

Intro to Self-Funding

FAQs about Self-Funded Health Plans

As the interest in self-funding continues to grow across the nation, many employers are asking if this is the right kind of health plan for their workforce. There are several factors that go into making that decision. We've put together this list of frequently asked questions as a starting point to explore self-funding. In it, you'll learn more about how the structure of self-funded health plans works, issues related to cost and planning and the flexibility for which these custom-designed plans have come to be known for. Questions have been organized into three categories below to help simplify navigation: **Self-Funding Basics**, **Self-Funding Costs & Planning** and **Self-Funding in Action**.

Self-Funding Basics

What is a self-funded (aka self-insured) plan?

A better way to approach this question is to start by clarifying what self-funding is NOT and dispel a few myths and rumors. Self-funding is not some new, untried scheme that is dangerous or just came about without being widely vetted and approved by employers. Self-funded plans already existed before 1974, but the passage of ERISA (Employee Retirement Income Security Act of 1974) law that year is what formalized them across the nation. As health coverage spread and became such a major employee benefit, self-funding caught on and has been booming ever since, especially in the past 35 years. It's a structure that allows employers and plan sponsors to control their own health plans instead of having them managed by a traditional carrier in a fully insured arrangement.

Who does the "self" in "self-funding" represent?

The word "self" represents the sponsoring employer or employment group (such as union/management joint plans). There is a common misconception that "self" refers to employees and that they are the ones who have to pay all of their own medical costs. This is not the case. A self-funded plan is designed and set up in an official Plan Document - a formal listing of all of the plan's benefit offerings, which also describes who is responsible for its management. This varies according to the type of plan and often includes a trustee(s), plan sponsor or employer (often one in the same person/entity). There is also an official "administrator" of the plan named in the Plan Document. Note: the official "administrator" is usually the trustee/sponsor, employer etc. It is not the same entity as a third party administrator (TPA).

What is the most popular feature of a self-funded plan?

The most popular feature a self-funded plan is the empowerment to decide what benefits, coverage and amounts can be customized to each workforce. (For example, let's say Company X has 98% female plan participants of child-bearing age. The employer knew that child and birth costs were a top coverage request, so the plan benefits put special focus on serving that employee need.) Self-funded plans allow employers to stretch their dollars further in tailoring benefits to their individual work population. In the past 25 years, the federal government has required (mandated) that certain types of benefits be covered under health care plans. Even with the number of mandated benefits increasing, a self-funded plan still has many opportunities to customize plan offerings and operations to benefit employers and their teams - as well as control costs.

What is the role of a third party administrator (TPA) in self-funding?

The TPA is a hired outside firm especially skilled in the day-to-day duties of operating the health plan. Thus, the TPA role is much like law firms, CPA firms or other types of experts who are hired to provide duties in a specific area on an ongoing basis. As complex as sponsoring a self-funded plan may seem, the TPA walks employers/plan sponsors through the process and performs any number of plan functions under the instruction or approval of the employer/plan sponsor. Just as a self-funded employer can choose which benefits to cover, the employer can also decide which duties it wants its TPA to manage. Main duties can include assisting with claims management and plan enrollment to offering support with reporting requirements and plan document coordination. The plan sponsor is always ultimately in charge of a self-funded plan just like the taxpayer is always responsible when a professional preparer does one's taxes. This is why it's so important to select a trusted and experienced TPA.

What are some main areas of a TPA's expertise?

Top TPAs have earned great respect amidst the constant flow of government compliance regulations that rain down on all forms of health coverage. Government agency regulation-writers and those who interpret the laws and how they will be applied often consult with TPAs to get real-world perspective. Rules/decisions that could have resulted in many headaches and excess costs are often avoided in this process, which is a major advantage for plan sponsors. Full-service, quality TPAs also devote intensive attention to costs, billing irregularities and over-charges. Unlike a large insurance company with separate departments, TPAs are organized to provide combined focus on individual health claims, potential scams and the billing history of medical providers. The savings and stories are often astounding.

