Employer Health Care

Listed below are articles related to employer-offered health care. The most recent article is at the top.

Determining Whether to Go Self-Insured

By Jeff Adams June 13, 2016

The question as to whether to self-insure or fully insure health care benefits can be a difficult one. Often the deciding factor in this determination is the cost analysis performed. A group may go self-funded for other reasons such as additional benefit flexibility or the desire for a more transparent cost structure whereby the group has more detail about for what it is paying. The purpose of this paper and the accompanying Excel spreadsheet is to discuss the cost analysis that could be performed as part of a self-funding analysis.

Overview

An analysis of the costs of a self-insured plan versus a fully insured plan must include all claims, administration, and retention costs for the plans and use the same set of benefits. Even though a group may decide to change benefits, the cost comparison between the self-insured and fully insured plans must use the same benefits in order to avoid misleading results.

The cost comparison should begin with a determination of the benefits to be used for the comparison. Once the benefits to be analyzed have been determined then the cost of the plans can be obtained. Often the cost of the fully insured program is obtained first as it may be less complicated than the determination of the cost of the self-insured plan. After the cost of the fully insured program has been estimated then the cost of the self-insured plan can be estimated. Determining the cost of a fully insured plan is to gather information about the components of the insurer's premium rate quote and may help ensure that all of the individual pieces of the self-insured plan are included (taxes, fees, etc.).

Determination of Benefits

When valuing the cost difference between a self-insured plan and a fully insured plan, it is important that the benefits used in both are as equal as possible and as close as possible to the desired benefits (if known at the time of the valuation) to be implemented so as not to make the cost difference estimate inaccurate. For example, if a fully insured plan is valued with a $500 deductible and the self-insured plan is valued with a $750 deductible then the cost comparison would inaccurate attribute a savings to the self-insured plan that was really just a benefit difference.

Other items that should be consistent are utilization management and other cost containment program fees and savings to claims. These programs may have a significant effect on claims costs and may also have administrative fees attached so it is important to ensure consistency. An alternative is to make adjustments to claims and administration if they cannot be made consistent. Determination of consistency may require on-site visits to the entities performing the cost containment services for both the self-insured and fully insured plans.

Much of the information needed for the cost analysis may be obtained from he quotes from

the entities offering the self-insured and fully insured plans.

Fully Insured Plan Cost

Generally the cost of a fully insured plan is just the premium paid but there may be exceptions. If contingent premium plans are involved such as a plan where 90% of the total possible premium is paid during the year with the rest paid, if necessary, upon retroactive settlement at the end of the year, then the 100% premium rate should be used and not the 90% premium that is paid during the year.

If possible, component pieces of the premium should be estimated, such as claims, administrative cost, utilization management fees, wellness programs, etc. This breakdown is important in ensuring consistency with the components used in the self-insured cost estimate. Often certain utilization management, wellness program, or other program cost are included in the base premium. It is important to understand such components so that the corresponding self-insured plan may be valued consistently.

Self-Insured Plan Cost

Costs for a self-insured plan may be more difficult to estimate than fully insured costs. Part of the reason is that fully insured plans have the cost bundled while the different components must be added up to determine to cost of the self-insured plan, making sure the components are consistent with the components of the fully insured plan.

In addition to cost adjustments for administrative fees for programs such as cost containment programs and wellness programs, it may be necessary to modify the claims cost if cost containment features or provider discounts are different for the self-insured plan than they are for the fully insured plan.

An adjustment may need to be made if provider discounts are different from the fully insured plan or if utilization management practices are different.

Summary

A cost assessment of the cost differential between fully insured and self-insured plan costs performed independently of the analysis performed by the entities offering the plans is essential in making the decision as to whether to be self-insured. Materials from the insurer or self-insuring TPA may be misleading and it may be difficult to get a full understanding of the cost difference using just their marketing materials. For example, TPAs may show the claims reserve as a cost savings for the self-insured plan although this is inaccurate. This is a slight cash flow advantage. However, the advantage of being able to invest these claims reserves is not extremely beneficial as they need to be invested in very short term instruments as they need to be liquid due to the possibility of needing to use these funds being used to pay outstanding claims.

It is important to look at total cost including claims and administration, especially if a different entity is quoting the two different plans. Utilization management practices and providers are different between entities and this difference is often overlooked. The difference in claims cost is more important than the difference in administration as claims are usually

75% to 85% of the total cost. Specific provider discount and utilization management adjustments may need to be made to the claims and administrative costs in order to get an accurate cost analysis.

Employer Health Care Costs

By Jeff Adams July 16, 2013

Many employers are complaining about the effects of ObamaCare on its health care costs. This is certainly a valid concern but it is also important to note that ObamaCare is only one of a variety of reasons for high health care cost trends. It is also important to note that one of the reasons that ObamaCare was enacted was to fix one of the major issues with our flawed health care system: The 50,000,000 citizens in the United States that are uninsured or underinsured. Whether it is appropriate to put these extra costs on employers' backs is a question that needs to be answered before we fix this problem for the long term.

