Identifying & Eliminating Waste in Medical Insurance Premiums

A properly designed & administered partially self-funded medical plan can help the small to medium size employer identify & eliminate wasteful spending.

Two of the bedrock principles underlying all forms of insurance are pooling of risk and transfer of risk. In very simple terms, pooling of risk states that in order to be financially viable, the insurance mechanism in question must cover as broad a pool of risk units as possible. In any given insurance pool, over a finite period of time, we know that a great percentage of those risk units will not produce any claims at all. A similar cohort of risk units will only produce limited claims. And finally, a very small number of the total risk units in the pool will suffer what can be termed catastrophic losses. The aggregate money generated by the entire pool—including those risk units producing either no claims or limited claims—is thus sufficient to pay for the very few number of catastrophic claims.

The concept of transfer of risk is equally simple. For any given perceived risk, the insured entity will choose what portion of that risk (potential losses) they can reasonably withstand without assistance, and what portion they absolutely could not withstand. The portion of risk or loss that is defined as unmanageable is then transferred to an insurance mechanism, which will usually charge a fee, expressed as an insurance premium, for assuming the unmanageable portion of the risk in question.

Now let's take a look at a hypothetical group medical insurance policy for ABC, Inc. Subtracting part-time employees, those covered by spousal coverage, and new hires not yet enrolled on the plan, ABC presently has 24 employees insured, with a few covering dependents. Their current group medical plan is a mid-range HMO, featuring a $20 office visit copay, with a $2,500 annual maximum out-of-pocket limit. ABC's gross annual cost for this coverage is approximately $180,000. Note that the above figures for ABC, Inc. were taken from an actual Southern California employer.

The insurance principles described above demand that we track just where ABC's money is actually going, and what protection ABC, Inc. is actually receiving for their premium dollars. In ABC's case, and as our understanding of insurance pooling would lead us to expect, about 46% of ABC's employees did not use their coverage at all over the benefit year in question. For ABC, this percentage represents approximately $83,000 in premiums ($180,000 annual premium x 46%). In other words, this $83,000 was used to purchase insurance protection against claims that simply did not occur. A further 48% or so of the insured population fell into the "infrequent or occasional" claim cohort. Some years ago, Blue Shield of California analyzed utilization across their entire book of business, and found that the average member only consumed about $600 in healthcare services. This study was recently updated, with similar results. The current version indicates that over 90% of all Blue Shield of California members still only consume just under $1,000 of healthcare services in a given year. For ABC, over the year in question, this low-utilization cohort averaged about $550 per employee in claims. Presenting these figures in premium dollars versus claims expenses yields the following results. Our low-utilization employees (48% of ABC's group) represent approximately $86,000 in paid premiums, but produced only $6,300 in claims (24 employees x 48% x $550). Here again, ABC has paid significantly more in

premiums than their insured population has consumed in healthcare expenses. Only 6% of ABC's employees suffered truly significant claims, and actually reached their annual out-of-pocket maximum. It should further be noted that ABC's claims experience falls right in line with both statistical expectations and demonstrated utilization across hundreds of small & medium size employers. Additionally, the larger the employer group, the more reliable these statistics become.

At this point, the alert reader will probably be screaming that claims experience ebbs and flows, and that you're statistically due for at least one rough year for every four or five good years. Very true. And no knowledgeable, professional benefits advisor will ever try to disguise that fact. Having said that, the picture presented by the case study detailed above is striking. In short, we know what claims to expect from a given group (insurance pool) over a given year, and can estimate with surprising accuracy the cost of those claims. If we then introduce the principle of transfer of risk to this knowledge and resulting calculations, we are left to question exactly where the majority of your medical insurance premiums go. If a full 46% of ABC's employees made no claims at all; 48% made only very limited claims; and only a meager 6% suffered what we defined above as "unmanageable losses," then why is ABC, Inc. paying insurance premiums based upon the flawed assumption that 100% of its employees will experience a catastrophic claim? More to the point, how can the astute employer control this waste of precious premium dollars?

Enter the concept of partial self-funding. For the small- to medium-size employer, this means purchasing a high-deductible, fully-insured medical insurance policy from a major carrier to protect against the very small number of large claims we can expect to develop, funding the limited claims made by "occasional users" from dedicated company funds, and finally retaining the money that otherwise would have gone to pay premiums for claims we know in all likelihood will never occur.

Several key points must always be kept in mind when discussing partial self-funding for the small- to medium-size employer. The first is that the purchaser is never going to be completely self-insured, and thereby fully exposed to unmanageable risk. Truly catastrophic claims will be properly covered via the fully-insured, high-deductible policy that underlies this concept, most often through a Health Reimbursement Account-approved product. Secondly, the employer should never be tasked with administering the complexities of paying the limited claims of our occasional users. That is a job best left to a properly licensed & bonded third-party administrator with verifiable experience in this particular niche. Thirdly, partial self-funding will provide the employer with far greater flexibility in designing the exact structure of benefits underneath their new high-deductible plan, affording the unique opportunity to tailor benefits much more accurately to the needs of their employees. Lastly, it is critical that complete transparency be practiced between employer, administrator, and employee benefits advisor. Integrity and trustworthiness are vital if the plan is to succeed.

The actual savings an employer can expect from the implementation of a partially self-funded medical policy can vary widely depending on myriad factors, including the cost and benefit design of their present coverage, demographic make-up of their employee population, and known medical conditions within the group. However, within the small employer market, annual savings of $20,000 to $30,000 are commonplace. Larger employers will often realize even greater savings. In broad terms, experience shows that implementation of such a plan will yield immediate savings in about 30% of all cases, with

future rate increases also blunted ("bending the curve"); another 30% of implementing employers will probably not see immediate savings, but will position themselves to benefit from reduced renewal increases; and essentially 40% of employers will not be suited to this approach, and should not implement it.

In this era of continually increasing employee benefits costs, partial self-funding should be seriously considered by even smaller employers. A brief review by a qualified broker and administrator should quickly indicate whether it is a worthwhile option, and the potential savings are simply too large to ignore.

Postscript: Four recent case studies to consider:

1) Southern California employer with approximately 150 employees. Current group medical coverage through Kaiser Permanente; high-deductible HMO with "medical bridge" supplement. Kaiser renewal increase of 13% for 2011–2012 plan year. Using alternative Kaiser plan and partial self-funding approach, potential annual savings equal to renewal increase.
2) Southern California employer with approximately 30 employees; close to half located in site offices across six different states. Current group medical coverage with Anthem Blue Cross, with employees spread between five different HMO and PPO plans. Partial self-funding with high-deductible PPO yielded potential annual savings of 25%.
3) Southern California employer with approximately 42 employees, and growing. Current group medical coverage with Anthem Blue Cross $30 Copay HMO. Anthem renewal increase of 8% for 2012–2013 plan year. Implementing partial self-funding with high-deductible HMO yielded potential annual savings of 30%.
4) Southern California employer with approximately 25 employees, and growing. Transferred from Kaiser $50 Copay plan to Kaiser high-deductible HMO & partial self-funding approach *three* years ago. No immediate savings at time of implementation, but benefits were significantly improved. By carefully monitoring both ongoing claims expenses and balance of employer-funded claims account, employer has been able to *decrease* deposits into claims account over time, effectively negating Kaiser renewal increases for three plan years consecutively.