WHITEPAPER

4 Ways Self-Funded Health Plans Benefit Companies of All Sizes

Executive Summary

To attract and retain the best workers, companies provide a rich assortment of benefits, the most critical (and expensive) of which is health insurance.

Workers — who may be familiar with "traditional" insurance companies such as Blue Cross and Blue Shield, UnitedHealthcare, or Aetna — might be surprised to learn that their company is either partly or fully self-funded, with their employer footing the bill for their healthcare claims. In fact, 61% of covered workers are in some sort of self-funded plan.

Companies with self-funded health plans have greater freedom to design plans that meet the needs of workers without many of the state regulatory burdens that fully funded plans must contend with.

This white paper will address:

- Healthcare cost trends in the United States
- Insurance funding mechanisms
- Role of third-party administrators (TPAs)
- TPAs versus administrative services only arrangements
- Advantages of self-funding
- Why TPAs make sense for organizations

Read on to learn how third-party administrators can bring more value to self-funded health insurance.

Introduction

Anyone who has paid a healthcare premium or an out-of-pocket expense recently knows that healthcare is expensive — and that costs continue to climb.

In 2022, healthcare spending in the United States grew 4.1% to $4.5 trillion. The Centers for Medicare & Medicaid Services (CMS) note that the increase is more than the 3.2% rise in 2021 but better than the 10.6% increase during the pandemic year of 2020.

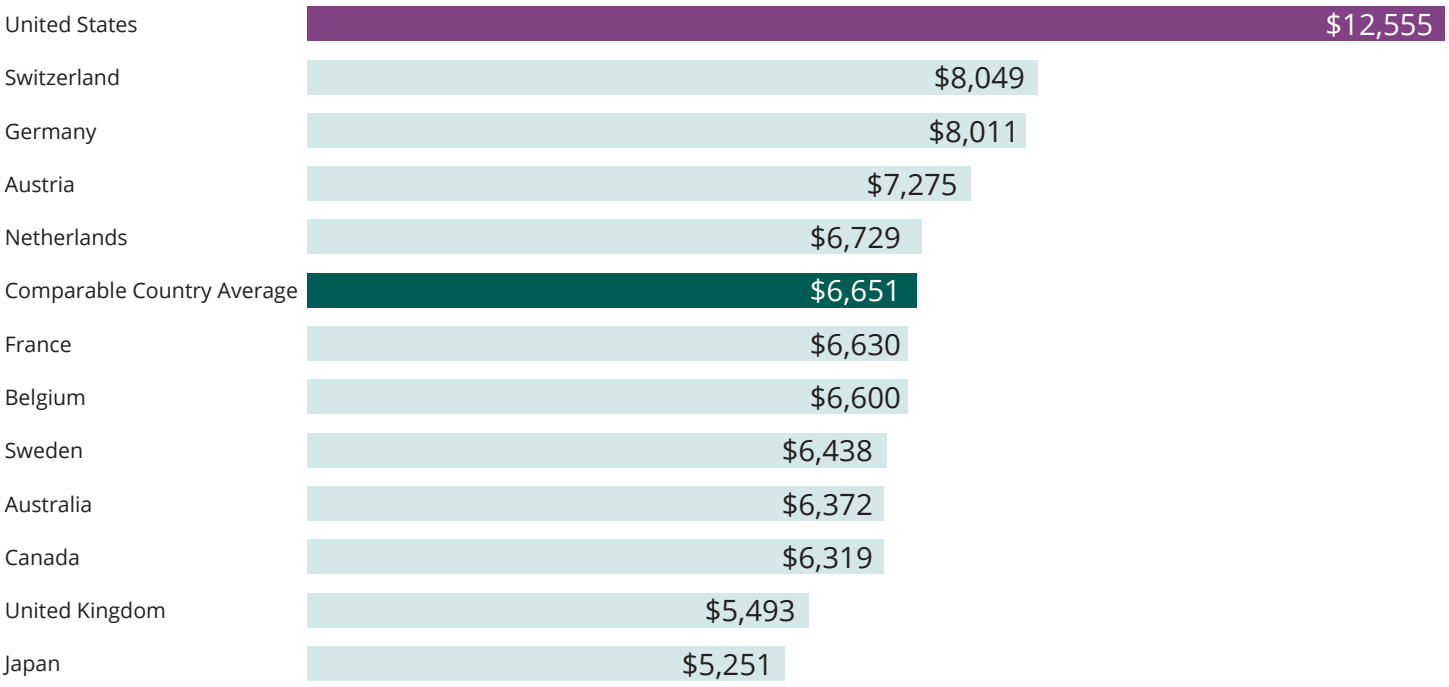
Healthcare spending in 2022 accounted for 17.3% of the nation's total gross domestic product (GDP), which represents a slight improvement from the 17.5% the nation saw in the 2016-2019 time frame. GDP is a measure of the value of goods and services a country produces over a period of time.

