Self-Funding Group Health Benefits

What Is It and How Does It Work?

By David Leo, President of WMI® Mutual Insurance Company & WMI TPA®

Part 1 of 2

Since the passage of the Affordable Care Act in 2010, many employers have opted to self-fund their employee benefits rather than insure them through licensed health insurance companies. Not only has the number of self-funded plans increased, but the minimum employee count and annual revenue requirements for a group to self-fund have dropped significantly. In other words, what used to be a cost-saving tool that was limited to the "big boys" is now available to employers with as few as 15 employees and is a legitimate alternative to high-cost ACA metal plans.

With so many employers asking me about self-funded benefit programs and exploring options to combat rising health insurance costs, I've decided to address this topic more formally in a two-part article. This first part provides a general overview of self-funding, the basics of how it works, and the main parties and the roles they play in a self-funded benefit program. The follow-up article will provide a detailed look at how self-funded plans operate and the nuances of the various relationships and components in the self-funded world. I realize this brief overview is an oversimplification of complex concepts and complicated relationships. I also realize there are many different ways to self-fund employee benefits and certain *quasi*-self-funded plans that are a hybrid between fully-insured and self-funded programs (*e.g.*, level funding plans, spaggregate programs, etc.) don't fit well into either category. That said, it is not my intent to fully address every possible aspect of self-funded plans in this article but rather to introduce the general concept of self-funding and to invite further dialogue.

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.
  - 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. The employer is responsible to pay the premium each month but is not liable for claims or administrative costs. The insuring entity 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." At that point, the employer's risk is fully transferred to the insurance company, and the employer is absolved of additional financial responsibility or risk.
  - 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 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 inordinate or unexpected financial risk, the employer usually 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 (most often) the Plan Administrator as those terms are contemplated in ERISA.

How does a self-funded health benefits program work?

- A self-funded program is an arrangement where: (1) the employer agrees to sponsor a plan and assume 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 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 catastrophe.
- There are three main partners in a self-funded benefit program:
  1. The Plan Sponsor - The employer adopts a plan that outlines the criteria for eligibility and the benefits provided. The employer then establishes and maintains a trust fund that is comprised of employer and employee contributions and is used to pay claims and other plan expenses;
  2. The Third-Party Administrator - Administrative support and services are provided by a TPA (*e.g.*, enrollment, claims processing, customer service, actuarial support, reporting, ID cards, EOBs, etc.). Shameless plug … WMI TPA is a third-party administrator that would love to be your TPA if you choose to self-fund your employee benefits; 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 and from an extraordinary 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.
- The plan is exempt from burdensome state regulation and onerous state premium taxes (which average 2.25%).
- The employer controls cash flow, establishes reserves, and manages risk through reinsurance.
- Reduced operating expenses are retained by the employer.
- 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 healthcare reform regulations and requirements.

How does an employer self-fund employee benefits?

- Most employers hire a TPA to 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 is on a per person basis; and (2) aggregate reinsurance which is company-wide protection.
- The plan establishes a trust account to hold plan assets and pay claims.

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: Some expensive medical conditions are kidney disease and dialysis, hemophilia, transplants, specialty drug treatments, and premature births).

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 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.***