

# Understanding & Benefiting from Self-Funded Health Insurance

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## QUICK LOOK

- ➔ Although self-funding will not work for every company, it is important to periodically review the potential financial advantages.
- ➔ The general underwriting rule is that it becomes advantageous to self-fund if an organization has about 1,000 employees.
- ➔ In general, when the move is made to self-funding, approximately 2 percent to 3.5 percent of insured plan cost can be eliminated overnight.

**M**ore than ever, financial conditions require organizations to look for ways to economize and improve cash flow. For some, self-funding the employee group health plan offers a great opportunity to reduce costs without sacrificing coverage.

According to the Kaiser/HRET *Employer Health Benefits Survey*, 1999-2008, the percentage of covered workers who are covered under either a completely or partially self-funded health plan has remained stable during the past few years at slightly more than half (55 percent). This indicates plan sponsors (employers) are not assessing their current funding arrangements and may be missing savings they could gain by self-funding. For fully insured companies, a funding analysis should be at the top of the list as an area to examine for improved financial economies.



Organizations with close to 1,000 employees (or more) that remain fully insured should analyze the feasibility of changing their funding arrangement at least once a year to find out if a change is beneficial.

### 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 therefore a direct liability of the plan sponsor and are paid out of corporate 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 some large plan sponsors self-administer their self-funded plans, most find it necessary to contract with a third party for assistance in claims adjudication and payment. Consultants and third-party administrators provide these and other services, such as access to preferred-provider networks, prescription drug programs, utilization review and the stop-loss insurance market. Insurance companies offer similar services under what are known as “administration only” 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 company, it is important to periodically review the potential financial advantages. The general underwriting rule is that it becomes advantageous to self-fund if an organization has about 1,000 employees. Organizations with close to 1,000 employees (or more) that remain fully insured should analyze the feasibility of changing their funding arrangement at least once a year to find out if a change is beneficial. Plan sponsors in this category that are concerned about the risk resulting from a funding change to their health insurance program

should consider self-funding just some ancillary coverages — perhaps the 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.** Under a fully insured arrangement, cash flow is fairly straightforward. A company 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 and administrative services only (ASO) fees. (See “Retention/ASO fees.”) The vast majority of plan costs — the claims — will hit the books via irregular daily or semiweekly wire-transfer deductions. A large plan will tend to develop some general, monthly paid-claim trends due to plan use 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 month.

**Financial protection.** To safeguard the plan’s finances from the adverse effects of catastrophic claims, many plan sponsors with self-funded health plans purchase stop-loss insurance. There are two types of such insurance.

- Specific (or individual) stop-loss insurance limits a plan sponsor’s liability for an individual’s large claims. The corresponding protection under a fully insured arrangement is called the pooling point.
- Aggregate stop loss-insurance limits a plan sponsor’s overall liability for claims payments during a year. This form of insurance does not exist under a fully insured plan because the

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very nature of the contract fixes the maximum cost during the given policy period at 100 percent of expected costs (i.e., the contract premium).

Plan sponsors can purchase either specific, 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 difference is that the profit and risk charges, which are included in fully insured retention, are eliminated within a self-funded arrangement. While profit is a standard component of all insurance premiums, sponsors of self-funded plans do not need to

include it in the development of equivalent premium rates or projection of 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 claims cost component of the premium. This buffer gets smaller (as a percentage of the total premium) as plan size gets larger and is eliminated in self-funded programs.

**Incurred but not reported (IBNR) reserves.** At any point in time there exists a liability for those claims that have been incurred but not yet reported and paid by the plan. This usually amounts to 20 percent to 25 percent of total annual claims. In a fully insured arrangement, the 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 cash flow of insured premium payments ever be absent when the client converts to self-funding or terminates.

Under a self-funded plan, the IBNR liability remains the same. Prudent plan management calls for establishing, monitoring (due to plan cost and

## Why Plan Sponsors 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 plan sponsors 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 company is unable to create a uniform strategy for a national program with customized solutions.
- Fully insured plans tend to consume dollars that could be better spent elsewhere.

# 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.

exposure fluctuation) and accounting for this expense. It is important to remember that organizations should have their auditors review the company's analyses of the reserves, including ongoing support for the conclusions regarding whether additional accruals are necessary. Accounting for the reserve liability, whether the item is material or not does not mean there cannot be accounting standards that apply to it.

**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, although the tax is included in stop-loss insurance purchased by a self-funded plan. Still, 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 percent to 3.5 percent 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 the plan sponsor. Thus, some indirect control is maintained by the plan sponsor. 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 most state mandates due to Employee Retirement Income Security Act (ERISA) pre-emption, and plan design is determined by the plan sponsor, which results in much more plan design freedom.

**Fiduciary liability.** Under a fully insured plan, the insurance company maintains control over claim determination and many other aspects of plan administration. With this comes potential fiduciary liability. Under self-funding, on the other hand, as discretion over claims determination and plan administration passes to the plan sponsor, so generally passes the fiduciary liability. Here lies the critical importance of thoroughly defining and properly maintaining the plan's governing documents. In many instances (but not all), an insurance company that is paying the claims on an ASO basis will take on the fiduciary liability for a fee.

## Conclusion

While fully insured plans offer predictability and safety, albeit at a cost, as the size of an organization increases, the benefits of self-funded plans become increasingly difficult to ignore, especially in these turbulent times.

(See "Why Plan Sponsors Switch to Self-Funding" on page 35.) Regularly reviewing the self-funding option will help organizations stand out as smart health-care managers who know how to get the best benefits value under difficult financial circumstances. 

## ABOUT THE AUTHOR

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