Per capita healthcare costs in the U.S. are roughly double the average in other industrialized nations.

Among funding sources, federal, state, and local governments accounted for nearly one-half of all spending (48%). Individuals and families paid 28% of the total, with private businesses picking up 18% and other private revenues accounting for the final 6%.

Per capita healthcare costs in the U.S. are roughly double the average in other industrialized nations ($12,555 vs $6,651) and $4,500 higher than the next most expensive country.

Health Expenditures Per Capita, U.S. Dollars, 2022

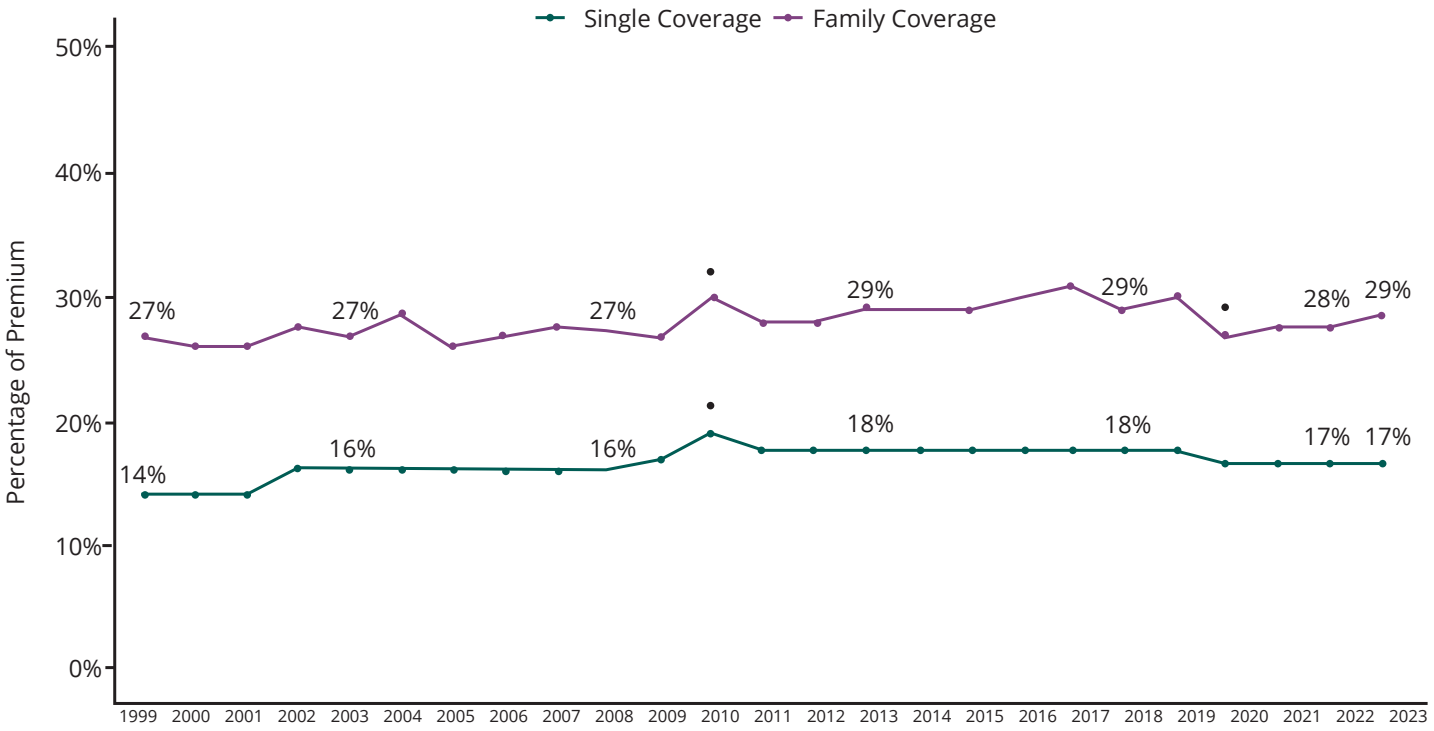


Notes: Data from Australia, Blegium, France, Japan, Switzerland, and the U.S. are estimated. Data from Austria, Canada, Germany, the Netherlands, Sweden and the United Kingdom are provisional.
Source: *KFF analysis of OECD data*