Who regulates self-funded plans?

Self-funded plans are regulated by ERISA (Employee Retirement Income Security Act of 1974), except in the case of plans sponsored by state and local governments (city employees' plans, school districts, etc.) and church plans (plans sponsored by religious entities for their own employees such as nuns, clergy, staff, etc.). Government/public employer and church plans are generally self-regulating for administrative functions, but may be subject to specific state law depending on the state. Recently, public employers have also become subject to relevant federal laws. In practice, TPAs usually recommend that government/public and church/religious plans follow the general fiduciary tone of ERISA plans. As explained in the question below, state and local governments and religious entities want their plans to operate according to the highest standards - the prudent person standard. It is important that self-funded employers work with a TPA that understands the multiple ways these laws and regulations interact and affect self-funded plans.

How does ERISA protect consumers/employees?

ERISA was designed to be the ultimate consumer (employee) protection law, and it remains as such today. Therefore, fiduciary, reporting and other responsibilities are stricter and more closely monitored than in normal business practices and insurance company laws. In short, everyone who has discretionary authority impacting the plan assets or beneficiaries is expected to perform and make decisions that are "prudent" (a key ERISA measure of fiduciary duty) for the plan and provide the promised benefits. ERISA is mainly regulated by the U.S. Department of Labor (DOL), which judges actions of those running the plan on a case-by-case basis. This protects the plan, the employer and the beneficiaries, such as employees. It is a key advantage of ERISA self-funded plans.

Self-Funding Costs and Planning

Why is self-funding a smart option for companies operating in multiple states?

The ERISA law has a provision that preempts state insurance mandates and laws. This is what allows ERISA plans to create uniform benefit packages nationwide for employers with employees or work locations in multiple states.

When starting a self-funded plan, how much should be budgeted toward claim costs?

The basic function of a self-funded plan is the same as a fully-insured plan: to have funds to pay for the approved medical needs of plan beneficiaries. How to budget? Employers often have a general or even specific idea of the claims dollar history of their plans. If not, TPAs can often assist based on years of experience. Instead of writing a premium check to an insurance company (which is loaded with charges to accommodate all worst-case scenarios), the employer makes its contribution based on whatever portion of the old premium amount seems "prudent". The sponsors do not have to pre-fund to the year's expected total, which avoids a sudden blow to cash flow. However, obviously, plan sponsors should be "prudent" to be sure that cash will be available as needed. (*See explanation of stop-loss insurance in the next question below.*) Employees pay a set amount as they did before, typically in the form of a payroll deduction. "Prudent" includes being fair and making sure the plan sponsor pays close to the percentage for the running and funding of the plan as the Plan Document describes.

What if a plan is hit with unexpected, high-cost claims for the year? Is there any protection available?

This is where stop-loss insurance comes in. Stop loss does exactly what it says by stopping the loss to the plan or employer if claims run unexpectedly high. The plan trustee/employer (controlling authority) can make the prudent decision of what trigger levels of specific and aggregate stop-loss should be purchased. (Note: stop-loss is not a sign of weakness in self-funding. Insurance companies also use the stop-loss concept as they buy reinsurance to protect the insurance company from unexpected high claims.) TPAs are very familiar with stop-loss providers and work closely with them. They often arrange stop-loss on behalf of the plan or employer to ensure smooth coordination of the plan's operation. The coverage can be bought by, and for, either the plan or the employer. The goal is simply to be sure that benefits promised in the Plan Document will get paid.

Are self-funded employers/sponsors required to set aside huge reserves like insurance companies?

No - if the planning, operation and funding of stop-loss is done prudently, huge reserves should not be needed. However, most self-funded plan sponsors keep some funding available (sometimes the difference between what the fully-insured premium used to cost and the new cash flow of the self-funded plan) for use if needed. This extra funding can reside as plan assets or employer assets. Note: part of the protective ERISA fiduciary duty is that money intended for plan use is considered a "plan asset" and treated as sacred ... not to be intermingled, borrowed or used in other ways. TPAs are well-versed in ERISA fiduciary duty, and can help you and guide you on protecting plan assets.

