SecurityHealth Plan
Security Administrative Services

A Primer on Self-Funding

Assessing whether a self-funded health plan makes sense for you!

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Overview


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The Affordable Care Act (ACA) has created financial incentives to consider a partially self-funded arrangement. These incentives have sparked many new players and products for employers that are seeking creative and financially sound ways to fund their group health plan.

Self-funding started with the passage of the federal Taft-Hartley Act in 1947. Its early use was primarily with union plans and it enjoyed steady growth until the 1970s with the passage of the Employee Retirement Income Security Act (ERISA). It was then that the state regulation of self-funded plans changed to the federal government and this accelerated self-funding acceptance as a funding mechanism for larger employer-group plans. According to the 2012 Annual Benefit Survey prepared by the *Kaiser Family Foundation*, 60 percent of covered workers nationally are in a partial or true self-funded health plan, 65% here in the midwest

A widely accepted rule of thumb is that an employer group with 100 or more covered employees without known large-claim potential, good claims experience evidenced by moderate- to low-rate increases in the recent past, might be a good candidate for partial self-funding.
However, with ACA in effect, self-funded products are being offered to employers with 50 employees, some at 25. There are even two vendors who recently launched products down to employers with 10 or more employees. As interest and new product launches respond to the demand of this funding mechanism,
I would suggest caution when you consider these newer products for those districts seeking this for the first time.

Self-Funded Models

This continued growth ultimately evolved into two basic self-funded models available to employer groups nationally. Both of these models provide ERISA-governed, self-funded products to financially sound employer groups.

The first model is an Administrative Services only (ASO), which is an insurance-company provided, self-funded arrangement. This is usually a packaged product that is built on the claims-paying platform of the insurance carrier. This bundled approach often includes all of the basic claims-administration features offered to its fully insured groups. These services include disease/care management, wellness plans, stop-loss protection, provider networks and other services required to properly administer a group health plan. An ASO model, viewed as a "take as is" product offering, might be the only product available in some markets.

The second model is a Third Party Administrator (TPA); that usually features an independent claims payer marketing self-funded plans and unbundled services to employer groups. Some TPAs have been acquired by insurance carriers, but for the most part, function independently within their specific market. The unbundled approach offers basic claim functions and provides additional a' la carte administrative services, enabling the employer to purchase services outside of the TPAs basic list of services and attach them as needed.

Each model has merits that will need to be considered in your evaluation. For example, an ASO model might have the best provider network discounts in the area, while a TPA might offer access to national networks for employers with multiple locations.

Advantages and Disadvantages

Self-funding an employer-sponsored health plan should not be a leap of faith but part of a carefully crafted, long-term strategy for an employer to fund its most costly expense after payroll.

There are several advantages in a partially self-funded plan that should be considered. Specifically, cash flow as payment is made only at the time of claim, not payment of a level premium, as with a conventionally funded insured plan. As a plan sponsor holds its own reserves, there is additional interest on those funds that are retained by the plan sponsor. Another important feature is that an employer has control of plan design, network configuration and can avoid selected state-mandated benefits. The ability to choose state mandated benefits is a critical advantage as each one of the state-mandated benefits applies to insured group business, not ERISA-governed, self-funded plans. The employer can select which state-mandated benefits it feels are appropriate for its employees and its financial situation. Each one of those state-mandated benefits has an associated cost and that cost is passed down to the employer in premiums for those who are fully insured. The Council of Affordable Health Insurance website provides an excellent summary. You will find that states vary greatly with mandates, and some are rather onerous. For example, our good neighbor to the west, Minnesota — as well as nine other states — mandates "hair prosthetics" coverage in their insured products. I hesitate to single out any state or mandate, but there are many special-interest groups who lobby for health- related items to become mandated, and many times don't consider the cost that is ultimately passed to the employer and to the employee who has a fully-insured plan. In addition, premium taxes charged by most states are included in insured- group plans that are provided by non-domicile insurance carriers, most of which are avoided in a self-funded arrangement.