What does the world's highest per capita healthcare spending mean in terms of outcomes? Compared to other industrialized nations, the United States "has the lowest life expectancy at birth, the highest death rates for avoidable or treatable conditions, the highest maternal and infant mortality, and among the highest suicide rates," according to the Commonwealth Fund. Additionally, Americans have the highest rate of multiple chronic conditions and nearly twice the obesity rate.

Despite the high cost of healthcare, the country has among the fewest number of practicing physicians and hospital beds per 1,000 people, and Americans see these physicians less often than in most other countries.

Average Percentage of Premium Paid by Covered Workers for Single and Family Coverage, 1999-2023



* Estimate is statistaclly different from estimate for the previous year shown. (p > /05)
Source: *KFF Employee Health Benefits Survey, 2018-2023; Kaiser/HRET Survey of Employer-Sponsored Health Benefits 1999-2017*

Given the high cost of care, it's not surprising that the average health insurance premium continues to rise, increasing 7% in 2023. That year, the average premium for single coverage was $8,435, with family coverage costing $23,968 per year. Family premiums have increased 22% since 2018 and 47% since 2013.

On average, covered workers pay 17% of the premium for single coverage and 29% for family coverage, percentages that have been relatively stable over time. Workers at smaller firms bear more of the brunt for family coverage, paying 38% of the premium costs compared with the 25% that workers in larger firms pay.

About half of U.S. adults say it is difficult to afford healthcare

Over the past decade, employers have been shifting more of the healthcare payment burden onto employees through higher premiums and less generous benefits, often raising deductibles before insurance kicks in, increasing copayments for physician visits, and lowering the percentage of a healthcare visit they will pay for.

Consequently, individuals and families are feeling the financial burden, with about half of U.S. adults saying that it is difficult to afford healthcare and 25% reporting that they or a family member in their household had difficulty paying for healthcare in the previous year. The issue is more acute among younger and poorer respondents, the uninsured, and those who describe their health as fair or poor. One-quarter of those with insurance say they've skipped or postponed a healthcare visit, a figure that passed 60% among the uninsured.

Nearly 75% of adults say they are "very" or "somewhat worried" about unexpected medical bills or the cost of other healthcare services for themselves or their families, with nearly one-half saying they could not pay an unexpected medical bill of $500 or more without going into debt.

Offering healthcare benefits is a bedrock of American industry as a way for companies to attract and retain good workers. Costs are escalating for employers, too, leading to tough financial decisions about how to keep their best workers without breaking the bank.

Savvy employers are looking for innovative ways to optimize their healthcare spending while offering robust coverage for their workers.

Insurance Funding Mechanisms

Employers now purchase insurance in one of three ways.

Fully insured plans

In this option, an insurance company designs the plan, including predefined health benefits and coverage levels. The employer has limited flexibility in plan design; it must select from the plans offered by the insurance company. Although this can simplify the process of choosing a plan, it can limit the options available to employees.

The employer pays a fixed premium each month, regardless of how many claims are filed by employees. This fixed cost helps employers with cash flow, budgeting, and financial planning.

However, the premiums are typically based on the average health costs of the entire insured population, which means that healthier groups may end up paying more than if they were part of a self-funded plan, which has much more flexibility in plan design. Additionally, the premiums for fully insured plans are set in advance and not adjusted based on actual claims experience, which can increase costs for employers and employees.

