Self-Funded Health Plans: Opportunity or Albatross?

By Jim Jackson, CIC, CRM, CLU

Few Americans are unaware that health insurance premiums continue to increase at a rapid pace, while employers find it necessary to reduce benefits in order to provide a health plan for their employees. While most small- and medium-sized firms typically implement “fully-insured” health plans, “self-funded” plans may offer them the same cost-saving benefits that are available to larger employers. However, employers must give careful consideration to many factors when determining if a self-funded plan is right for their company.

While the terms “self-insured” and “partially self-insured” are common labels, self-funded plans are simply a way to funnel monies directly into the plan to pay claims. The employer assumes the financial risk of providing health care benefits for covered employees and dependents, and often contracts with an insurance carrier or “third-party administrator” to administer the plan on their behalf.

Self-funded health plans rose in popularity in the mid 1970s after the passage of IRS Section 514, otherwise known as the Employee Retirement Income and Security Act (ERISA). ERISA regulates certain employer-sponsored pension and welfare benefit plans, and exempts private sector, non-church plans from state regulation. ERISA also exempts self-funded plans from state premium taxes, state mandates, and guaranty fund assessments (except Hawaii).

Self-Funded Plan Considerations
Several factors should be taken into account when deciding whether or not a self-funded plan is appropriate for a specific firm. Although many employers and brokers typically consider the number of employees as a determining factor, total premium should also be considered. A company with 50 employees and significant dependent participation may be as good a candidate for self-funding as a firm with 100 employees and low dependent participation. The significant factor in this instance is the total amount of premium for the entire group, rather than only the number of employees participating.

In addition to the total amount of money necessary for payment of claims, the company’s cash flow is of greater concern when deciding if self-funded is the right choice for the employer. Money must be readily available, whenever necessary, to pay claims or to reimburse the administrator if claims have been paid. A firm with a significant variance in cash flow may be unable to pay claims in a timely manner, creating payment issues with medical providers or the plan administrator.

History Lesson
Perhaps one of the most important factors influencing the self-funding decision is the firm’s history of claims activity. Historical utilization patterns—which are the types of claims, frequency of claims, and severity of claims—are significant when determining self-funding eligibility. Claim frequency can be controlled through education, by helping employees and dependents to understand how to make favorable health care decisions. For example, decisions such as when to use primary care physicians rather than specialists, and the cost savings generated by using generic prescriptions rather than brand or non-formulary medications, can have a positive effect on the firm’s claims activity.

Large or catastrophic claims—those typically exceeding a threshold of $20,000 to $25,000 or more—cannot be controlled as well as the frequency of claims. However, large claims may expose the employer to a larger financial liability than smaller claims, and their impact should be weighed carefully when considering self-funding.

A final factor in the self-funding decision is management’s understanding of self-funding, as well as their willingness and ability to implement and monitor cost-saving strategies for medical expenses. Management must continuously communicate with employees to remind them of the need to consciously attempt to control the firm’s health care costs, via their selection of providers, medications, and other health care expenses.

ERISA’s Role
ERISA does not regulate loss protection strategies for self-funded plans, but does attempt to ensure the soundness and stability of plans. Written plan documents are required, and must provide specific information pertaining to plan fiduciaries, funding, administration, and claims payment practices. Records must be maintained for a minimum time period, and must clearly indicate that the plan’s funds are being used solely for the benefit of plan participants. In many instances, a trust must be created to hold plan assets, and stringent audit requirements are mandatory.

Additionally, the employer has a fiduciary responsibility to the plan and to the plan participants, and a fiduciary bond equal to 10
percent of the plan’s assets may be required. Although exceptions to this requirement do exist, the relative low cost of a fiduciary bond indicates when it is prudent for the employer to obtain one, even if exempt from the bond requirement.