Added Costs to Employers

There are several reasons why employer health care costs will increase more than the normal trend under ObamaCare in 2014:

Employers are being charged extra fees that are designed to allow for subsidized, lower premium rates for individuals purchasing coverage through the Exchanges and for small groups. The reasoning behind this is that this will make Individual coverage more affordable for individuals who cannot obtain affordable coverage through their employers. The Premium Tax Subsidy will pay a portion of the premium for low income individuals, at least in the short term.

Many employers will be forced to cover more employees due to the new "counting" rules for counting the number of employees. This change is the inclusion of hours worked for part-time employees in the calculation and requiring that an employee count all of its employees in one calculation and elimination of the ability, in some cases, of an employer separating employee counts into different categories to avoid having over 50 employees.

The expansion of Medicaid may have the impact of changing employer costs. Medicaid fee schedules are much lower than the commercial fee schedules on which employer claim payments are based. Providers have little leverage as to what Medicaid fee schedules are but negotiate with insurers for commercial fee schedules. If there is an influx of patients at the very low Medicaid fee schedule then there may be instances where providers will seek additional monies from the payors in the form of higher commercial fee schedules to compensate for actual costs not covered by the Medicaid payments. In some cases this could actually lower employer costs if Medicaid payments are sufficient to cover provider costs since the additional number of claimants would allow the providers to spread its fixed costs over a larger base.

The $2 per year fee assessed to policies for the Patient-Centered Outcomes Research Trust Fund is designed to fund research that will lower costs and increase quality of care in the long term. The major failure of our health care system is that costs are extraordinarily high and need to be controlled. This fund is designed to fund research in best practices in health care

treatment.
The $1 per year Risk Adjuster Fee is designed to fund the administrative costs of running the Risk Adjuster program. Risk Adjusters pay issuers that have the sicker patients, thereby eliminating incentives for the insurers to try to enroll only the healthier patients.

There may be other direct or indirect effects of ObamaCare. For example, one of our local employers has announced that it will drop coverage for employees not working 30 hours a week. These employees will now have the opportunity to obtain coverage through the Individual Exchange and may be able to obtain Premium Tax Subsidies and Cost-Sharing Reductions if their income level is below 400% of the Federal Poverty Level.

The Uninsured Problem

What I see as one of two major weaknesses in our health care system is that 50 million citizens are uninsured or underinsured in the United States. That is roughly 17% of our population. I see three predominant viewpoints on how to deal with this situation:

1. "Let them be, not having insurance is their own fault because they either are not working, not working for the right employer, or choose to not have coverage. Anyway, it is not my problem." I would like to think there are not many people who think this way but there are more than we would expect. Most of them would not actually make this statement but many inherently make this decision by ignoring the problem or any discussions of the problem.

2. "Let the employers cover it. It should be a part of its cost of doing business to provide coverage for its employees. Anybody who is not employed would get coverage through Medicaid or Medicare anyway." There is a ring of truth to this mentality but, as usual, nothing is that easy. Many industries face stiff competition from home and abroad. In many industries it would mean that all companies would need to add health care, therefore all companies would still be on a level playing field, with consumers footing the bill in the form of higher product prices. In some situations, such as where the competition is from overseas and employers do not have to pay for health care, would put the U. S. firm at a competitive disadvantage.

3. "Let the government pay." Ultimately this means that the citizens would need to pay through additional income taxes or sales taxes. Opponents of bigger government would vehemently oppose this, especially depending on the details of how it would work.

The answer to the problem of the uninsured is probably a combination of all of the above.

The Cost of Health Care

The other major weakness that I see is the extraordinarily high cost of health care in the United States. As an example, the federal and state governments have to cut funding for other programs each year due to the high cost of health care in the budgets. Health care will probably be around 25% of the Federal budget in Fiscal Year 2014 or 2015, easily reaching 35% to 40% of the Federal budget by 2034. This would mean other programs representing 10% to 15% of the Federal budget would need to be eliminated during that period. This problem gets worse in each successive year. Fixing this problem is not easy, especially in the very political setting in which it need to be fixed, as the normal "band-aid" approaches to

fixing this problem increase costs on the commercial side, including employer coverage. These approaches and budget battles may go on for years before te problem is fixed.

The cost issue for employers precedes ObamaCare. Employers have been complaining about high trends and high premium rates for decades. Sadly we are not much closer to fixing the problem now than we were in the 1980s. Employers continue to drop coverage due to the high costs. ObamaCare exacerbates that problem slightly but is not the major issue. I honestly see no end to the employer cost issue. Employers will continue to lower benefits and policyholders will pay more, but the underlying problems with our health care system will still be there.

Do Not Fixate on Repealing ObamaCare

I have heard talk of fixing our health care system by repealing ObamaCare. I am not a huge proponent of ObamaCare but I see no better plan being proposed. Most who want to repeal it do not offer any tangible alternatives, just gimmicks that will, at the very least, have no effect on health care cost increases or, at most, actually increase health care costs in the United States above and beyond the exorbitant levels that currently exist.

I am not offering any new ideas as to how to fix our health care system in this article. Several other articles that I have written, such as *Controlling Health Care Costs*, have included such ideas, however.