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## Self-Funding Health Benefits Can Help Plan Sponsors Control Costs



by **Dean C. Hatfield, CEBS** and **Andrew D. Sherman**

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**I**t may be time for health plans that don't already self-fund medical coverage to take another look at the practice. This article explains the key differences between self-funding and fully insured plans, as well as the administrative options available.

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More than ever, financial conditions require plan sponsors to review expenses to make sure money is being spent wisely. While many health plans already self-fund their medical coverage, those that do not may be missing an opportunity to reduce costs without sacrificing coverage.

According to the *Kaiser/HRET Employer Health Benefits Survey 1999-2008*, the percentage of workers who are covered under either a completely or a partially self-funded health plan has remained stable for several years at slightly more than half (55%). This indicates that a funding analysis should be at the top of plan sponsors' lists as an area to examine for improved financial economies.

### Self-Funding Fundamentals

A *self-funded health insurance plan* is an arrangement where the insurance risk is assumed by the plan sponsor rather than by a commercial insurance carrier or other licensed, risk-bearing insurance organization. The vast majority of all claims are a direct obligation and are paid out of plan assets. Effectively, the sponsor of a self-funded plan is acting as its own insurer and in this capacity needs to undertake the same types of underwriting, financial and risk-management activities as an insurance carrier in a fully insured environment.

While many health and welfare funds self-administer their self-funded plans, others contract with a third party for assistance in claims adjudication and payment. Third-party administrators and vendors provide these and other services, such as access to discounts in preferred provider networks, pharmacy benefit programs, utilization review, disease management, wellness programs and the stop-loss insurance market. Insurance companies offer similar services under administrative-services-only (ASO) contracts. In these arrangements, the insurance company provides the typical third-party administration services but assumes no risk for claims payment.

Although self-funding will not work for every fund, it is important to periodically review the potential financial advantages.

The general underwriting rule is that it becomes advantageous to self-fund if a plan covers about 1,000 participants. Funds with close to 1,000 participants (or more) that remain fully insured should periodically analyze the feasibility of changing their funding arrangement as the conditions of the plan sponsor and the market change. Plan sponsors that are still concerned about the risk resulting from a funding change to their health benefits program should consider self-funding just some ancillary coverages—perhaps the prescription drug, vision and/or dental programs. This is a perfect way to introduce self-funding, but on a relatively small scale.

### Key Differences Between Self-Funded and Fully Insured Plans

Organizations that are thinking of self-funding need to understand the following key differences between a fully insured and self-funded health plan—cash flow, financial protection, retention/ASO fees, reserves for claims that are incurred but not reported, tax and plan design control.

#### Cash Flow

Under a fully insured arrangement, cash flow is fairly straightforward: A plan sponsor pays a fixed, regular, monthly premium within the agreed-upon grace period. Under a self-funded plan, fixed, regular monthly payments are not made other than for stop-loss insurance premiums (see below for a full discussion of stop loss) and ASO fees. The vast majority of plan costs—the claims—will be paid via daily or semiweekly wire transfer deductions. A large plan will tend to develop some general, monthly paid claim trends due to utilization and/or claim filing behavior (e.g., early winter months tend to run higher due to year-end claim filing), however, rarely will one month be similar to the adjoining months (or the same month the prior year, for that matter).

#### Financial Protection

To safeguard plan finances from the adverse effects of catastrophic claims, many sponsors of self-funded health plans purchase stop-loss insurance. There are two types:

1. *Specific (or individual) stop-loss insurance* limits a plan sponsor's liability for an individual's large claims. The corresponding protection un-

der a fully insured arrangement is called the *pooling point*.

2. *Aggregate stop-loss insurance* limits a plan sponsor's overall liability for claim payments during a year. This form of insurance does not exist under a fully insured plan because the very nature of the contract fixes the maximum cost during the given policy period at 100% of expected costs (i.e., the contract premium).

Plan sponsors can purchase either specific or aggregate or both types of stop-loss insurance at various levels of coverage, depending on plan finances and the sponsor's attitude regarding risk.