There are several *disadvantages* in a partially self-funded plan that must be considered to include possible poor claims experience and budgeting for claim costs. Your financial folks will love you during the low claim months. But in those months that trend higher, they may start to question you and this funding mechanism. Additionally, there is more employer involvement, such as banking, and there is additional fiduciary and legal responsibility. However, the most disconcerting aspect of any partially self-funded plan is the use of *"lasers"* on individuals with large shock claims or large- claim potential. The use of a laser is a practice of stop-loss carriers, commonly used on the initial effective date and at renewal time, when they carve out those large claims from stop-loss protection and shift the risk back to the school district. Additionally, it is easy for employers to get into a self-funded arrangement, but it can be very difficult to return to an insured product should you get cold feet on risk tolerance, experience a down-size of the employee population or experience changes in the local insured market.

Stop-Loss Protection

Make no mistake; partial self-funding is all about the stop-loss contract available to protect the employer from abnormal risks. Entering into a self-funded arrangement without a full and complete understanding of stop-loss protection is a disaster waiting to happen.

An employer-sponsored, self-funded group health plan is a lot like a promissory note to the employees to provide certain employee benefits. The employer who has established a plan document guarantees employees and their dependents a health plan that would be funded with employer and employee contribution dollars. Stop loss protects the employer's plan for claims exceeding predetermined levels. There are two types of stop-loss protection to protect the employer from unaccounted-for fluctuations in claims — *specific* and *aggregate*.

Specific stop loss provides protection for that single catastrophic claim; an accident, premature baby, organ transplant or cancer claim. It is not health insurance; it protects the employer and is expressed in dollar amounts from a low of $20,000 to a high of $750,000 on a contract- year basis. *Specific* stop loss usually reimburses the employer after proof of loss is submitted to the stop-loss carrier. In addition, there are special stop-loss arrangements that may provide immediate transfer of funds when a claim exceeds the stop loss level and can vary from one TPA/ASO vendor to another. *Specific* stop loss

can be offered in conjunction with aggregate, but may be written free-standing for larger employers who choose not to purchase aggregate. My favorite underwriter will utilize the following guide when pricing a particular employer.

Again, this is only a guide and the ultimate selection of a Specific stop loss level is determined by the school districts' risk tolerance, the recommendation of your consultant and by the underwriting guidelines of the reinsurance carrier.

Number of covered employees	Minimum per person	Maximum per person
101-150	$30,000	$75,000
151-250	$50,000	$150,000
251-500	$100,000	$200,000
501-1000	$150,000	$250,000
1000+	$200,000	$500,000

Aggregate stop loss protects the employer against unusually high overall claim levels for the entire employer group, because of high frequency or an unexpected number of large claims not quite meeting the specific stop-loss level. *Aggregate* is commonly offered in conjunction with *Specific* and is rarely offered free-standing. *Aggregate* stop-loss claims are expressed as a "single and family aggregate attachment point factor" which is offered as a percent of "expected" claims. Most common are 125% or 130% of expected claims, but can be found as low as 105% and as high as 150%, though very rare. The 125% or 130% is the percent over the expected claims or the *Corridor,* which is the difference between expected claims and the aggregate deductible; this is the risk the employer is accepting in its self- funded plan.

Reimbursement for Aggregate stop- loss claims usually occurs at the end of a contract year, but can be offered with a monthly aggregate feature that would reimburse monthly when one-twelfth of the aggregate attachment point has been breached. The monthly aggregate feature is generally for smaller employers that might be concerned with cash-flow issues.

Larger employers who have been self-funded for multiple years and whose claims experience is actuarially considered near or at 100% creditability may drop aggregate protection. It is at this point when they are comfortable with the risk and because actual claims usually do not differ significantly from expected claims due to that credibility.

Contract Types

If there is one thing that you need to take away from this article, it is a complete understanding of the various contract types that are available in the market. You might see the use of terms such as "true paid" or "gapless" stop-loss contracts, which are variations of the traditional description of the terms of coverage. The most common approach when the contract terms are expressed with two numbers reflecting the contract period. The first number is the incurred period and the second is the paid period. For example, a "12/12" means claims incurred in 12 months and paid in the same 12 months would have stop-loss protection. A 12/12 would not have incurred claim run in or incurred claim but not reported run out, and is viewed as an immature contract year. However, a 12/15 contract is defined as incurred in 12 months, paid in 15 months or hard run out of three months.

