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Self-Funding Employee Health Benefits

… a more detailed look

Part 2 of 2

In Part 1 of this article, we looked at the basics of self-funding and the general considerations an employer should work through before deciding to self-fund employee health benefits. I discussed how self-funded benefit programs work, several reasons an employer may want to self-fund, the three main partners in the self-funded program, and the essential components of a successful self-funded benefit program. This article will get a bit more into the weeds and examine in greater detail the components and roles of self-funding employee benefits. If, after reading these two articles, you're considering self-funding your company's health benefits, the next step would be to get in touch with me so we can specifically apply this information to your company and determine if self-funding makes sense … or more accurately, if it makes "dollars and sense."

By way of a quick refresher, here are some bullet points about self-funding from Part 1 of the article. I should note that the terms "employer" and "plan" are used 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.

- **There are two main ways** for an employer to provide health benefits to employees and their dependents:
  (1) fully insured plans offered and purchased through a health insurance company or health maintenance organization ("HMO"); and
  (2) self-funded plans established and funded by an employer.

- In an oversimplified nutshell, here's **how self-funded plans work:**
  (1) the employer decides to sponsor a plan and assumes the financial responsibility and risk for the payment of claims incurred by plan participants up to a predetermined amount (*e.g.*, $25,000 per participant);
  (2) the employer contracts with a third-party administrator ("TPA") to provide administrative services and support, administer benefits, pay claims, provide customer service, secure reinsurance, and to help manage the program; and
  (3) the employer purchases stop loss coverage from a licensed reinsurer that limits risk exposure and protects the plan from financial catastrophe. Employers may utilize the services of a licensed insurance agent/broker or benefit consultant to help manage the self-funded program, but if you're working with WMI TPA, that is optional and most of our clients work directly with us in order to save commission expenses.

- **There are three main partners** in a self-funded benefit program:
  (1) the plan sponsor (*i.e.*, employer);
  (2) the TPA; and
  (3) the reinsurance carrier.

- **Important reasons** to self-fund employee benefits:
  (1) favorable risk is rewarded;
  (2) reduced operating expense;
  (3) the plan is exempt from burdensome state regulation;
  (4) the plan avoids onerous state premium tax (approximately 3%);
  (5) the employer controls cash flow, establishes and builds a reserve fund, and manages risk through reinsurance; and
  (6) plan design flexibility and more controlled claim costs.

Before deciding to self-fund, it is important for employers to consider the strength of the company's balance sheet and the risk tolerance of the owner(s) because, unlike a fully-insured program, self-funding will inevitably be a bumpy ride. If the employer has

the stomach and financial wherewithal to self-fund, the next step is to partner with a TPA, develop a written plan document, and secure reinsurance protection. I should note that although small employers can self-fund their employee benefits, self-funding is usually reserved for employers with at least 51 employees.

While there's a huge distinction between the mechanics (and legal standing) of a fully-insured health plan and a self-funded plan, there's not much difference as far as employees and their dependents are concerned. Both programs have eligibility requirements, enrollment criteria, benefit schedules, premiums, provider networks, ID cards, customer service support, and many other similarities. Generally speaking, the plans are so similar that most employees don't even know if their plan is fully-insured or self-funded. Hint: *It's usually pretty easy to tell if a plan is fully-insured or self-funded by looking at the ID card. If it says something like "This plan is administered by," it's most likely self-funded.*

The main difference between a fully-insured and a self-funded plan lies in the mechanics of how benefits are provided and paid. That distinction starts with whether the benefits are "insured by a licensed health insurance company" as they are for a fully-insured plan, or "funded by an employer and reinsured by a licensed reinsurance company" as they are for a self-funded plan.

There are two types of reinsurance used by self-funded plans to protect the plan from financial disaster. These coverages are similar, but they are not equal in importance or protection. The first type is called "individual specific excess loss" insurance, and as the name implies, it protects the plan against high claims on any one individual. The second type is called "aggregate excess loss" insurance, and it protects the plan as a whole against the accumulation of claims from the entire group that exceed an agreed upon amount.

Specific excess loss coverage provides protection for the plan against high-dollar claims on any one individual plan participant. Depending on the employer's size, this might range anywhere from $25,000 to $100,000 (or even more in the case of very large employers). Specific insurance is protection against abnormal severity of a single claimant rather than abnormal frequency of claims for the entire group. Before the reinsurance kicks in and the reinsurer begins paying, however, the employer must satisfy an agreed upon dollar threshold. This is known as the "specific deductible," and once that is satisfied, the reinsurance carrier pays the rest of the claims during the contract period. Those contracts will also most likely include "run-in" or "run-out" protection which is explained in greater detail below.