#### Retention/ASO Fees

*Retention* (the portion of premium retained by the insurance company to cover its costs) and ASO fees are the nonclaim expenses incurred by fully insured and self-funded plans, respectively. Included in this will be the cost of claims administration, network access and management, case management, disease management, review services that determine the appropriateness of a provider's services, and some communications or materials expenses (e.g., for identification cards and summary plan descriptions). All of these costs exist under both types of funding arrangements and run approximately the same for an equivalent level of service.

The profit and risk charges, which are included in fully insured retention, are eliminated within a self-funded arrangement. Profit is a standard component of all insurance premiums. Sponsors of self-funded plans do not need to include such a component in the development of equivalent premium rates or when projecting overall program costs. Like profit, risk charges are often elusive and not clearly identified in retention. These fully insured costs are designed to protect the insurer in the event that claims experience is poorer than that anticipated in the claim cost component of the premium. This "buffer" gets smaller (as a percentage of the total premium) as plan size gets larger and is completely eliminated in self-funded programs.

#### Incurred But Not Reported Claims

At any point in time, a liability exists for those claims that have been incurred but not yet reported and paid by the plan. This

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## Why Plans Switch to Self-Funding

Although understanding the differences between fully insured and self-funded group health plans is a good place to start thinking about self-funding, most plans make the change because they become disappointed with their fully insured plan. Many complain that:

- Fully insured plan designs remain relatively inflexible in terms of mandated benefits.
- Effective cost-containment programs are not always available.
- Population-specific claim detail is not available to effectively manage risks.
- The plan sponsors are unable to create a uniform strategy for a program with customized solutions that best fit participants' needs.
- Fully insured plans tend to consume dollars that might be better spent elsewhere.

amounts to approximately 20% to 25% of total annual claims. In an insured arrangement, the incurred but not reported (IBNR) reserves are usually funded by initial premiums—those paid during the first three months of a policy period when paid claims lag premium payments. Most commonly, these reserves are maintained by the insurance company to pay for the run-out liability should they ever lose the cash flow of insured premium payments when the client converts to self-funding or terminates. Under a self-funded plan, the IBNR liability remains. Prudent plan management calls for establishing, monitoring (due to plan cost and exposure fluctuation) and accounting for this expense. For a multiemployer plan, the IBNR is also included on a plan's financial statements as an obligation.

### Tax

Most states require the payment of a premium tax for insurance. This is largely eliminated as a plan expense under a self-funded arrangement. Premium tax is included in stop-loss insurance purchased by a self-funded plan; but again, the stop-loss insurance itself is a small piece of the overall plan cost. In general, when the move is made to self-funding, approximately 2% to 3.5% of insured plan cost can be eliminated overnight. This represents one of the

single greatest sources of guaranteed savings when comparing a self-funded arrangement to its fully insured counterpart.

### Plan Design Control

Fully insured plan designs are directly controlled by the insurance company; however, the insurer is underwriting a plan of benefits that has been specified by



**Dean C. Hatfield, CEBS**, is a senior vice president and health practice leader of The Segal Company. He has more than 20 years of experience working with health plans on a wide range of issues, including benefit strategies, funding and plan management.



**Andrew D. Sherman** is a senior vice president and the multiemployer health practice leader for The Segal Company. He has nearly 25 years of experience in working with health benefits plans and multiemployer plans in particular. Additionally, Sherman consults to several large public sector employee benefit plans and state health plans.

the plan sponsor. Thus, some indirect control is maintained by the group. Due to state regulation of fully insured plans, plan sponsors do lose some degree of control in the form of mandated coverage, administrative provisions or plan definitions. Under self-funding, plans are exempt from state mandates due to ERISA preemption and plan design is determined by the plan sponsor, which maintains much more plan design freedom.

While fully insured plans offer predictability and safety, albeit at a cost, as the size of a plan increases, the benefits of self-funded plans become increasingly attractive, especially in these challenging times. (For more information, see the sidebar "Why Plans Switch to Self-Funding.")

## Conclusion

Regularly reviewing the self-funding option will help plan sponsors assure that they are obtaining the best benefit value for all participants under difficult financial circumstances.

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