different risk charges taking considerations for age, sex, prior performance.

Next own decision is about the access to national networks of HMO (Health Maintenance Organization) or PPO (Preferred Provider Organization) or others, and resulting financial savings.

More expected advantages – financial savings coming from:

- Savings from keeping underwriting profits that a health insurer is normally expected to make.
- Savings from not using an intermediary in purchasing a fully insured plan (or using to a lesser extent).
- Savings from not paying State and Federal insurance premium taxes.
- The cost of claims processes can be modified to make lower admin costs (bundling payments as an example).
- Starting with risk management initiatives leading to lowering the overall claims frequency.
- Self-funded plans should have full transparency of claims data, which allows employers to set up an EPO (Exclusive Provider Organization), which can be more effective than PPO selected supplier in order to eliminate high cost providers.

Disadvantages from self-funded health care plans:

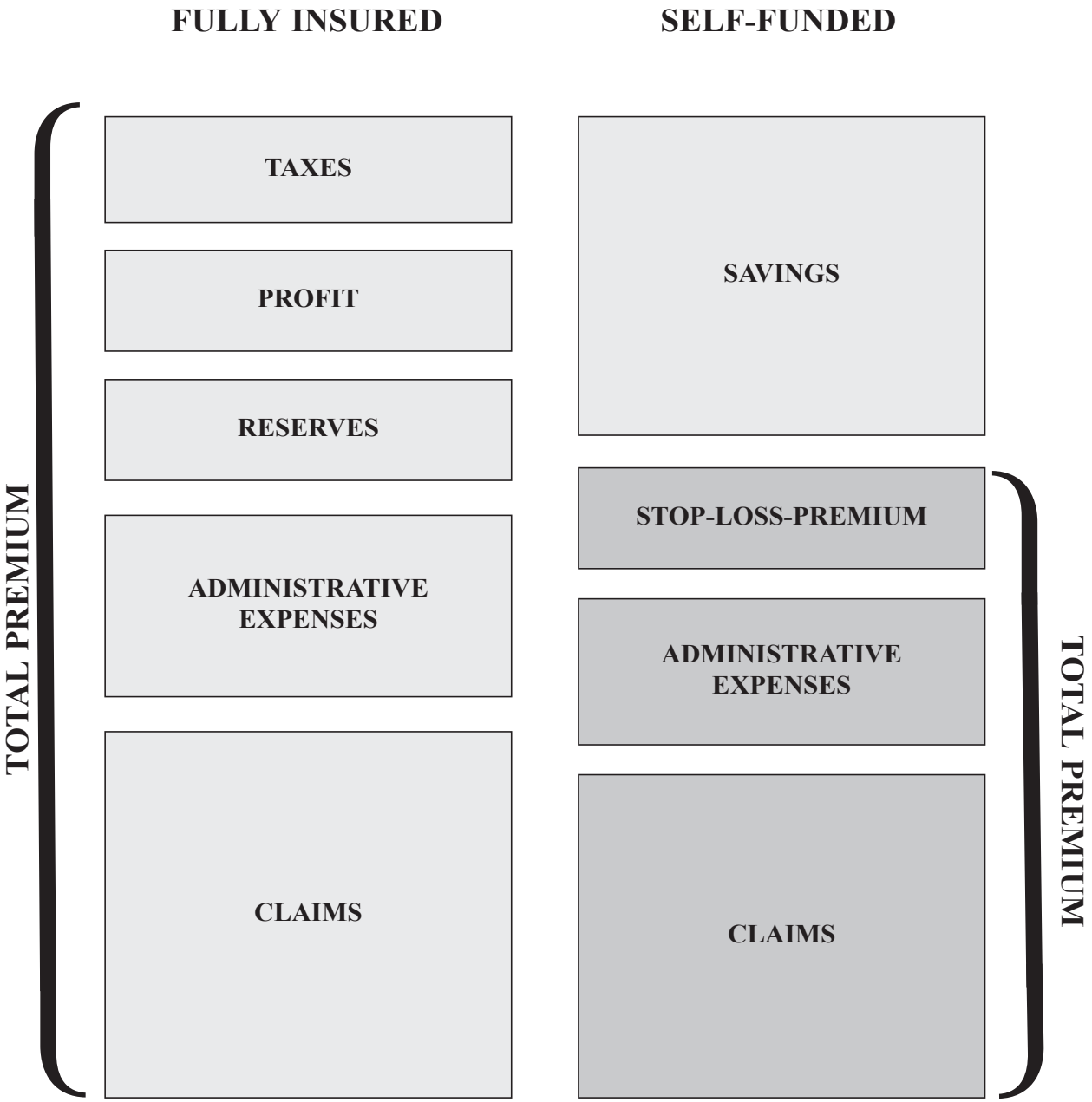
- No stability in cash flow. Claims (especially large ones) may come at unpredictable times, meaning sometimes a fund could not carry enough funds and it would have to be topped up.
- Underwriting loss, meaning a company/employer may receive more claims than it budget for, therefore ending up with the costs higher than a total premium offered before by a commercial insurer
- Lack or limited availability of adequate stop loss insurance.