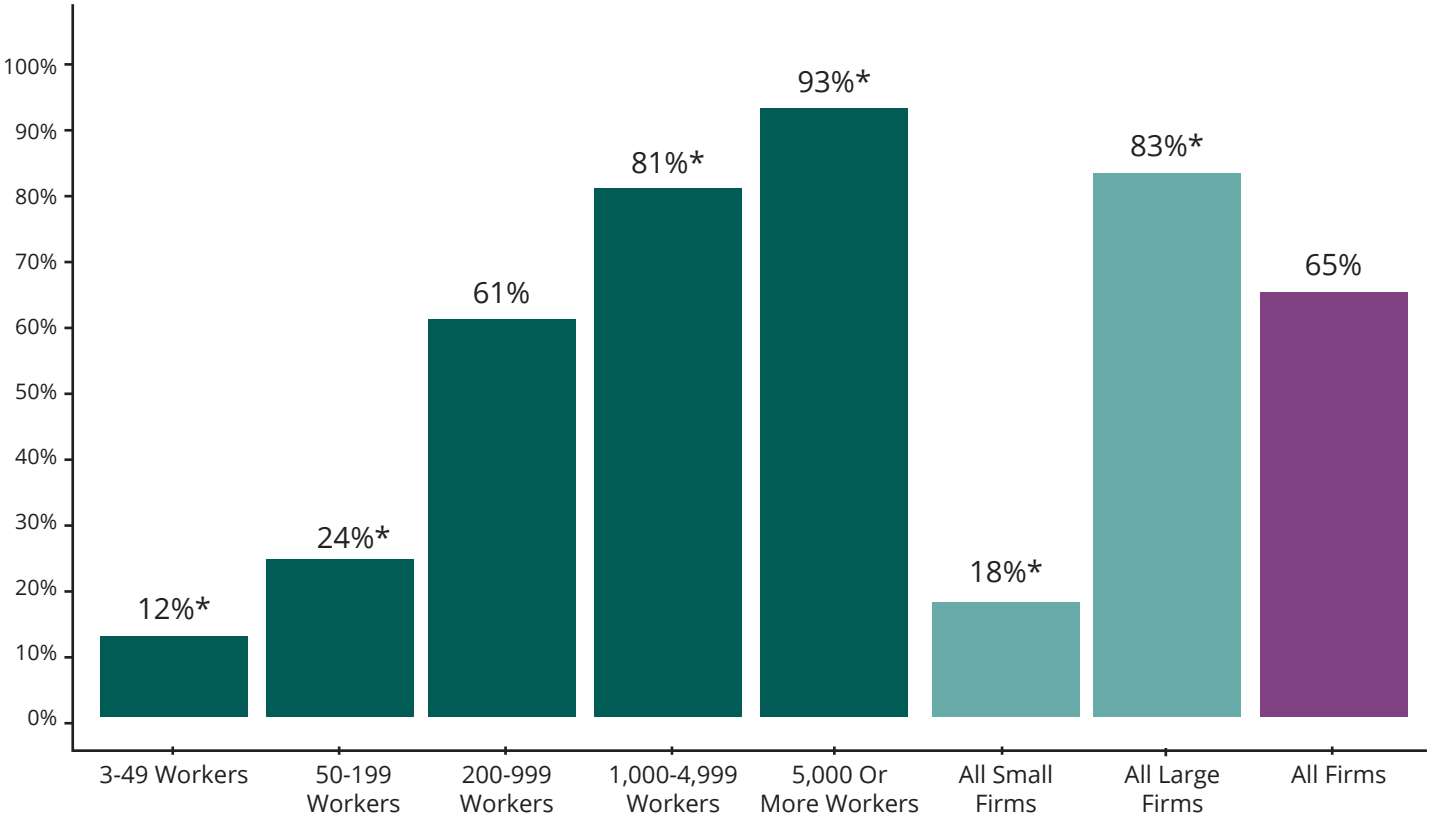
Fully insured plans are subject to federal and state mandates about minimum coverage, as well as state taxes, which may include premium taxes and assessments on health insurance carriers.

Policies of this type are often sold by a "BUCA," one of the larger insurance companies: Blue Cross Blue Shield, UnitedHealthcare, Cigna, and Aetna. These companies often have significant market share in various regions of the country and offer a variety of health plans, including employer-sponsored plans, individual plans, Medicare, and Medicaid plans.

Self-Funded Plans

Self-funded plans offer greater flexibility and usually a lower cost. Employers can customize their plan to meet the specific needs of their workforce, including choosing which benefits to cover, setting deductibles and copayments, and selecting providers. Nearly two-thirds of covered workers are in self-funded plans, a figure that has held steady over the past decade. Unsurprisingly, employees at large firms are more likely to participate in a self-funded plan than workers in small firms (83% vs. 18%).

