

Five reasons

hospitals should consider self-funding

1 Plan design flexibility

Self-funding allows hospitals the ability to design a benefit plan that better aligns with their organization's strategic goals while also meeting the health care needs of employees. With a benefit plan designed to promote domestic utilization, hospitals can maximize the care and revenue that stays within the organization. In addition, UMR can administer customized domestic fee schedules, allowing hospitals to set their own reimbursement. By doing so, hospitals are less dependent on local health plans and able to eliminate conflicts of interest.

2 Greater financial control

With a self-funded benefit strategy, the hospital pays for claims as they are incurred rather than paying an upfront, fixed premium to an insurance carrier. As a result, cash flow improves as funds are available to use at the hospital's discretion throughout the year, and interest income on reserves remains under the hospital's control. In addition, increased cash on hand positively impacts bond rating.

Furthermore, UMR has the capability to suppress checks for payment to the hospital's domestic providers. While these transactions are reported in all claim data, the hospital's funds are not suspended during processing and delivery, resulting in significantly improved cash flow.

Keeping care (and dollars) within the organization

Let's assume a hospital has 1,000 covered lives with an \$8,000 per employee per year (PEPY). The annual plan costs are \$8,000,000. With 30% domestic utilization, the hospital keeps \$2,400,000 within the organization. By increasing domestic utilization to 50%, the hospital can realize an additional \$1,600,000 of domestic revenue.

ANNUAL PLAN COSTS	DOMESTIC UTILIZATION	DOMESTIC REVENUE
\$8,000,000	30%	2,400,000
\$8,000,000	50%	4,000,000

Improving cash flow

Continuing with the previous example, with annual plan costs of \$8,000,000, the hospital has an average monthly spend of \$666,667. With a 20% increase in domestic utilization, the hospital has an additional \$133,333 on hand each month as a result of check suppression.

AVERAGE MONTHLY SPEND	DOMESTIC UTILIZATION	MONTHLY CASH ON HAND
\$666,667	30%	\$200,000
\$666,667	50%	\$333,333

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3 Maximize internal resources

With the flexibility afforded by a self-funded benefit plan, hospitals have even more opportunity to manage plan costs. In addition to the cost savings associated with domestic network use, self funding allows hospitals to leverage existing hospital resources in the execution of health management and wellness programs. By doing so, hospitals can avoid duplication of efforts with their benefits administrator while maximizing the use of domestic clinicians, initiatives and facilities.

4 Reduce plan costs

In most states, self-insured claim funds are not subject to insurance premium taxes. While premium tax is applied to stop loss premiums, it is significantly less than a fully insured plan. In addition, the profit margin and risk charges imposed by insurance carriers are drastically reduced with self-funded benefit plans.

Furthermore, because self-insured benefit plans are federally regulated, the requirement to cover costly benefits mandated by state health insurance regulations is eliminated.

5 Better decision making

Many fully insured carriers are unable to provide detailed plan data, whereas UMR provides online tools that allow plan sponsors to review claims and utilization data. With extensive plan information, benefit plans can be evaluated and strategies revised if necessary. In addition, detailed data on domestic and foreign services allows hospitals to increase competitiveness by helping them identify business development opportunities to better meet demand.

Leveraging existing hospital resources

Suppose a hospital system offers a diabetes education program to its employees through its primary care clinics. Through the use of predictive modeling and case management monitoring, UMR identifies hospital employees and dependents that are diabetic or at risk of developing diabetes. UMR then provides the hospital's primary care clinics with a list of identified employees and members for outreach and inclusion in the diabetes education program.



UMR identifies at-risk members



Information is transferred to hospital clinicians



Members are engaged in hospital's health management program(s)

For more information about developing a benefit strategy to support the goals of your organization, contact your UMR representative.



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