An overlook of where the savings may come from. In this simple diagram, savings come from taxes (not paying insurance premium taxes), profits of insurers (normally expected) and a common policy of over reserving by an insurer (lack of transparency.

In reality potential for savings is much higher and comes with smart and risk management.

There are two types of self-funded plans managed by employers

- Fully funded plans, those where companies (employers) takes on themselves the entire risk of future medical expenses without any limit and protection from a stop-loss insurance policy. These type of plans are used only by the largest employers in the US, with thousands of employees covered.
- Partially funded plans, where only high frequency and low individual costs risks are carried by employers. The high costs and low frequency type of medical or disability risk of events are insured by stop-loss insurers.



Source: https://www/bluestoneadvisors.com/benefits/self_funding/self-funding-basics.html

Self-insured plans expose companies to much larger risks in the event that more claims than budgeted must be paid.

Like with any insurance arrangement, in the case of self-funded health plans, there are also two main type of costs to consider:

Fixed costs such as administrative fees, stop-loss premiums and other fees charged per employee or claim by TPA and variable costs, which are payments for health care claims coming from those who are eligible under the plan and/or for disabilities of employees.

In order to limit the risk exposure, some employers use stop-loss insurance or excess of loss re-insurance, which reimburse the employers (or their captives) for claims that exceed a predetermined level. Such types of a coverage can be purchased to cover "catastrophic" claims (catastrophic – in terms of financial consequences to self-funded plans) on any covered person or to cover claims that significantly exceed the expected level for the group of covered persons.

There are insurance captives behind self-insured health plans and Willis Towers Watson in its report declared there're about 80 health and employee benefits captives.[4]

Overall, captives servicing the life and health risk are still in their "infancy period" (only 80 employee benefits captives vs. almost 7000 captives worldwide speak for themselves).

Likely, local regulations (depending on a domicyle) may also not promote this type of source of covers, however, despite the fact that no strong evidence has been found that they are gaining popularity amongst US companies, they should be taken into account at the models to be considered for the future.

In line with such a thinking, a regulation has been proposed in the US to allow small employers to form Associations Health Plans (AHP). *"The rule, still in proposal stage, would effectively broaden the definition of an "employer" under the Employee Retirement Income Security Act of 1974 (ERISA) to include AHPs, which provide properly qualified health benefits to participants… Potential captive implications:*

I expect that it will take several years before captives come into significant play relative to AHPs. As discussed above, AHPs will be targeted primarily at small employers and allow them to be collectively treated as a single entity for underwriting and regulatory purposes. Until a sufficient critical mass (i.e., more than 1,000 lives) having credible experience data and track record (i.e., three to five years) can be attained, most AHPs are likely to remain in a fully-insured structure.

After a few years of established credibility, I would expect many AHPs to make a conversion to self-insured structures to capitalize on the benefits associated with assuming greater levels of predictable risk while continuing to transfer higher levels of catastrophic-level exposure to a re/insurer".[5]

The proposed AHP regulation, would somehow resemble MEWA (Multiple Employer Welfare Arrangement), which has been about marketing health and welfare benefits to employers for the benefit of employees. MEWAs collect premium contributions from employers, which are then paid into a single trust or custodial account or fund and subsequently used to purchase insurance or to pay the cost of benefits to medical service providers or employees. MEWA funds are controlled and managed by a centralized administrator, without a direct control from participating employers. Cases of mismanagement of MEWAs' funds have been a problem in the past years leading to some states disallowing such arrangements. US Department of Labor also has had issues about MEWAs on its agenda.[6]

There are many variations of self-insured health plans that help employers reduce the cost of health insurance. One of the options is *"a partially Self-Insured Health Plan, with an Integrated HRA. One variation of a partially self-insured health plan is to raise the deductible on the group (commercial) health insurance plan and self-insure the difference with an integrated Health Reimbursement Arrangement (HRA). For example, the company increases the deductible from $500 to $5,000. The company uses an HRA to reimburse employees for up to $4,500 (the difference in the deductible). Using the HRA in this way, the employer is self-insuring the $4,500 additional deductible*

[4] Willis Towers Watson Multinational Pooling and Benefit Captives Research Report 2016/2017, https://www.towerswatson.com/en/Insights/Newsletters/Europe/UK-Corporate-and-Trustee-Briefing/2018/01/financing-employee-benefits-via-captives, as accessed on 20.03.2019

[5] Phillip Giles, Captive International, The implications of captives for associations health plans, https://www.captiveinternational.com/contributed-article/the-implications-of-captives-for-association-healthplans, As accessed on 20.03.2019

[6] United States Department of Labour, https://www.dol.gov/agencies/ebsa/about-ebsa/ouractivities/enforcement/healthcare-fraud, as accessed on 20.03.2019

and seeing costs savings because most employees won't reach their $5,000 deductible".[7]

HRA is not a health insurance product but merely a supplementary account offered by some employers as a way to finance a patient's out of pocket medical costs in connection to their healthcare plans.