Percentage of Covered Workers Enrolled in a Self-Funded Plan, by Firm Size, 2023



*Estimate is statistaclly different from estimate for all other firms not in the indicated size category (p > 05).
Note: Includes covered works enrolled in self-funded plans in which the firm's liability is limited through stoploss coverage.
Source: *KFF Employee Health Benefits Survey, 2023*

In self-funded plans, claims are paid as they are filed. This means that expenses for the employer fluctuate based on the health status of the workforce. This can help to reduce costs for the employer compared with fully insured plans, which usually charge a fixed premium regardless of whether claims are ever filed and processed. Self-funded health plans are typically subject to the Employee Retirement Income Security Act (ERISA) and the Affordable Care Act. Employers must comply with these regulations to avoid penalties and legal liability.

The employer manages self-funded plans, including processing claims, paying providers, and administering the plan. This may necessitate additional staffing and resources, particularly for larger employers, or require the employer to engage an entity known as a third-party administrator (TPA) who provides those services for a fee.

Self-funded plans offer more flexibility with reporting and analytics than fully insured plans. Employers own the claims data and can use it to identify areas of high healthcare spending and adjust the plan to control costs. Additionally, self-funded plans can be customized to maximize cost savings. This may include offering wellness programs, managing medical referral programs, negotiating with providers for lower prices, providing prescription drug programs, and implementing cost-sharing measures such as deductibles and copays.

Importantly, self-funded plans are exempt from state premium taxes. However, the premiums for stop-loss insurance (which protects employers from catastrophic claims) may be subject to state taxation.

Level-Funded Plans

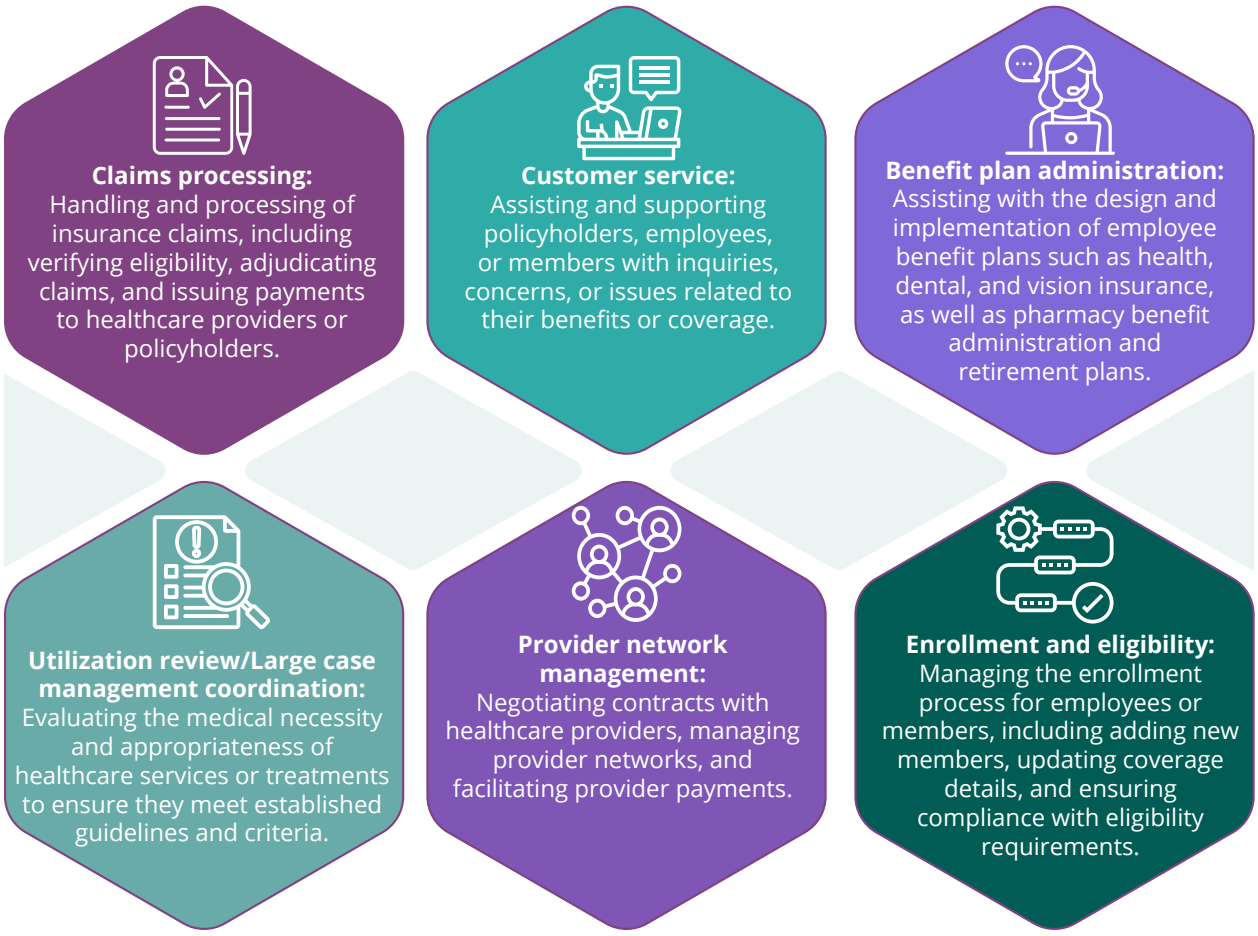
A level-funded health plan is a type of self-funded health insurance plan that combines aspects of both fully insured and self-insured plans. In a level-funded plan, the employer pays a fixed monthly premium to the TPA, which is used to cover administrative costs, stop-loss insurance, and claims funding.

