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SELF FUNDING Group Health Benefits ...Deeper Dive

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In part one of this series, we examined the nuts and bolts of self-funding group health benefits and how employers can utilize these programs in order to better control their health care spending. We reviewed what a self-funded program generally looks like, the various components of the program, and different options employers can consider in an effort to reduce the amount of money allocated to and spent on health care benefits. In this article, we're going to look at a couple self-funding options for employers of varying sizes and how they might comfortably implement a self-funded program within their risk tolerance.

One myth we should dispel up front is that larger employer groups are healthier and less expensive than smaller employer groups. While that may be true (due in part to the more effective allocation of risk), it may not. It is important to understand that just because a large group may be more actuarially credible or may spread risk more effectively than a small group, it isn't necessarily healthier or cheaper than the smaller group. In fact, in many instances, large employer groups are more expensive *per capita* than small employers because they have a greater concentration of expensive claims and a more influential workforce that is in a stronger position to drive a harder bargain and demand richer benefit plans with fewer cost controls.

In order to attract smaller employers into the self-funded market and to protect these plans from unacceptable or intolerable financial risk, many unique programs have cropped up over the years that blend fully-insured concepts with self-funded concepts. In this article, we will discuss several of those options. Inasmuch as we don't have unlimited time to delve into any of these programs in great detail, we will briefly explain the program and how it works. If you would like to discuss the specifics of these programs and how they might work for your company, I invite you to contact me.

I should note I have used the terms "employer" and "plan" somewhat interchangeably in this article despite the fact that they are quite different in federal law and in the self-funding world. Strictly speaking, the employer is the entity that establishes and funds the self-funded plan, and the plan is the vehicle under which participants are covered and receive benefits. This is not an insignificant distinction, but for purposes of this article, it's unnecessarily technical. I also use the term "self-funding" as opposed to "self-insurance," but for purposes of this article, these terms can be interchanged.

Traditional Stop-Loss Insurance

Perhaps the simplest and most well-known self-funding program is a traditional stop-loss arrangement where the employer assumes direct responsibility for individual participants' claims (rather than an insurance company) and self-insures them up to a predetermined dollar amount (*e.g.*, $50,000 per member). To protect the employer from catastrophic risk, the plan purchases reinsurance protection for amounts in excess of the plan's retention. In addition to the individual member retention threshold (called "specific deductible"), the employer often purchases companywide protection known as "aggregate coverage" to protect the company from an inordinate amount of total claims spread amongst the group (*e.g.*, $1 million per contract year). In this scenario, the employer's

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plan is protected from the perils of one individual with high claims threatening its solvency, and it is also protected from high claim costs that are spread throughout the group as a whole.

Level-Funded Plans

When an employer isn't large enough or financially strong enough to comfortably take on the risk of a traditional self-funded program or to ensure adequate risk spreading, the employer will often look for "poor man" alternatives. One such arrangement is known as "level funding," and it's basically a hybrid between fully-insured plans and self-funded plans.

In a level-funded program, the employer pays a flat pre-determined amount every month to an insurance company, and the insurance company divvies up those funds to pay for claims, administrative costs and premiums for stop-loss coverage. This fixed amount stays the same every month for the term of the contract (usually one year), and if there's money left over at the end of the contract period, a portion of it is returned to the employer (usually in the form of a credit against future expenses … assuming the employer continues the level-funded program). If claims and other costs exceed the funded amount, the stop-loss insurance protects the employer from additional exposure.

There are certain advantages to a level-funded plan, but as is often the case with hybrid options, the benefits are somewhat tempered. Perhaps the biggest (and most unfortunate) difference between these programs and truly self-funded programs is that most level-funded programs offer credits against future claims and/or administrative expenses rather than cash refunds or rebates. In other words, employers that implement a level-funded benefit program must continue the program (even if their business needs have changed and it is no longer a good fit) in order to reap the benefits of a year with low claims. If the company terminates the program, any outstanding or accrued refunds are forfeited. On the positive side, some insurance companies that offer these types of plans allow for (limited) benefit customization and options, more access to plan data, and the opportunity to mitigate premium increases if they have a healthy workforce. These benefits can be a very good selling point for level-funded plans, especially when compared to the restrictive and expensive "cookie cutter" plans available on the market thanks to the Affordable Care Act ("Obamacare").

Aggregate-Only Programs

A very simple stop-loss plan that is based on level-funded principles is an aggregate-only program. In this type of program, the employer pays a monthly premium amount and a fixed monthly claim cost. As long as funds are available, claims are paid from the claim fund. If claims exceed the amount in the claim fund, the stop-loss policy advances funds to the plan to cover the difference. If funds remain at the end of the contract period (including a period for claim runout), the funds are retained by the employer. One of the most popular aggregate-only programs is called Spaggregate® and it is offered by TPAC Underwriters, Inc.

Captive Insurance Programs

A captive insurance company is an insurance company that is formed for the primary purpose of underwriting the risk of the sponsor. In general, these captives can be divided into two types: (1) "Pure captives" that are formed by a single owner (or by controlled unaffiliated businesses); and (2) "Sponsored captives" that insure the risk of several participants.

Like traditional stop-loss insurance, captive insurance costs will generally be broken down into fixed costs and variable costs. The fixed costs (which average 15-20% of the total spend) include administrative costs and reinsurance protection. The far larger portion of the costs are the claim expenses, and these can vary wildly.

Captive arrangements will often have three different levels of claim retention: (1) the amount the sponsoring employer will self-insure and will be responsible to pay before any other sources of funds are available (*e.g.*, $10,000 per member); (2) the risk the captive pool pays for all participating groups when a member's claims exceed the employer's retention (*e.g.*, up to $500,000 per participant); and (3) the balance of the claim that exceeds the pool's liability and is assumed by the reinsurance carrier (*e.g.*, $500,000+ per member).

Captive insurance companies have a lot of flexibility and can offer many advantages to their members. They can work with different third-party administrators ("TPAs"), preferred provider networks ("PPOs"), pharmacy benefit managers ("PBMs"), and insurance advisors, and they can structure their plans to match their specific needs while offering much greater transparency and control. Most importantly, if pooled funds exceed claim costs, the excess is refunded to the participating member companies. Of course, as mentioned above, just because risk is pooled amongst more members doesn't necessarily mean the costs to the participating companies will be less than other self-funded options or even a traditional fully-insured policy, so companies should be careful and diligent in their analysis before deciding whether to participate in a captive.

If you would like to discuss this article or explore how self-funding might work for your company, feel free to get a hold of me.

If you have questions about this article or would like to discuss your company's health insurance progam, feel free to contact me at ***(801) 263-8000*** or ***info@wmimutual.com.***