Availability of medical claims' data and its deep analyses should help employees and employers in preventing some of the type of detrimental health events an in the consequence avoid some of the health costs and introducing changes to the services' usage (tailoring a plan) or changing medical suppliers?

Many of the unknowns, should become knowns, such as cost/benefits of using a particular "ASO"/TPA. Whether "ASO" report from a health insurer or TPA can be used to measure the business performance of "ASO"/TPL itself (whether benchmarking could be made). Whether "ASO"/TPA is able to implement improvements a company/employer suggests or demands. Whether "ASO"/ TPA is able to deliver a risk management advice to the employer and employees.

Self-funding had become popular before Obama's Affordable Care Act. With the rising cost of healthcare in the previous years, the self-funding has become a serious option that is considered also amongst smaller employers (<100).

It is estimated that the average self-funded plan covers 300-400 employees in the private sector who have now a workplace health plan, 59% were covered by a self-funded plan that is at least in part self-insured.[8]

As far as risk management in a self-funded health plan, at least two approaches should be considered:

Risk management approach – focus on a proper set up of a fund by employer.

This should include:

- Employees / patients' health safety risks (i.e. to consider suppliers' external market reviews before employers finally selects them and which employee is told to use)
- Financial risk (putting the adequate amount of funds aside so that overall financial performance of the self-funded health plan is sound)
- Legal, tax, regulatory and compliance (entire structure must be reviewed from all the angles with a special attention to the proper management of sensitive medical data)
- Reputational risks (selected "ASO"/TPA must work efficiently and stay reasonably available and able to control performance of contracted medical services, maintain a proper system of complains management, deliver a promised in the health plan scope of cover met with sufficient financing and clear procedures)

All of the above must be monitored and periodically reviewed. Findings need to be analyzed in order to be properly risk managed.

Risk prevention approach – decrease of costs related to health problems of employees. The wellness programs should include:

- Detection (i.e. vision and hearing screening, mammograph, physical examination)
- Advanced assessments (i.e. advanced check-ups, health of heart, use of substance, level of fitness)
- Coaching (i.e. availability of a health consultants – i.e. back care, health incentives, materials on health issues on intranet communication, support in quitting smoking)
- Health education (i.e. health and fitness education, advice on nutrition, stress management, building up a culture of health risk aware)

[7] Christina Merhar, Fully-Insured vs. Self-Insured (Self-Funded) Health Plans, 04.02.2016, https://www.peoplekeep.com/blog/fully-insured-vs-self-insured-self-funded-health-plans, As accessed on 19.03.2019.
[8] New York Times quoting Employee Benefits Research Institute, 13.02.2013 https://www.nytimes.com/2013/02/18/us/allure-of-self-insurance-draws-concern-over-costs.html?_r=0 Accessed on March 23, 2019

Other approaches for risk management in self-funded health solutions may consist of:

- Identify and characterize threats (identifiable health exposures and risks that are most certain to occur i.e. influenza, type of work related accidents)
- Assess the vulnerability of human health in relation to specific threats (i.e. work related accident exposures, how exposures to health threats are mitigated)
- Determine the risks (i.e. the likelihood that a specific types of flu viruses may attack employees performing specific jobs of i.e. office administration, call center, drivers
- Identify ways to reduce those risks (i.e. early detection, vaccines, health education)
- Prioritize measures on risk reduction in relation to a strategy (i.e. implementing rules for stress reduction, having procedures in place to follow when a risk materializes)

Principles of risk management

The International Organization for Standardization (ISO) codified the principles of risk management in ISO 31000:2009. The purpose of it is to provide principles and guidelines on risk management to:

- have a systematic and structured processes
- become an integral part of organizational processes
- become part of decision making process
- create value and take resources to mitigate risks vaddress uncertainty and assumptions
- become tailorable
- always to be based on the best available information
- take human factors into account
- take machine wear and tear into account
- become transparent and inclusive
- become capable of continual improvement and enhancement
- become continually monitored or periodically re-assessed

In summary, in the markets where local law permits self-funded health plans or least does not penalize it, such as on the US market, the self-funded health plan is a viable option, which should be considered by medium to large employers (100 employees and family members). With potentially legal and organizational opportunities of sharing health risks amongst smaller employers, it may even become a bigger opportunity than perceived at this time.

Adopting risk management approach can only improve the financial results and the satisfaction of all stakeholders who use self-funded health care plan.

Availability of stop loss insurance should make self-funding health plans less risky, however, it need to be noted that some stop-loss insurers can put limitations on less healthy individuals in smaller groups. Interesting enough, stop-loss insurance is not treated a health insurance and can impose limitations that are illegal under current health insurance rules for people. One needs to remember though, that a policyholder under stop loss insurance is not a person/employee but it is his/her employer (therefore limitations under stop-loss cover are legal).

Moreover, there is a concern that too many self-funded plans with young and healthy employees will erode bases for commercial insurers health plans offered on health exchanges to employers.

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