Traditional contract terms may change at renewal date, and/or when there is a change in stop-loss carriers. Therefore, use caution as these can be different between specific stop loss and aggregate stop loss for the same contract year. It is imperative that you understand the implications of improper use of contract terms and understand that the use of a Terminal Liability Option (TLO) might appear to be the same as a hard run-out contract, but they are not.

Wisconsin Administrative Code, Insurance 8.11 requires school districts and county governments with less than 1,000 enrolled employees (not members) to purchase aggregate stop-loss on an incurred basis. Acceptable contract types for those groups would be 12/15, 12/18 and 12/24.

Consider the following chart as an explanation of how contract terms can change at renewal time and how these might differ from one stop-loss carrier to another when a change in carriers is warranted. Understanding the run in and run out responsibility is critical when considering self-funding for the first time. I prefer to start plan sponsors who may be new to self-funding with a hard run out contract, 12/15, 12/18 or 12/24 from the inception of the self- funded arrangement. Doing so will help facilitate a change in stop loss carriers in the future and help smaller employers return to a fully insured arrangement if they need to.

First year	First year description	Renewal year
12/12	Incurred in 12; paid in 12	24/12,18/12 or 15/12
12/15	Incurred in 12; paid in 15	12/15 or 12/18
15/12	Incurred in 15; paid in 12	24/12, 18/12 or 15/12
12/24	Incurred in 12; paid in 24	12/24

Plug and Play Services

A partially self-funded product with a third party claims administrator can be very transparent in the various services provided. Those "a la carte or "plug and play" services, enables you and your consultant to evaluate each service to assure it is performing at optimal levels. When a service is not performing as promised, remove it and replace it with one that meets the requirements of your school district and your staff. It should be noted that some ASO vendors will entertain a select "plug and play" approach to these services but for TPA's, they might include, but not limited to:

- Stop-loss protection
- Preferred provider networks
- Pharmacy benefit managers
- Utilization review
- Disease, care and case management
- Lifestyle/wellness plans
- Transplant, specialty pharmacy and dialysis carve-out protection
- TeleMedicine service
- Member support, transparency and health-care navigation
- Data-integration tools

Affordable Care Act

With health care reform and the Affordable Care Act (ACA) now in full effect, the employer-sponsored health care industry will morph again. We will find many smaller employers with fewer than 100 employee lives consider this funding mechanism to avoid some health- care reform provisions. This becomes even more important after 2016 when the definition of small groups grows to include 50 to 100 employee lives.

The renewed interest of school districts seeking self-funding for the first time can be partially attributed to one key exemption to the ACA of being assessed the Health and Human Services (HHS) calculated annual tax to which health insurers are subject starting in 2014, starting at an estimated 1% increasing to 1.5% by 2018.

It should be noted that partially and fully self-funded plan sponsors would not be able to escape all of the ACA provisions and would be required to pay or comply with:

- Reinsurance contributions to fund the Transitional or Temporary Reinsurance Program (2014-2016). Estimated per-person cost of $63 annually 2014, $44 annually 2015 and $26.25 annually 2016.
- Patient Centered Outcome Research Institute (PCORI) from 2013 to 2019. This would be $1 annually per person per year 2013 and $2 annually per person 2014.
- Other provisions of ACA including the preventive mandate, minimum value, the $6,350 cap on out-of-pocket expenses, eliminating pre-existing or exceeding the 90-day limit on waiting periods.

Summary

The use of partial and fully self-funded products for employer group plans is certainly not a new concept. As noted earlier, more than 60% of covered workers nationally utilize this funding mechanism to effectively manage their health care spend. What will be new is the infusion of new stop-loss contracts and vendors seeking to fill the demand of school districts, counties and commercial employers seeking a financially sound alternative to manage their group health plan.

Please use caution. During my travels around the country hosting self-funded workshops for agents, brokers, consultants as well as employers and plan sponsors, I have uncovered many variations in stop-loss contracting, some of which are rather unnerving for those who might be risk adverse. Each variation has its implications and must be fully vetted so that you and your school board fully understand this funding arrangement before signing on the dotted line.

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