

An Introduction to Self-Funding

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Guide to Self-Funding



Health care costs have been rising at an alarming rate for decades, prompting employers to look for new ways to reduce the cost of providing health care to their employees.

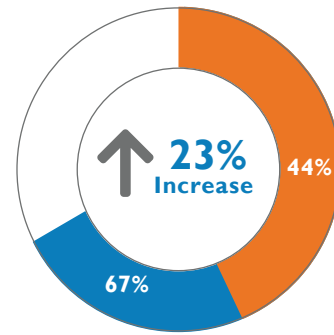
Large companies have been self-funding health plans for years, but companies of all sizes are now finding that self-funding allows them to exercise greater plan design control while realizing significant reductions in the cost of health care—all without compromising the quality of the health care provided to their employees.

We created this guide to help you understand self-funded plans and how they work so you can determine if self-funding is right for your company.

What is Self-Funding?

Employers can financially manage health care and the payment of claims for their employees and their dependents in two ways: fully insured plans and self-funded plans. At a high level, the two methods work the same way, with the employer using company and employee contributions to pay for health benefits for its covered population. However, in a self-funded plan, the employer funds the plan and pays claims incurred by its employees, rather than paying premiums to a commercial insurer.

There are four major areas in which operating a fully-insured plan differs from self-funding: paying for benefits, risk assumption, plan design, and compliance. Each is described below.



From 1999 to 2020, the percentage of employees covered by self-funded plans grew from 44% to a record high of 67%.

(Statista, 2021)

→ **Paying for Benefits**

In a fully-insured plan, an employer pays premiums to an insurance carrier, which provides and administers the benefits offered under the plan. If the amount of claims exceeds the premiums collected, the insurer pays the difference. If the premiums collected exceed the claims, the insurer keeps the difference.

In a self-insured plan, the employer pays for employee health care as it is used. Rather than paying premiums, the employer instead pays employee health care claims and any fixed costs, such as administrative costs and stop loss premiums, associated with the plan.

→ **Plan Design**

For employers that rely on an insurance carrier to provide health benefits, the plan design options are typically limited to the carrier's "shelf" plans.

By self-insuring, employers have greater control over plan design and cost-containment decisions. Instead of buying a one-size-fits-all plan, employers have the ability to provide the benefits their employees actually need and reduce costs by removing unnecessary or underutilized benefits.

→ Risk Assumption

Providing insurance is an exercise in assessing and assuming risk. Insurance companies use past claims experience and actuarial projections to predict claims during a coverage period. If the premiums collected are greater than the claims paid, the carrier makes a profit. If the dollar value of the claims is greater than the amount of premiums collected, the carrier will take the loss and adjust its projections and increase premiums for the following coverage period.

In self-insured plans, the employer, or its chosen third-party administrator (TPA), performs the risk analysis and determines the premium cost to employees, and then pays the claims the employees incur. This means that it is the employer – not a third-party insurance carrier – that assumes the financial risk associated with the plans. As a result, the employer must find ways to mitigate the risk, such as purchasing stop-loss insurance to cover catastrophic claims, developing wellness programs to keep its covered population healthier, and moving toward consumer-based plans, such as high deductible health plans.

→ Compliance

Insurance companies are typically governed by state law, which is often more restrictive than federal law. For employers with locations and employees in more than one state, tracking and complying with insurance regulations in each state is a heavy burden. Although insurance carriers will carry some of the load with regard to state compliance and disclosure rules, the ultimate responsibility falls on the employer to comply.

Administration of self-insured plans, on the other hand, is governed by the Employment Retirement Income Security Act of 1974 (ERISA), which preempts state law. From a health care perspective, this allows employers to treat all employees the same, regardless of where they live or work.

What is Your Solution?	Fully Insured	Self Funded
Plan Design Flexibility	✗	✓
Claims Information	✗	✓
Reward for Performance	✗	✓
Managable Risk Level	✗	✓

Why Self-Fund?

Cost Savings

Ultimately, most employers that self-fund their benefit programs do so because it saves them money. Health care is expensive, and the monthly premium paid to a commercial insurer typically includes a significant amount of costs unrelated to health claims, such as state premium taxes (which generally range between two and three percent of the monthly premium cost), broker and agent commissions, administrative and overhead costs, and the carrier's profit margin. Self-insured plans do not have these costs, resulting in less expense to the employer.

In addition, self-insured plans allow the employer to reap the benefits of good claims experience, since their costs are not impacted by the experience of an insurance company's pool. In other words, an employer's efforts to control claim costs will not be affected by other groups in the pool incurring higher claims.

Finally, self-insuring allows employers greater control over their cash flow. In a fully-insured arrangement, the employer pays a monthly premium to the insurance company regardless of what claims, if any, the employee has incurred (or will incur). By self-funding, the employer is able to retain (and earn income on) its funds until after the claim has been incurred, submitted, approved for payment, and paid.

Employer Control

Self-funding allows the employer to retain greater control over the benefits it provides to employees and the vendors it does business with. Employers who self-fund can exercise a higher level of flexibility in plan design, customizing its plans to its employee base and to the employer's goals. For example, a self-funded plan can cut coverage on services that employees don't use, reducing health care costs.

Employers who self-fund can choose the networks available to employees, and have more control over selecting and monitoring plan vendors. In some cases, the health plan negotiates directly with providers to set fees. However, self-funded plans usually "rent" networks from larger carriers, such as Blue Cross or Anthem.