The key feature of a level-funded plan is that it offers employers the opportunity to benefit from lower costs if their employees' healthcare expenses are lower than expected. If claims plus the premium is lower than the funded amount, the employer may receive a refund or credit at the end of the year. Conversely, if claims exceed the funded amount, stop-loss insurance kicks in to protect the employer from catastrophic losses.

Level-funded plans often appeal to small and mid-sized businesses looking for cost savings and greater control over their healthcare spending, while maintaining the security of a fully insured plan's predictable monthly payments. Level-funded plans can introduce many employers to the value of self funding while controlling the variable cost of claims.

What Is a Third-Party Administrator (TPA)?

A third-party administrator (TPA) is a company that provides administrative services for group health benefit plans. TPAs play a crucial role in helping organizations manage their insurance and benefits programs efficiently, often by leveraging their expertise, technology platforms, and economies of scale to streamline administrative processes and control costs. Overall, a TPA plays a vital role in helping organizations effectively manage their insurance and benefits programs while providing personalized service and unbiased advice.



A third-party administrator operates autonomously from insurance companies or other large entities that may provide insurance or benefits services. TPAs typically offer their services to a wide range of clients, including employers, unions, associations, and government agencies, without being tied to a specific insurance carrier or financial institution. Overall, TPAs play a vital role in helping organizations effectively manage their insurance and benefits programs while providing personalized service and unbiased advice.

TPAs play a crucial role in helping organizations manage their insurance and benefits programs efficiently

Objective advice: TPAs offer advice and services tailored to the specific needs of their clients, without any bias toward insurance products or providers.

Customized solutions: They have the flexibility to create bespoke solutions for their clients, including designing benefit plans, managing claims, and providing consulting services based on the unique requirements of each organization.

Vendor neutrality: TPAs are not restricted to working with specific insurance carriers, providers, or vendors. This independence allows them to offer a wide range of options and negotiate favorable terms on behalf of their clients.

Client advocacy: TPAs represent client interests in dealings with insurance companies, healthcare providers, and other stakeholders in the insurance and benefits industry.

Comprehensive services: TPAs typically offer a full suite of services, including claims processing, enrollment and eligibility management, benefit plan administration, compliance support, and more.

Expertise and experience: TPAs often have specialized expertise and extensive experience in various areas of insurance, benefits, and healthcare administration, enabling them to provide high-quality service and strategic guidance to their clients.

BUCAs May Also Offer TPA Services

Health insurance companies of all sizes (including the largest ones, referred to as "BUCAs") may also offer TPA services as part of their business operations. However, the primary focus of these companies is typically on providing health insurance coverage rather than TPA services. Some insurance companies may have subsidiaries or divisions that specialize in TPA services such as claims processing, benefit plan administration, enrollment management, and utilization review.

Despite offering TPA services, BUCAs may not be as specialized or independent in their offerings as dedicated TPA firms.

