SELF FUNDING Group Health Benefits

(Part 1 of 2)

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Over the past decade, employer self-funding of health benefits has grown immensely. What used to be a program for just very large employers has transformed into a platform that even small to mid-sized companies can utilize. My general rule of thumb is that employers should start thinking about self-funding when they have at least 50 employees, and they should strongly consider it when they hit the 100-employee threshold. That said, an employer with the right balance sheet and risk tolerance might reasonably consider self-funding outside of those general recommendations.

If this article looks familiar, it's because it is very similar to an article that I wrote several years ago. While the general principles and operations of self-funding have remained consistent, there are a couple of tweaks and a few fancy new programs that deserve mention (but probably not strong consideration). In this article, we will explore the mechanics of how a self-funded program works and the various roles involved. We will take a 20,000-foot view of how self-funding works in general terms, and we will oversimplify the various components of the self-funding platform so you can get a sense whether it merits further exploration for your business. If at the end of the process you determine it might work well for your business, I would invite you to contact me for a deeper dive and perhaps even a formal quote.

How Do Employers Provide/Fund Group Health BENEFITS?

- **Group Health Benefit Programs** are generally established and maintained in one of two ways. They are either: (1) fully-insured under a policy that is issued by an authorized health insurance company; or (2) self-funded under a plan that is sponsored and maintained by an employer. The main difference between these two types of benefit plans lies in the entity that actually and ultimately assumes the financial risk. Aside from that defining and distinguishing characteristic, these plans are really quite similar because they both cover the same employees and dependents, they provide similar benefits, and they offer the same customer service and support. Indeed, with the exception of the underlying funding mechanism, the differences between a fully-insured plan and a self-funded plan are often so subtle that even participating employees don't know (or care) whether they are covered under a fully-insured insurance policy or a self-funded employee welfare benefit plan. It should be pointed out that there are variations on the traditional concepts of fully-insured and self-funded benefits (*e.g.*, hybrid level-funding plans). Those variations will be explored in greater detail in the second part of this article which will appear in the next *WPMA News* magazine.

– **Fully-insured Plans:** In a fully-insured plan, an insurance company or health maintenance organization ("HMO") assumes risk in exchange for an agreed upon and fixed premium amount that is usually adjusted every year upon plan renewal. The employer is responsible to pay the premium each month but is not liable for claims or administrative costs (which are the responsibility of the insuring entity). The insuring carrier calculates the premium amount, and if the premium exceeds claim expenses and overhead, the insurer keeps the profit. If, on the other hand, the premium is inadequate, the insurer incurs a loss. Once the employer accepts the terms and pays the premium to the insuring entity, its money is considered "out the door," the employer's risk is fully transferred to the insurance company, and the employer is absolved of additional financial responsibility or direct risk on the claim.

– **Self-Funded Plans:** In a self-funded plan, the employer (*i.e.*, the plan sponsor) establishes and funds a benefit program that is designed to assume and pay claim risk. If the plan runs well and the premium/claims loss ratio is profitable, the employer retains the profit. If claim costs exceed expectations and the plan runs poorly, the company is on the hook for the additional expense. In order to protect the plan from great or unexpected financial risk, the employer purchases reinsurance from a licensed reinsurer to safeguard against high-dollar claims above a predetermined dollar threshold.

Note: I have used the terms "plan" and "employer" somewhat interchangeably even though in the self-funded world they are legally quite different. A self-funded plan is established and maintained by an employer in accordance with the federal law known as the Employee Retirement Income Security Act of 1974 ("ERISA"). The plan is the legal entity under which employees and their dependents (*i.e.*, plan participants) receive benefits. The employer that establishes the plan is the Plan Sponsor and by default the Plan Administrator as those terms are contemplated in ERISA.

How Does a Self-Funded Health Benefits Program WORK?

- **While there is no one-size-fits-all** template for self-funding, a self-funded program is generally an arrangement whereby:
  (1) the employer agrees to sponsor a plan and to assume the financial responsibility and risk for the payment of claims incurred by plan participants up to a predetermined agreed upon amount (*e.g.*, $35,000 per participant during the contract year);
  (2) the sponsoring employer contracts with a third-party administrator ("TPA") to provide administrative services and support, administer benefits, pay claims, provide customer service, and to manage the program; and
  (3) the sponsoring employer purchases stop loss coverage from a licensed reinsurer to cap risk exposure and to protect the plan from financial hardship.