**Limiting the Employer’s Claims Liability**

Although the employer is responsible for the claims incurred under a self-funded plan, a way to limit their liability does exist. Stop-loss insurance is available, and it is strongly recommended that the employer avail themselves of this protection. Stop-loss insurance limits the employer’s liability for claims on any one individual to an amount commonly known as their “Specific Stop-loss.” The Specific Stop-loss limit typically varies according to the size of the plan, and is usually negotiable with the underwriter for a corresponding adjustment in the rate. Smaller groups of approximately 50 employees may obtain a Specific Stop-loss of $20,000 to $25,000, while a larger group may have a stop-loss of $100,000 or more. Obviously, the employer will want to reduce their Specific Stop-loss to the lowest amount possible; while balancing that objective with the corresponding increase in stop-loss rates and premium.

The employer is also encouraged to obtain Aggregate Stop-loss coverage, which limits their claims liability exposure for the entire group. The Aggregate Stop-loss limit is often a multiple of the Specific Stop-loss amount, multiplied by the total number of employees participating in the plan. Although an employer may “gamble” that their entire group will not incur multiple large claims during a contract term, it is strongly recommended that they obtain Aggregate Stop-loss coverage, considering the relative low cost for aggregate catastrophic claims protection.

Self-funded plans require that claims be incurred and paid within a specific time period. Although the incurred time period may be different than the paid time period, it is important for both the employer and the employees to beware of these requirements. Should a claim be incurred, yet unfiled for payment processing within the required time limit, the employer could find themselves liable for 100 percent of the claim amount plus the responsibility of processing the claim.

For example, a “12/12” contract requires that claims be incurred and paid within the 12-month period of the contract. A “12/15” contract requires that claims be incurred within the 12 months of the contract, and paid within the same 12 months or within three months thereafter. The incurred/paid time requirements are negotiable with the underwriter, and affect the rate, depending on the additional amount of time allowed for claims being either incurred and/or paid. These time periods may be extended to as much as 24 months before and/or after the 12-month contract period.

**Underwriting and Pricing Stop-Loss Insurance**

Several factors influence the underwriting and pricing of stop-loss coverage. One important factor that affects the pricing of both self-funded and fully-insured plans is “medical trend.” Also known as medical inflation, this is the percentage increase in rates due to the increased cost of health care delivery, improvements in medical technology, and similar health care-related factors. Another trend factor, known as “leveraged trend,” considers that the value of a claim incurred today, paid at some point in the future, will cost more at the time of payment due to the increasing cost of health care over that period of time.

Although the above-mentioned factors are two of the most important, underwriters also weigh risk factors such as the demographics of the group, employee turnover within a specified period of time, and the diagnosis, current treatment, and prognosis of large claims. Other factors such as age and gender ratios of the employee population, SIC code, geographic locations of employees, and overall claims experience within the past five or more years also influence the Specific and Aggregate Stop-loss rates.

Similar to fully insured plans, factors such as deductibles, maximum out-of-pocket limits, co-payments for physician office visits, and co-payments for prescription medications, influence the final self-funded plan rates. The inclusion or exclusion of specified medical expenses is much more flexible in a self-funded health plan than in a fully insured plan, allowing the employer to design a plan that encourages awareness of healthcare cost-saving decisions by the covered participants. However, the objectives of using plan design to positively affect the plan’s medical costs will only be achieved through consistent education of covered employees and dependents.

**Importance of Accurate Claims Administration**

The final factor when establishing a self-funded plan is selecting a claims administrator who will process claims in a timely, accurate manner. The claims administrator is typically approved by the stop-loss carrier and the plan administrator. It is important that the claims administrator issue accurate claims reports frequently; in a format in which the employer can easily understand the data and its significance. The broker and the plan administrator are vital to the process of analyzing claims data, determining if cost-control strategies are effective, and designing and implementing alternative methods as necessary.

Is a self-funded health plan appropriate for your client? There is no immediate answer, and an informed decision can only be made after careful analysis of several important factors as indicated here. If you determine that your business client is a responsible candidate,
understands the concept of self-funding, and may benefit from a self-funded plan design, it is definitely worthy of serious consideration.

**About the Author: Jim Jackson, CIC, CRM, CLU**

Jim is an employee benefits and risk management consultant. He is an educational consultant and faculty member for the CIC and CISR Programs, and also teaches at the university level. Jim entered the industry in 1971, and has been an agency producer, owner, and manager active in life and health insurance, as well as P&C insurance.

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