TPA vs ASO Arrangements

In an Administrative Services Only (ASO) arrangement, an insurance carrier provides administrative services, including claims management, to a self-funded employer group without assuming financial risk for the claims. An ASO arrangement often includes plan design and implementation, claims processing, customer service to employer/employees, and reporting and analytics on relevant claims and cost data. The employer is responsible for funding the claims payments and paying a premium to the carrier for the administrative services.

This can be a cost-effective solution for employer groups that do not have the financial reserves or cannot meet the state regulations for providing minimum self-funding. ASO contracts and processes can cost more than those offered by TPAs because the insurance carrier's contracts, systems, and processes tend to be less flexible and cannot provide the cost containment features that most TPAs offer. Also, any cost savings the carrier achieves remain with the carrier and not the employer.

In the early years of self-funding, most large health plans used an ASO model, in which an insurer provided administrative services and stop-loss insurance against excessive total or individual claim amounts. Most smaller plans used a TPA model, which offered claims administration, stop-loss insurance, and provider networks bundled into a package.

Larger employers chose the ASO model because they did not understand self-funding and felt they needed the familiarity of a "named" insurance company. Also, insurers were not "renting" their healthcare provider and hospital networks to anyone who didn't buy a policy directly. Consequently, larger employers felt more confident that their employees could retain their primary care doctors if they chose to stay with the insured model.

Today, insurers routinely rent their networks, transparency has removed the barriers to knowing where the premium dollars are going, and the requirement of providing detailed information about healthcare costs has taken away the rationale for choosing an ASO. Further, lawsuits filed in 2023 regarding the failure of ASO carriers to provide requested claims and reporting data to their clients shows growing weakness in ASO relationships.

Advantages of Self-Funding

Self-funded health insurance can offer significant financial, administrative, and strategic benefits for employers, allowing greater control over healthcare costs and plan design, as well as enhanced opportunities for employee wellness and satisfaction. However, it also requires a readiness to assume financial risk and manage the complexities of plan administration, which is where TPAs can help.

Advantages can include cost savings, flexibility, transparency, and mitigation of risk.

01 | Fiduciary Due Diligence

Benefits are the second-most-expensive line item for employers after wages, accounting for 31% of each dollar spent on employee compensation. Health insurance undoubtedly represents the lion's share of that expense, making the potential cost savings of a comprehensive self-funded healthcare plan attractive to employers.

Companies can avoid paying the profit margin included in fully insured premiums, leading to potential cost savings. They also can save on state health insurance premium taxes, which are typically around 2%-3% of the premium cost.

Self-funded plans often have lower administrative costs when companies use TPAs for claims processing and other services. By paying for actual claims as they are incurred, employers can improve cash flow and investment opportunities, retaining funds that would otherwise be held by insurers to earn interest that can, in turn, benefit their members.

Self-funded health insurance can offer significant financial, administrative, and strategic benefits for employers

02 | Flexibility

Because most self-funded plans are subject to federal ERISA regulations and not state laws that govern fully insured plans, companies can craft policies that adequately cover the workforce, tailor benefits to the company's unique worker mix, and better reflect a company's values. Not only can well-designed plans enhance employee satisfaction and retention, but they can also be more easily adjusted to reflect changing workforce needs or cost-containment strategies without waiting for insurance company renewal periods.

For example, several states have laws in place to cover certain infertility treatments. While fully funded plans in those states are required to follow state law, self-funded plans have the flexibility to dismiss those mandates. Of course, a self-funded employer might offer those benefits to keep worker satisfaction high, but a religious organization that self-funds may choose not to offer infertility coverage.

Fully insured plans maintain their own networks where cost and quality may be secondary concerns to keeping providers and facilities happy.

03 | Transparency

Fully insured plans typically provide limited information on how healthcare dollars are spent. This can make it difficult for employers to identify areas of high healthcare spending or assess the effectiveness of the plan. Employers that have self-funded plans enjoy greater access to claims data and health trends, enabling them to make informed decisions about plan design and wellness initiatives. With detailed claims information, companies can work with their TPAs to identify cost drivers and implement targeted health programs to manage expenses.

For example, dialysis clinics and infusion centers often have high service costs that may have nothing to do with quality. Armed with the relevant data, TPA can develop a network of providers and facilities that offer high-quality, lower-cost services that employees can be incentivized to use, ensuring quality care while saving companies money.

