



# Self-insurance — could it work for you?

## Rethinking the delivery of employee benefits



By Francis Ignatz,  
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With escalating healthcare costs, smart employers are contemplating a novel funding method — self-insurance — to finance employee benefit plans.

Though self-insurance has been around since the '50s, for most of this time its use has been confined to large companies, like banks and railways. Now, self-insurance,

using an administrative services only (ASO) contract, is a viable option for smaller enterprises, thanks to a blend of better technology, developments in financial and insurance products and the rise of third-party benefit administrators.

A benefit plan can be divided into two parts. The first part is an insurance component to cover a catastrophic event, such as long-term disability, the death of an employee or an unforeseen need for special medicines or treatments. The second part is a cash contribution component used to pay for everyday benefits, such as drug costs or dental care.

In a self-insurance arrangement employers only pay for the benefits they use. This provides them with more flexibility, cuts down on administration costs and gives firms greater control over the amount they actually spend on benefits.

Traditionally, most firms have simply purchased a benefit plan through an insurance company. That was fine when benefit plans were first introduced and multiple insurers were competing to provide employers with different options.

However, a number of events are conspiring to force employers to think about benefits differently. First, consolidation and demutualization of the insurance industry means fewer competitors and therefore fewer options when it comes selecting a plan.

Second, rates are rising quickly. While the cost of inflation has been running between two to three per cent, insurers have been hiking the cost of their benefit plans higher. Health care inflation trend factors used by insurance companies are averaging increases between 18-22% annually.



### Traditional models

In the group insurance industry, insurers spread the risk associated with loss of life, long-term disability and other catastrophic claims over their entire client base, so employers pay similar rates within their industry regardless of their claims record. There's no way for insurers to accurately predict what these low-frequency, high-expense claims will be for each employer, so the risk is spread across many employers based on actuarial assumptions. This is the purpose of pure insurance — to cover high-cost, unpredictable losses.

On the other hand, medical and dental claims occur frequently but are relatively inexpensive. Claims experience in a group tends to remain relatively stable when monitored over time. As such, you can essentially predict and budget for these types of expenses.

However, insurance companies often try to recover more in expenses than what they pay out, so when they get it wrong, they simply hike their rates or increase their claim reserves.

Reserves are an ill-understood concept that insurance companies use to protect themselves should an employer with high claim costs decide to terminate the relationship and move elsewhere. It's an amount over and above what they actually think it will cost them to insure an event — a rainy day fund, if you will. Frequently reserves are explained as funds held to protect the employer in the event of unexpectedly high claim costs, or "run-off claims" paid out after a contract ends. I look at it differently. I say it's there to protect the house, and we know that in the long run the house always wins.



Employers now have another option — ASO plans managed by third-party benefit administrators.

**Another option**

A third-party benefits administrator protects against risk by assessing the correct type of insurance coverage needed to cover the catastrophic event component. This depends on a number of factors, ranging from the type of business to the number of employees. The administrator works with group insurance brokers and insurance firms to obtain quotes and find the appropriate stop-loss insurance plan that fits the employer's needs. By separating the pure insurance component from the budgeted, or cash flow, portion of the plan, the administrator can take advantage of group buying power and shop for lower rates, which are passed onto the employer.

In our group benefits consulting and administration business, we frequently purchase stop-loss insurance with a \$5,000 deductible to protect the employer from catastrophic medical claims, like prescription drug “cocktail” treatments (some of which can run \$30,000 to \$40,000 annually), hospital claims or out-of-country emergency medical expenses.

When it comes to the self-insured health and dental care component, the administrator and the employer work together to establish a budget for those items, and the monies are placed in trust with the administrator, which runs the plan and adjudicates claims. Employees or their health-care providers simply submit their claims directly to the administrator, which processes them and issues claim cheques. Some administrators can issue health cards for purchases like drugs and medical devices.

The administrator's job is to monitor the claims experience and help clients develop a better understanding of their true costs. If, at the end of the year, there are surplus funds left in the trust account, they are either returned to the employer or become part of the budget for the next year's claims and the employer need only top up the fund. Alternatively, if the account is overdrawn, the employer must make up any deficit with additional contributions. The plan can be monitored monthly and spikes in claims can be quickly identified and dealt with.

The flexibility of a self-insured health and dental plan allows employers to reward loyalty. They can set up a phased-in benefits schedule so that more

benefits are provided the longer the employee remains with the company. A company can also budget for benefits across an organization according to profit centres and category of employee or management level. This helps the employer better understand the source of their true benefit costs.

These plans work best with organizations that employ 15 or more people. This threshold size minimizes cost volatility. The employer usually pays the administrator a percentage of self-insured contributions as a plan operation fee. The strategy applies to any industry, from retail to manufacturing and for most business structures, from family-owned companies to professional firms.

While benefit costs have been rising, our firm's experience with the self-insurance model over the past five years shows a number of employers have had minimal increases in the costs of their benefits coverage.

So are self-funded benefits nirvana? Not necessarily. Employers that have never had a benefit plan do not have historical experience to model accurate budgeted costs. But for the average employer, they open the door to a new way of thinking about benefits and how best to structure a plan that meets the needs of both employers and employees, while providing the flexibility needed to grow a successful company. ■

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**Things to watch for in a third-party administrator**

When it comes to selecting a third-party administrator to assist in your efforts to create a self-insured benefit plan, there are several key things that you need to look for.

**First,**

how long has the company been in business and is it an experienced provider of services for your size of company? Employers need a benefits administrator that has been around the block a few times and knows the complexities involved. The administrator should be a solid and reliable player, so don't be afraid to ask for client references.

**Second,**

can the company meet your specific requirements? That means looking for previous experience in setting up such plans. Check to see that the firm has the necessary staff resources, such as actuaries and access to skilled medical and dental professionals.

**Third,**

check out the technology. The key to containing costs lies in the ability of the provider to track and manage the plan with no fuss or muss. What is the turnover time for processing claims? How does the adjudication process work? What are the reporting procedures? Will it provide a drug card if you want one?

By shopping carefully, employers can find a partner who will help take their benefits management to the next level.