Why is self-funding a viable and financially appropriate alternative to fully-insured plans?

The answer to the "viable and financially appropriate" aspect is why so much emphasis is placed on prudent consideration, planning and selection of a TPA. Self-funding allows the savings that result from paying actual claim costs vs. fixed costs to stay with and benefit the plan instead of going to a traditional carrier. It all comes back to the "prudent" factor. The larger risk-spread of a fully insured plan might make more sense if an employer has an unreliable cash flow, weak finances or permanent medical conditions within the plan that are impractical to cover. TPAs will be candid about a company's viability for self-funding because they don't want to see a plan or employer struggle.

Self-Funding in Action

How many people in the U.S. are covered by self-funded plans?

Even the top statistics agencies within the U.S. government come up with different figures related to percentages of which employers have what type of coverage. Varying usage of the basic vocabulary terms is one of the main reasons for this. People who have watched this market and its trends for 40 years and have the ability to translate and cross-check differing statistics, say that at least 80% of U.S. employees with benefit plans are in self-funded plans. Self-funding has become, by far, the most widespread form of employee benefits health coverage today.

What percent of large employers, or those with 15,000+ covered lives for example, have self-funded plans?

Virtually all large employers have self-funded plans. It makes no sense not to unless an employer has poor cash flow or is approaching a financial dead-end. The percent of medium-sized employers (let's use 1,000+ lives) has been growing rapidly in the past 30 years, too, with the sophistication and useful designs of stop-loss. It is estimated that more than 66% of medium-sized employers (and even higher in some studies) use self-funding.

Is self-funding recommended for employers with 100 covered lives?

When considering small employers down to about 100 lives covered, there are more variables involved. Do they have enough covered lives to spread the risk efficiently? Do they have reliable cash-flow and funds to fulfill the duties of sponsoring a plan? Do they have some people in their already-smaller risk pool who have enormous ongoing costs? Here's the situation: the percentage of small employers with self-funded plans is growing. Many more would like to move to self-funding, but when weighing all the factors, it has to be a prudent fit.

Which is the greater cost to an employer: the cost of a fully-insured plan or a self-funded plan?

Structurally, the answer is a fully-insured plan because an insurance company premium has worst-case costs built into the premium. In other words, you are paying for (and/or the insurer is keeping the money for) terrible events that may not happen. This is different in a self-funded plan as any money not spent remains in the plan assets to offset future costs. Meanwhile, when factoring in something like a bad flu year or an Ebola- or Zika-like scare, there are issues - some that may not directly apply to your workforce - that can make any year look better or worse for any kind of plan.

What is a reasonable projection of first-year savings under a self-funded plan?

It's hard to assign a general number - or even an estimate - to projected savings, as every self-funded plan is totally different. The real answer is up to the plan sponsors in how they design coverage to fit the wants and needs of their workforce and what elements are built into the plan. With that said, it is not uncommon to see significant savings in a year's time.

How is flexibility such an advantage with self-funded plans?

These are some questions that commonly come up when exploring the structure of a self-funded plan.

Would employees and dependents lose benefits under self-funding? Is there greater flexibility in benefit design for things like wellness benefits, disease management and other types of coverage? Could employees realize a reduction to their cost of health benefits? Could retirees age 65+ be in the plan?

Ultimately, the plan sponsors (or designers) have the power to shape the answers to all of these questions when they implement a self-funded plan. That's because each plan has the flexibility to be fully custom-designed to the company and workforce. Employers provide employee benefit plans because they want to have happy, productive workers. The near-universal attitude of plan sponsors is to design a self-funded plan that gives workers the most useful benefit package for the best price while still offering the greatest fiduciary protections.