The Future of Self-Funding

by Carlton Harker

This article deals with two important topics: (a) employer-sponsored health care as a national institution and (b) the role of self-funding as an equal or dominant player in the funding thereof, which are both being challenged.

There will be a significant evolution from traditional health care plans to defined contribution health care plans as the full effects of the claims and privacy regulations are felt, as well as the concern by employers over any patients’ bill of rights law. That is, the pension 401(k) experience will be repeated with health care. This transition, properly understood and planned for, will be a positive to self-funded plans and most vendors. Numerous additional actions by self-funded plans to hold, or improve, their competitive advantage are enumerated and discussed herein. In fact, if employer-financed health care is to be saved, it will be self-funding that will do it.

The Challenges

Self-Funded Health Care Plans

The current challenges to self-funded health care plans are many:
- Increasingly aggressive federal mandates
- Continuing difficulty with controlling health care costs
- New provider force—the Rx companies
- Changing politics and national ethos
- Economic conditions and the need to redefine the employer’s plan-payroll-disability-workers’ compensation-productivity paradigm.

In this time of great change, the concerned self-funder will be the target of many vendors who seek to take advantage of this uncertainty as well as many who will say a single payer program is needed.

This analysis presents a program, suitable to the self-funder, which will allow the self-funder to continue a self-funded plan without any medical decision-making liability and at less cost than any of the available options.
- The suggested program is of necessity not time tested and has some objectionable features to all of the parties involved.
- The failure of self-funders to respond in some aggressive manner will result in (a) business reverting to fully insured or (b) employer-financed health care no longer being possible.

All Employer-Financed Health Care Plans

In many ways, all employer-financed health care plans are being challenged; the primary adversaries to our present system are as follows:
- Large federal government advocates
- Globalists and internationalists with their economic agendas
- Those participants wishing benefits of an income-protecting nature, as opposed to an asset-protecting nature
- A small percentage of trial lawyers.

This analysis shows how self-funding may retain its competitive position with other funding methods (fully insured, prepaid medical and capitation). It also should be viewed as a method by which all employer-financed health care plans may be saved.

Possible Responses

Proposed solutions for survival would modify the existing system, which has been in place many years, with these 20 optional modifications.

1. Bifurcation of the Plan. Each plan should offer a defined contribution or a defined benefit option to each participant. The defined contribution option is an income protector; the defined benefit option is an asset protector. Plan bifurcation might also be an option where a high-benefit plan (both an income and asset protector) is offered.

2. Micromanaged Plan Document. Every procedure/diagnosis, etc., is clearly shown as covered or not covered so that the terms medically necessary/appropriate or experimental/investigational are not required. All federal mandates must be honored, of course. Further, document attachments include (a) an Encyclopedia of Questionable or Not Covered Procedures or Conditions, (b) claims processing rules, (c) administration guide and (d) privacy provisions. The plan booklet and SPD benefit summaries are congruent; the booklet text is ap-
3. New Employer Economic Model. In large part, the employer, after adopting the new program, should have much closer control over its health care costs. This includes the integration of its health care costs into its personnel/payroll, productivity, time-loss, disability and workers' compensation costs. Using a good health care plan as an inducement to hire or retain personnel should be reconsidered; what was reasonable in the past is not reasonable in the present.

4. Stop-Loss Modifications. These modifications should be considered:
- **Nature of Coverage.** The traditional stop-loss agreement (reimbursement) might be replaced with a high-deductible group policy.
- **Aggregate Coverage.** Such might be phased out as not necessary or appropriate.
- **Level of Specific Attachment Point.** Such might be trended downward when offered without aggregate.

5. Employer Liability. Consider the following areas of decision-making activity and the employer’s liability for each area:
   a. **Defined Contribution**
      Since the decisions are participant driven, there is no liability to the employer or to the plan supervisor (TPA, e.g.).
   b. **Defined Benefit**
      i. **Over the specific**
         Since the decisions are insurer driven, there is no liability to the employer. Rather, as with the fully insured plan, any liability is with the insurer.
      ii. **Below the specific**
         (1) Plan supervisor directed
            The plan supervisor assumes the liability for the claim decisions, which are all up/down decisions using the micromanaged plan document.
         (2) Utilization review firm directed
            The UR firm assumes the liability for the claims decisions that involve provider steerage, medical care influence, etc. Neither the employer nor the plan supervisor has liability in such instances.

6. High-Tech. The program, including the micromanaged plan document, lends itself to high-tech applications. Significant changes to existing software will be needed.

7. Small Self-Funded Plan. In the management of such plans, there should be (a) brochure-type marketing, (b) trusted risk pools (with each employer group financially responsible for its own experience) and (c) structured benefits.

8. Demand Management. The first generation (second opinions, e.g.) picked the ripe fruit from the ground; the second generation (managed care) has lost most of its bite because of (a) unfavorable court decisions or (b) pending legislation; the third generation is demand management (and its corollary, consumer-driven health care financing) and is likely the last cost-containing hope of employer-financed defined benefit health care plans. Since over 50% of health care dollars go for health conditions of our own causation (either by initial behavior or by underdisciplined ongoing care), demand management gains high marks for logic alone.

