INSURANCE FUNDING AND SOURCING OPTIONS: DISCOVER NEW TOOLS THAT BRING RESULTS

Empower Your Employees and Cut Costs with New Health Insurance Management Options
Health care costs have risen at three times the rate of inflation over the past 10 years—that’s no secret. What may be less widely reported is how the number of strategic funding and budgeting strategies for small to medium companies have also greatly increased over those same 10 years. Companies with 100 to 500 employees have the most to gain from these programs.

While there are no silver bullet solutions, there are robust tools, programs, and strategies that can straighten out the upward curve to a more manageable incline. Though there seems little method to the madness of costs, there are methods to contain the madness. It is time to make the unmanageable once again manageable.

The main strategic advantage you can realize quickly,
regardless of your company’s internal policies, is to have a method to respond to actionable data midstream. The next, naturally, is having policies that are flexible enough to adapt to that data on the fly. This strategy brief will go over a few of the ways companies and their resource managers can take advantage of trends in healthcare insurance that open up options to control costs today—and prepare for future changes in the market.

We’ll explain the five most important shifts in healthcare funding practices and provider practices in Part I, then take a look at one—Captive Self-Funding—in depth in Part II. The five major trends that offer new opportunities for cost savings and shared risk are:

1. Self-Funding
2. Defined Contribution
3. Accountable Care Organizations
4. Pharmacy Benefit Management Tools
5. Employee-Directed Wellness Programs

PART I: FIVE TRENDS TO WATCH

All insurance is aiming at a moving target. The employer insurance market is continuously responding to shifts in both healthcare provider industry practices and employee coverage needs. However, along with the many changes in the healthcare insurance landscape, there have also come unprecedented innovations across the spectrum.

For employers, this new reality creates a rare opportunity to overhaul health care benefit offerings significantly while potentially reducing costs and improving the overall health and wellness of their employees. Studies have proven that healthy employees are more productive and take fewer sick days than their less-healthy coworkers.

Products and services are teaming up to make it simple for employers to offer such options. As consumers get accustomed to the new world of health care insurance, more of them will be looking to their employer-sponsored plans for wider choice and non-traditional benefit options such as wellness and weight loss programs.

1. **Self-Funding**
   
   **Not Just for the Big Guys Anymore**

   Most small employers are trapped in the fully insured market, unable or unwilling to self-fund for fear of risk and volatility. For those companies, it’s difficult to determine what size programs make the most sense.

   Larger companies have long been able to reap the benefits of self-funded and group captive programs because of their size. They often take a multiple-tiered approach for different levels of risk and insurance. Now, for the first time, medium and smaller companies can get in on those same “volume” savings.

   The risk and volatility that small employers fear is now much more manageable. Self-funded programs no longer require a tradeoff of security and risk.

   These programs may pool the resources of a number of companies and insurers, but they are centrally managed by specialized staff and are sourced through established networks of providers and vendors. Benefits include greater freedom to adjust plans based on past claims and stated goals, the reduction of overhead, and more autonomous fiscal control.

   If the administrator overestimates projected claims, the employer will hold on to the reserve cash. If claims by other groups covered by the insurer show significant loss, however, those losses are not shared in the self-funded group.

   And there is also additional “Stop-Loss” insurance available, which cap an employer’s exposure to financial risks.

   “Control” is the key element for employers that choose self-funding. They can control what benefits to provide, control what those costs will be, and control what amount of risk they are willing to accept.

2. **Defined Contribution**
   
   **More Choices, More Freedom**

   One of the best ways for employers to participate in this revolution is to switch to a defined contribution method of paying for their employees’ health benefits. That is, offering a fixed amount of money allocated to
each employee for his or her health care coverage.

To make a defined contribution system work, employers provide workers with access to an online private marketplace/exchange. These “private” exchanges mimic the new “public” exchanges by offering a wide range of health care coverage options, including medical, dental, vision, and even weight management and fitness programs.

By contrast, a traditional defined benefit program is built around a small number of insurance plans and presents limited options for employees. Defined benefit plans often result in higher costs and less predictable expenses for the employer. Defined contribution programs empower employers to make expenses more predictable.

Many employers are already switching to private exchanges and defined contribution programs. For 2014 open enrollment, Accenture estimates that more than three million employees were covered under private exchanges. By 2018, Accenture projects that 40 million employees will be enrolled in these exchanges under the defined contribution model. While large employers have already made the jump, most of the growth is among mid-market employers with around 1,000 employees, according to Accenture.

Though insurance marketplaces and private exchanges are not cost-savings mechanisms in and of themselves, they are the storefront for the new era of employee-empowered insurance decisions. With parameters clearly defined, and fixed-dollar, defined benefits, employees can use software to get the greatest bang for their buck.