Occasionally, when there is a known or expected large claimant, the reinsurance carrier might increase the employer's retention for that particular individual. This is known as "lasering" and while it might seem a bit unfair, it allows the employer to keep reinsurance premiums affordable for the group as a whole in exchange for accepting additional risk on one specific member. Another option that is available when two or more individuals are expected to incur large claims is known as an "aggregating specific deductible." This is an additional level of retention where the employer takes on additional financial risk for those named individuals only (but not the entire group).

Appropriate specific excess loss reinsurance is crucial for the success of a self-funded plan because it protects the plan and smooths out the peaks and valleys while allowing the employer to budget a reasonable and predictable amount toward benefits every month. Any individual can suffer a catastrophic illness or injury and incur high medical claims at any time. Without reinsurance protection, the randomness of those individuals and the magnitude of their claims would undermine the foundation of a self-funded plan and doom it to failure. Data from The National Institute for Health Care Management ("NIHCM") Foundation puts this into perspective: the top 10% of health care spenders account for two-thirds of all spending with an average of more than $30,000 per year, and the top 1% of spenders account for a whopping 20% of all spending with an average of more than $100,000 per year! As you can see, it would be very disruptive (and potentially disastrous) to a self-funded plan if an employer didn't have specific excess loss reinsurance to protect against large shock claims. (Incidentally, the bottom 50% of health care spenders only account for 3% of all health care spending!)

While not as important as its specific excess loss cousin, aggregate excess loss coverage is groupwide protection that protects the plan as a whole against the accumulation of many claims exceeding an agreed upon level. This is protection against abnormal frequency of all claims combined rather than

continued on page 60

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.***

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... a more detailed look *(continued)*

the abnormal severity of a single (*i.e.*, specific) claim, and it establishes the maximum claim liability for the entire group. It is the plan's expected claims plus a margin factor (usually 25%). Once this cap is reached, the stop loss policy kicks in and covers all eligible claims (typically up to $1 million).

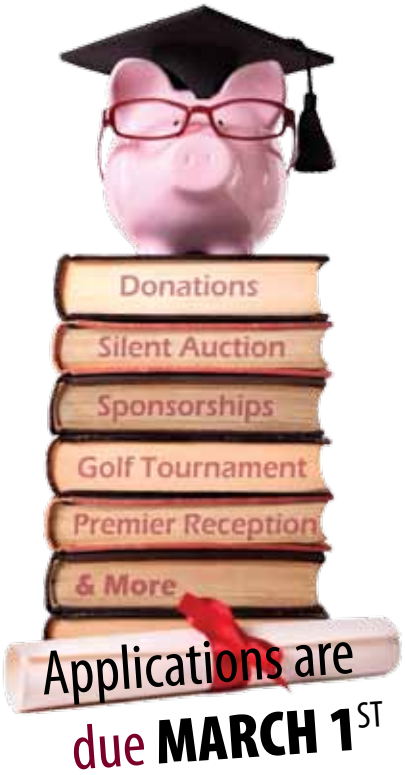
Aggregate insurance coverage comes in various shapes and sizes, but most policies cover claims paid during a 12-month period with either "run-in" or "run-out" protection. Run-in protection covers claims incurred prior to the effective date of the aggregate coverage as long as the claims are paid during the policy term. The most common run-in aggregate contracts are 18/12 and 15/12 terms. This means claims incurred six (or three) months prior to the contract period will be covered (along with any claims incurred during the contract period) as long as they are paid during the contract period. Run-out protection covers claims incurred during the policy term as long as they are paid within the run-out grace period. The most common run-out contracts are 12/15 and 12/18 terms. This means claims that are incurred during the contract period are paid as long as they are paid during the contract period or three (or six) months after the end of the contract period.

Once reinsurance is nailed down and the self-funded plan is up and running, there are three payments the employer must make every month:

(1) premium to the reinsurance company;
(2) administration costs to the TPA; and
(3) claim funding to the plan's trust account in order to pay claims.

It's hard to assign an exact figure to these monthly payment obligations because rates vary from plan to plan and claim costs are so unpredictable, but if we were to use a fully-insured premium rate as a gauge for comparative purposes, I would estimate 3% would go to the TPA to pay administrative costs, 20% would go to purchase reinsurance, and 70% would go to pay medical and prescription drug claims. The remaining amount (7% in my estimate) would be retained by the employer and could be used to build a claim fund or (subject to certain restrictions) could remain a corporate asset. Of course, in "good" years, the amount left over would be higher than the 7% (possibly significantly higher). In "bad" years, the amount would be less (maybe even negative).

If you're interested in exploring a self-funded program for your company, please get in touch with me. I'm happy to visit with you about self-funding, and depending on your interest, I'd be delighted to get you a "no obligation" quote so you can compare your fully-insured rates with a self-funded proposal. Getting a quote is easy and unintrusive to you and your business, and you never know, it could be a gamechanger for your employee benefits.



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If you have any questions, comments or ideas on how your company is promoting the scholarship, please call Kathy Michaelis at the WPMA office *(888) 252-5550*. HELP US make this program WORK FOR YOU!