9. Fraud. Numerous changes affecting the plan increase the likelihood that fraud will become a problem; e.g., high-tech, quick decisions on claims, demands for broader coverage and elimination of medical necessity and experimental disciplines.

10. Medical Errors. The document/booklet should both provide that provider-assignees refund claims back to the plan where a demonstrable medical error occurred.

11. Employer Aggregate Stop-Loss Choices. The employer has three choices as regards such aggregate coverage:

- Forgo such coverage; for example, go specific only.
- Buy aggregate (with or without specific coverage at the market from an insurer).
- Elect membership in an established, trusted aggregate-only noninsurance reciprocal. Such reciprocal has much of the features of traditional aggregate, but members share with each other the claims burden by repayable loans or callable receivables so as to avoid any employer being at risk.

12. Role of the Utilization Review Firm. The typical role of the UR firm, following the HIPAA-required DOL claims regulations, should be expanded (helping with weekend confirmations, e.g.) and such firm should be independent in all ways from both the employer and the plan supervisor.

13. Funding Factors Using Attained Age. Funding by attained age is appropriate when both provided by the plan document and also in accordance with the ADEA regulations relative to economic parity.

14. Lifetime Maximum and the Advance Medical Directive. A plan amendment that results in a variation in the lifetime maximum depending upon whether or not the participant has an advance medical directive (living will) has merit.

15. Consortium of Plan Supervisors. Expanded administrative services by the smaller plan supervisor may be delivered by (i) renting such from a larger TPA or a vendor or (ii) being part of a consortium of plan supervisors.

16. Consortium of Plan Sponsors. Particularly useful for small employers, but by no means limited to such, the concept of a shared plan has merit and will yield economies of scale but must stop short of being shared experience wide. Financially speaking, each must stand on its own.

17. Eliminating the Antiselection From Duplicate Coverage. Simply put, duplicate coverage is not cost containing.
18. Fully Insured Carve-Outs. Several benefits, offered on a fully insured basis but as part of the self-funded plan (critical illness and/or organ transplant), become particularly useful with the defined contribution option. Also, death benefits, with the same tax advantages as with fully insured, may now be self-funded if a VEBA is used.

19. Retiree Health Care Coverage. Following the Supreme Court’s decision in the Erie County Retirees Association matter, employers may be well advised to amend their plan documents so as to treat under age 65 retirees as COBRAs and phase out, or eliminate, age 65 and over coverage.

20. One-Stop Shopping. The defense of using multistop vendor shopping, still heard, is that it is better, cheaper and more prudent to have as “few eggs as possible in one basket.” While this logic has merit in some instances it must be reconsidered for self-funded plans in the future.

Knowledge, gained both as a student of self-funding and as an expert witness to many plaintiffs and defendants, leads the author to conclude that it is safer, cheaper and better for self-funded plans to be served as much as possible by one-stop service.

One-stop service, for purposes of a self-funded plan, means that all vendors shall be controlled or coordinated as a general contractor would with multiple building trades. It does not mean that one vendor firm could bring all of the requisite skills to the plan “under its own label.”

The essential idea is that plan slipups, while rarely made, may be so costly, that it is essential that the plan fiduciary have maximum accountability for vendor actions.

The more vendor services that are under a general contractor, the more accountability will the fiduciary possess.

One-stop service might be deemed essential in order that there be a level playing field between self-funders and insurers (and HMOs).

New Risk Management Techniques

In General

Self-funded plans must be able to respond, not only with facility but also with accuracy, to the many challenges ahead. Many new tools or practices are becoming available to the self-funder:

- Maximizing high-tech applications
- Using a new economic paradigm
- Combining defined contribution and defined benefit options in one plan
- Adopting a micromanaged plan document
- Targeting the health care benefit to economic, age, gender and ethnic needs
- Increasing the role of demand management
- Bringing vendor service under unified accountability
- Funding by attained age
- Eliminating double coverage
- Rethinking status of the retiree and independent contractor
- Increasing vigilance for fraud, abuse and medical errors
- Varying benefits by absence/presence of a living will

- Having employer and participant each share in both the participant and dependent plan costs
- Using new gatekeeper discipline of corporate doctor or nurse
- Using Monte Carlo simulations to modify plan design
- Using a consortium of plan sponsors to gain economies of scale
- Eliminating aggregate stop-loss
- Rethinking fully insured carve-outs.

The choice of tools and practices recommended to the self-funder is a risk management task and should be so treated. In order that appropriate tools and practices are recommended, certain questions relative to the plan should be answered (to the extent possible).

Tools and Practices

- Is claims experience bad because of overutilization or shocker claims or both?
- Does the plan overemphasize accessibility to benefits, providers, Rx?
- Is the plan a lightning rod to poor risks?
- Is the conduct of the self-funded plan dominated by the financial or the personnel functions of the employer?
- Is overutilization identifiable by age, gender, occupation, participant dependent status or marital status?
- How many individual participants may be identified as being eligible for coverage under their spouse’s plan?

The Author

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