The goal is to provide employees with the “Amazon” experience in shopping for insurance. Empowering employees to make choices and feel good about those choices is the first step in creating a lifelong commitment to wellness and health that produce the most productive and happy employees. These employees take control of their health and insurance in the short run, employers pay substantially less in the long run, and employees are often healthier in both the short and long run.

3. Accountable Care Organizations
A New Decentralized Era of Managed Care

An accountable care organization, or ACO, is an entity that consolidates service providers for patients with Medicare. Networking the resources of regional hospitals, physicians, and support staff creates more seamless and less disruptive care for patients that might need long-term or frequent attention.
The goal of promoting ACOs is cost savings from better-coordinated care that will, for example, reduce duplicated efforts, tests, and procedures. These same benefits positively affect patients’ health and their healthcare experience as well.

Shared Savings Programs between Medicare and ACOs are the backbone of the ACO system. The lure of joining an ACO for service providers is both to grow their network of providers and to see some of those savings passed on to them. But for ACOs to collect on those savings, they...
must meet specific quality standards in five areas:

- Patient experience
- Care coordination
- Preventive health
- Patient safety
- Care of at-risk, frail, and elderly

4. Pharmacy Benefit Management Tools

*Outsourcing the dirty work of drug contracts*

By some estimates, drug spending will increase by 10% annually over the next 10 years. Pharmacy Benefit Managers (PBMs) is another way both costs to employers and costs to employees can be maintained at manageable levels.

Like other trends discussed here, the pooling of resources and the consolidating of services offers both efficiencies of scale and market buying power. PBMs work for insurance carriers to provide quality medications at the lowest price. There are dozens of ways to trim costs here and there, as the drug industry is highly fragmented and highly volatile. Government intervention into the process may yield further gains, but the PBM industry doesn’t hold its breath waiting for the reactionary, yet slow-moving, gears of legislatures to light the way.

And, no surprise, the market is a competitive one. Large contracts with major pharmacy chains can make or break a PBM company, but this competition is the reason employers can reap the benefits that insurers working with PBMs can sow.

5. Employee-Directed Wellness Programs

*Preventive programs can reap immediate gains*

Employee behavior and lifestyle are significant factors in health status and, ultimately, the cost of healthcare—more so than genetics, the environment, or access to care.

Beyond understanding the cost of healthcare, most consumers are not engaged in taking charge of their health. One example is the growing prevalence of obesity in the United States. According to the Centers for Disease Control and Prevention (CDC), more than 35% of American adults aged 20 years or older are obese.

Employers, who pay the majority of their employees’ healthcare costs, have an enormous stake in engaging their employees in their own healthcare, from the lifestyle decisions they make to the healthcare they seek out.

Studies have shown that behaviors can be modified through the use of workplace wellness programs. Employees will seek appropriate, cost-effective care if they are motivated, engaged, and accountable.

A Full Handful of Options

Again, there is no one silver bullet, but there are many tools and strategies in your managed insurance arsenal that you might not be using to their greatest effect. The ultimate solution is often a combination of the above programs that are structured for both sound long-term planning and responsive short-term flexibility.

PART II. SELF-FUNDED CAPTIVE IN-DEPTH

*How “Captive” Programs Create New Value*

Many credible forecasts predict that costs of self-funded programs will increase 3.4% annually over the next decade, while fully insured programs will increase 9.9%. Compound that increase differential over 10 years, and the costs quickly multiply. For a mid-sized company with a $1 million premium policy, that could turn into a $1 million difference in total cost to an employer over a decade.

For employers with over 100 employees, self-funding will become more and more attractive—and it can start today, not just pie in the sky “future” savings. Many employer-sponsored plans will realize savings almost immediately.

One path to quick savings is through group “captive” programs that pool resources of cooperating employers. This offers an additional layer of control and protection for employers and employees. Captive programs also provide aggregated purchasing power and economies of scale.
Additional Layers of Protection

How Captive Tiers Reduce Risk

A group captive’s principal function is to reduce volatility. To step back a minute, let’s review the three layers of risk under a tiered approach:

1. Small and predictable claims (covered by the employer).
2. Medium-sized claims (covered by the group captive).
3. Catastrophic claims (covered by the insurance carrier).

Let’s take a closer look at the group captive “tier,” or “layer,” and the benefits of that strategy. The main benefit comes from the power of collective purchasing at higher scales than a company could achieve on its own.

