MARCH 07, 2013

HEALTH CARE REFORM LEADS EMPLOYERS TO CONSIDER SELF-FUNDED MEDICAL PLANS

Last month, HHS issued final rules on "essential health benefits" required under the Patient Protection and Affordable Care Act ("PPACA"). Those rules are important for the future of state and federal health insurance exchanges because they finalize the rules with which insurance companies must comply in providing benefits to their insureds. However, these essential health benefit rules do not apply to self-funded medical plans. In fact, many PPACA rules do not apply to self-funded plans. Because of the differences in the rules governing self-funded plans versus those governing fully insured plans, some employers who have not previously thought self-funding was a better approach to providing health care benefits are now revisiting the issue.

Self-funded plans actually cover most workers who get their health insurance through their employer. The Kaiser Family Foundation has surveyed employers concerning health benefits since at least 1999. The Foundation reports that 60% of American private and public sector workers who received employer provided health care in 2012 were covered under self-funded plans. In 2000, 39% of all workers were covered by self-funded plans. Their surveys have consistently shown that the prevalence of self-funded plans increases with employer size. In 2012, 93% of plans covering 5,000 or more workers were fully or partially self-funded. That 2012 number is up from 72% in 2000. For 2012, 15% of employers with 3 to 199 workers maintained self-funded plan. For employers with to 200 to 999 workers, 52% were covered by self-funded plans in 2012.

SELF-FUNDING SAVINGS

One of the primary reasons why employers are considering self-funding today is the cost savings that may result from self-funding. Self-funded plans escape the health insurance industry fee under PPACA, the proceeds of which are used to fund state and federal health insurance exchanges. The cost will run 2% to 2.5% of premiums in 2014.

Self-funded plans also avoid the essential health benefits mandates of PPACA. These services include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devises; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. One large insurance company estimated in 2012 that the services mandated for fully insured plans by PPACA will increase premiums from 7.5% to as much as 15%.

Self-funded plans also avoid state premium taxes, which cost participants and employers around 1.75% of premiums each year.

In total, a self-funded plan may realize savings of as much as 20% over a fully insured plan.

OTHER ADVANTAGES

Among the other advantages to self-funding are:

- Self-insured plans are not tied to community rating for determining premiums as are insured arrangements.
- Self-funded plans will be more adept at allowing employers to determine what their true costs of coverage are. With this data, employers can more directly address high cost services.
- Medical loss ratio requirements do not limit self-funded plans' expenditures on administrative expenses as they will for insured plans.
- Self-funded plans are likely to be in a better position to manage future uncertainty because they escape greater regulation that the health insurance industry faces.
- Review of premium increases by the Secretary of HHS under the health care reform law does not apply to self-funded plans.
- Self-funded plans avoid the adverse selection insured plans are likely to encounter.

Self-funded medical plans are not a panacea, however. If you have questions about the pros and cons of the self-funding medical benefits,

contact Bill Roberts at (502) 568-1890 or ebplans@hallrender.com or your regular Hall Render attorney.