Since the payment of premium is what 'seals the deal' with the fully insured plan, there is no incentive to share the true cost or quality differentiations with the employer. Further, depending on the provider contract, the payment made to the provider by the insurer might not reflect the true cost of service but instead, more reflect a deal between the insurer and provider for a certain reimbursement rate.

04 | Risk Mitigation

When properly designed and implemented, self-funded plans can save companies money while covering all their risk bases. Flexibility and transparency play important roles in mitigating risks, as companies have more freedom to devise plans that cover the unique needs of their workers.

Patients facing catastrophic conditions or expensive, multiple chronic conditions might forego necessary treatments because of the overwhelming costs of deductibles and copays. But delaying treatment is also very expensive for companies when the patient finally seeks care, because the patient's condition has deteriorated to the extent that they might need costly hospitalization or rehabilitation.

With the patient's consent, one mutually beneficial solution could be for the employer to enroll the worker in an Affordable Care Act marketplace plan, paying the premiums as well as any deductibles and copays. This way, the patient receives needed care, and the employer better understands the costs for that patient.

Why TPAs Make the Most Sense

Many employers prefer the accessibility and flexibility of a TPA over traditional ASO insurance products or the added expense of a traditional fully insured plan. For example, at renewal, an employer might find the TPA offers renewal showing a wide range of options, whereas the insurer offers its product only.

They run lean. National insurers generally have high fixed costs and heavy salary loads. A TPA's overhead tends to be lower.

They act fast. TPA managers are usually directly involved in plan administration, which speeds up responses to client issues.

They are more flexible. TPAs are not as encumbered with mandates from insurers, state regulators, bankers, or outsiders, so they tend to be more accommodating and willing to experiment with benefits, processes, and reporting.

They are more current. TPAs are on newer, more robust processing systems, versus insurers that usually are on legacy systems with limited data capture.

They concentrate their efforts. Most TPAs emphasize medical plans and cost containment to avoid nonrelated, peripheral services that can add to their overhead (e.g., pensions, life insurance, brokering other products).

They can provide data. TPA systems capture huge amounts of data that can be utilized by the employer and their adviser to track costs, develop programs to improve wellness, and provide needed reporting. Many insurers cannot provide such robust data and would not wish to for reasons that usually include unfavorable comparisons.

Additionally, many TPAs have expanded their services beyond claims processing and reporting. They are stepping up with additional services, such as:

Plan design that includes managed-care options or high/low plans, as well as tracking profit-sharing arrangements with providers

Claims management that includes monitoring excessive coding (upcoding), use of individual codes that should be bundled, coding inconsistencies, overly frequent physician visits, and fraudulent coding

Financial management that includes editing bills, obtaining medical advice to combat possible abuse, internal quality assurance edits, and detailed performance measurement

Data management by such criteria as procedure codes and medical reserves

Provider negotiation such as selection criteria, credentialing, and outcomes tracking

Additional services such as pharmacy benefit management, medical management, and care navigation

Assistance with managing such services as Health Savings Accounts (HSAs), Flexible Savings Accounts (FSAs), COBRA and workers compensation claims.

The flexibility of TPAs can help employers focus on the unique cost pressures within their organizations, helping to home in on problem areas.

Working with Creative Advisors, Brokers, and Consultants

Many employers rely on trusted advisors to help them with their employee benefits decisions. Unfortunately, most of these advisors are driven by the BUCA influences in the market. TPAs can partner with creative advisors to customize a solution that is right for their clients' needs without the red tape rules of the BUCAs.

Conclusion

As healthcare costs continue to spiral, employers are fighting back by reducing benefits and increasing copays and deductibles, which places an ever-growing financial burden on workers. Self-funding health insurance makes sense for many reasons, including the ability to tailor benefits to a company's unique employee population and providing incentives for patients to take a greater interest in their health and seek lower-cost options when they need care.

Third-party administrators play a pivotal role in the healthcare landscape, working with companies to collect and share aggregate claims on employees and performing plan administration tasks at a lower cost than traditional insurers.

The benefits are numerous, which is likely why more than 60% of covered patients in the United States are participants in a partially or fully self-funded health insurance plan.

For more information on how self-funded health plans can benefit companies of all sizes, please contact the Health Care Administrators Association via the contact information below:

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