There are certainly economies of scale. Another source of savings comes from reduced administration and fixed costs. In the past, captives formed inside one industry with 10 or more like-minded companies. Today, there is more freedom to form group captives across different industries and different company sizes.

In the group captive layer, all claims in the captive layer are pooled—including during the renewal process. Excess funds in the captive are returned on a pro rata to premium basis. (Distributions are calculated months after the policies expire and quarterly thereafter until all reserves are gone.)

Here’s typically how a layered approach will play out in practice:

1. Self-Insured Layer. Each employer retains a self-insured layer of claims. This layer is not shared with other employers and the experience is unique to each employer. It is more efficient for employers to pay all of their small, predictable claims directly, eliminating insurance company overhead and profits. Your company is responsible for self-insured claims below $25,000 (ISL) per individual, up to an annual cap.
2. Captive Layer. The participating group of employers...
shares their medium-sized claims through a group captive. A captive is an insurance company that is owned by the employers. The captive provides coverage for claims that are larger than a single employer should retain individually, but appropriate for the group of employers to assume collectively. Through the captive, your company will share claims that are greater than $25,000 per individual and less than $300,000 per individual, up to an annual cap.

3. Catastrophic Insurance Layer. Each employer purchases catastrophic claims coverage from a common stop loss insurance company. This coverage provides protection for claims that exceed $300,000 and to cover claims in excess of the captive’s annual program aggregate.

Managing Self-Insured Captive Plans

How self-funding within a captive works in practice

While your benefit plan is likely to change very little on the surface, the way that the plan is financed changes significantly. A traditional insurance company charges a premium that includes estimated claims, administration expenses, and a “risk premium.” The risk premium is an amount that the carrier charges in exchange for accepting the risk that actual claims might exceed expected claims. It is also where the carrier derives its profit.

There are robust reporting, monitoring, and modeling tools that keep the plan and claims within more predictable ranges. Managing claims closely means lower risk, and potential catastrophic claims are often identified, prepared for, and avoided before it’s too late. There is also a high level of transparent reporting of member company data for both employers and employees to use for their policy decisions. Actionable data is made available to empower managers and employees, and adjustments can be made midstream.

Reporting actionable data changes the normal “reactive” model of insurance decisions to engaged, “proactive” models. Most employees, and many employers, feel trapped into policies that may quickly seem inadequate if a large claim rocks the boat. The flexibility of self-funded and captive programs dampens the highs and lows of those fears and perceptions—and the realities.

Upon embarking on a tiered program that includes group captives, your insurance consultants will lay out a three- to six-year model plan, with built-in monitoring guidelines and adjustment parameters. The data can be both very broad and very narrow, because the more information you have the more control you have, and the more proactive you can be.

The benefit goes the other way as well. Without the data and analysis, you might be at the mercy of the policy or program. In this case, what you don’t know does hurt you.

Consultants analyze the data critically at very deep levels to identify trends and savings opportunities. Aggregate shock claims, for example, are managed quite differently from prescription plans. But the main point is that they can be managed. At every point in the process, policyholders can feel confident that they know where they’ve been, where they are now, and where they’re headed.

Managing Your Corporate Culture

Are Self-Funded Captive Programs Right for Everyone?

Every company is different, from founding philosophies to the day-to-day operations. There’s no way to learn about that corporate culture without going and finding out firsthand. You should not hire consultants who will not come out and observe your corporate culture from an “embedded” perspective.

Truth be told, self-funded and group captive programs are not a good fit for all employers. The first step is a thorough study to help employers determine their suitability. Employers that are a good fit for these programs typically have these characteristics:

- They recognize that their current health insurance path is unsustainable, that the fully insured market is flawed, and that they themselves will have to do some-
thing different if they want to change their future path.
• They are willing to roll up their sleeves and engage fully to create a different future. Engagement includes not only the work necessary to transition into the program, but also beginning to change the culture of the company to one of good health.
• They see financial incentives for employees (e.g., charging tobacco users a higher monthly premium contribution rate) as a good thing.

Self-funded group captive programs build confidence by relying on your own programs rather than on a combination of insurance companies, regulators, and government agencies. Exploring your options in this market will make you better educated to respond to the changes ahead.

There is no one silver bullet, but there are effective tools and efficient strategies that will support your goals. For many companies, a combination of several healthcare management tools fits the bill. Educating yourself about your options holds no downside—only a big upside.

Who is AHT?
AHT Insurance is a team of insurance brokers and consultants with extensive experience in self-funded and group captive programs for small- to mid-size companies.

What Can AHT Do for Your Company?
We have developed strategic employer healthcare plans for manufacturing companies across the United States. We offer customized solutions that save employers money in both short-term compliance and long-term management strategies.