- **There are Three Main Partners** in a self-funded benefit program:

1. **The Plan Sponsor -** The plan sponsor is the employer that adopts a plan that outlines the criteria for eligibility and the benefits provided. The employer then safeguards employer and employee contributions to pay claims and other eligible plan expenses;

2. **The Third-Party Administrator –** A TPA provides administrative support and services to the self-funded plan (*e.g.*, enrollment, claims processing, customer service, actuarial support, reporting, ID cards, EOBs, etc.). A TPA helps design and implement the plan document to the sponsor's specifications, enrolls members, pays claims and helps employees and their dependents understand and utilize their benefits while working to protect the employers and the plans they sponsor from high costs or unsustainable expenses; and

3. **The Reinsurer -** A contractual reinsurance agreement is entered into between the employer and the reinsurance carrier. This protects the plan from large catastrophic claims related to one or more individuals and from an unexpected quantity of smaller claims.

What Benefits Can Be SELF-FUNDED?

Employers have a lot of flexibility in determining which benefits they will cover. The most common benefits that employers self-fund are medical, prescription drugs, dental and vision benefits.

Why Should a Company Self-Fund Employee BENEFITS?

- Favorable risk is financially rewarded.
- Federal law exempts the plan from burdensome state regulation and onerous premium tax laws which alone costs the plan an additional 2-3% every year!
- The employer controls cash flow, establishes reserves, and manages risk through reinsurance.
- Reduced operating expenses are retained by the employer.

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- Lower insurance company profit margin and risk charge is passed along to the employer.
- Plan design flexibility and lower claim costs due to the elimination of many burdensome health-care reform regulations and requirements.

How Does an Employer Self-Fund Employee BENEFITS?

- Most employers hire a TPA to set up the plan, pay claims, field customer service calls, coordinate enrollment, perform billing functions, and provide necessary banking and other support.
- The employer works with the TPA to develop a plan document and to determine eligibility criteria, benefit design (*e.g.*, deductibles, co-payments, coinsurance), network criteria, various benefit limitations, and to implement cost controlling mechanisms.
- The TPA secures reinsurance on behalf of the plan and serves as liaison with the reinsurance company. Self-funding involves two main types of reinsurance:
  (1) specific reinsurance which provides reinsurance protection on a per person basis; and
  (2) aggregate reinsurance which provides company-wide protection.
- The plan safeguards funds to pay claims and plan-related expenses.

Who Should Consider SELF-FUNDING?

- Employers with 50 or more employees should consider self-funding (although some reinsurance companies will quote groups with as few as 15 employees).
- Employers with a healthy cash flow, strong balance sheet, and an adequate risk tolerance.
- Employers willing to take responsibility for their benefit offering.
- Employers with a stable employee base, better than average claims experience, and few or no ongoing potential large claims. (Note: Examples of expensive medical conditions are kidney disease and dialysis, hemophilia, transplants, specialty drug treatments, and premature births).
- Employers who are committed to a long-term solution to providing affordable benefits. Self-funding is not something a company can approach impulsively or willy-nilly. Plans will inevitably experience "good" and "bad" claim years; but over time, self-funded plans will generally outperform fully-insured plans and will produce better results for the employers that sponsor them. For a company to reap the benefit of self-funding, it is essential that the employer remain on the self-funded platform even when claims experience is adverse.

What Information is Necessary to Get a Self-Funded QUOTE?

- **Employer Data:**
  (1) name of employer and all subsidiaries to be covered;
  (2) location (zip code) of the employer and subsidiaries;
  (3) current census (*e.g.*, employee names, age, gender, work status, and dependent coverage); and
  (4) SIC code or industry type.
- **Health Insurance History:**
  (1) employer coverage history (three years if available);
  (2) prior/current insurance company information;
  (3) prior/current insurance policy information (*e.g.*, contract type, benefit levels and schedule of benefits);
  (4) premium rate history;
  (5) enrollment and census information; and
  (6) monthly claims history (if available).

If you would like to visit about the possibility of self-funding your company's health benefits (or even just dental and/or vision benefits), please contact me. I would love an opportunity to see what WMI TPA might be able to do for you!

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.***