Uniform Regulations

Fully-insured plans are governed by state regulations. This means that multi-state employers are subject to the laws of each state in which they operate. Benefits compliance regulations can vary greatly from state to state, adding to the complexity of health plan administration for multi-state employers. Self-insured plans are governed by ERISA, resulting in uniform compliance regulations across all states.

Access to Data

Carriers of fully-insured plans typically provide employers with summaries of charges and trends but do not give employers access to detailed claims information. Self-funding allows employers to see claims per enrollee and by diagnosis and service code, including providers (and types of providers) that are used the most. Access to this type of data allows employers to make adjustments to their plan design for greater efficiency and cost savings, and to better meet the needs of their particular populations.

Savings From Self-Funding	
State premium taxes	1.5% – 3.5%
State-mandated benefits	3% – 6%
Interest on cash flow advantages	2% – 3.5%
Administrative savings	2% – 5%
Utilization review program will yield savings of	5% – 10%

Disadvantages of Self-Funding

Risk Assumption

The employer pays all claims in a self-funded plan, resulting in a risk that claims could exceed estimates, or even exceed the employer's ability to pay. Employers can mitigate this risk with the purchase of stop-loss insurance, which reimburses them for claims that exceed the stated policy amount. A managing general underwriter (MGU) specializing in health benefits can evaluate the risks and amount of coverage needed to develop a stop-loss policy and provide appropriate financial security. However, smaller employers may find the cost of stop-loss insurance prohibitive.

Increased Employer Involvement and Responsibility

With self-insured plans, the employer must provide services that the insurance carrier provides under a fully-insured plan, such as claims administration, appeals, and fulfillment of compliance requirements. Although most companies hire a TPA to handle these tasks for them, the company must still assume fiduciary responsibility for the health of the plan.

Asset Exposure

Depending on how the plan is established and funded, the assets of a company with a self-funded plan may be exposed to liability in the event of legal action against the plan.

The TPA's Role in Administering a Self-Funded Plan

Due to the complexity and regulatory hurdles associated with self-administering a health plan, employers who wish to self-fund typically hire the services of a TPA, such as Pinnacle Claims Management Inc., to provide administrative services for the plan. The level of services offered by a TPA can range from simple claims processing to full-service plan design, COBRA, and compliance support.

Depending on the terms of the service agreement between the employer and the TPA, the TPA may:

- Adjudicate claims
- Produce and distribute ID cards
- Maintain enrollment files
- Provide customer service support
- Provide utilization management services, disease management programs, and other cost-containment initiatives
- Negotiate rates with providers, or otherwise provide access to a provider network
- Assist with plan design and communication materials
- Provide compliance support, such as drafting summary plan descriptions, distributing benefit materials, and coordinating regulatory filings
- Administer COBRA enrollment and benefits

The Fiduciary's Role in Administering a Self-Funded Plan

ERISA requires companies with self-funded health plans to appoint fiduciaries to exercise discretionary authority over the plan and its assets. The fiduciaries must be named in the plan document and are tasked with managing the company's self-funding policies.

Fiduciaries are responsible for:

- Acting in the best interests of plan participants
- Administering the plan in accordance with the terms outlined in the plan document
- Holding the plan's assets in appropriate reserve funds
- Monitoring plan expenses, and ensuring they are reasonable
- Following fiduciary standards of conduct

The Role of the Broker

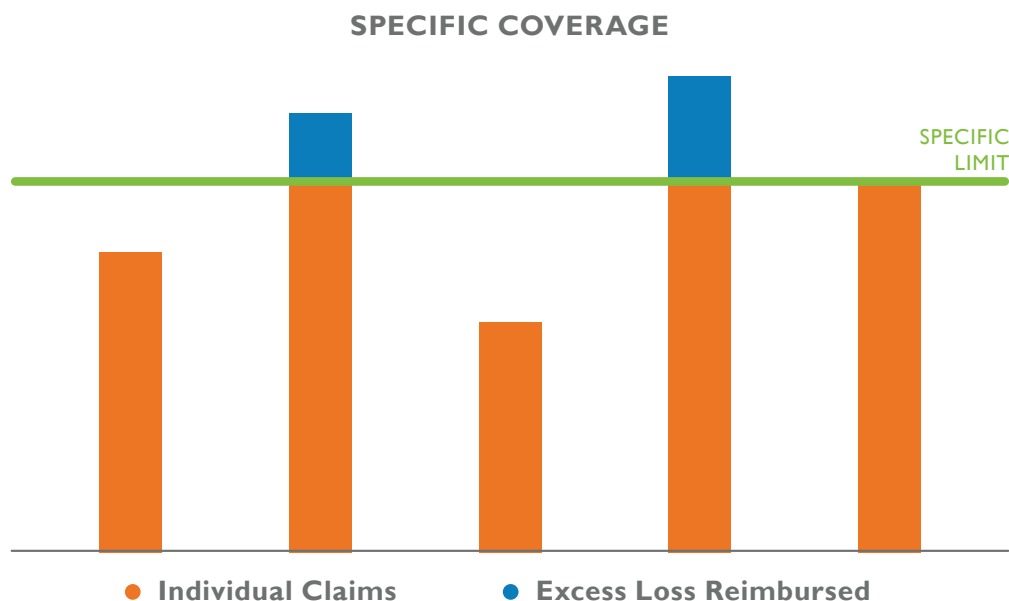
Along with a TPA, a health insurance broker can help guide employers through the best options for their coverage and help optimize plan performance.

Stop Loss Coverage – How It Works

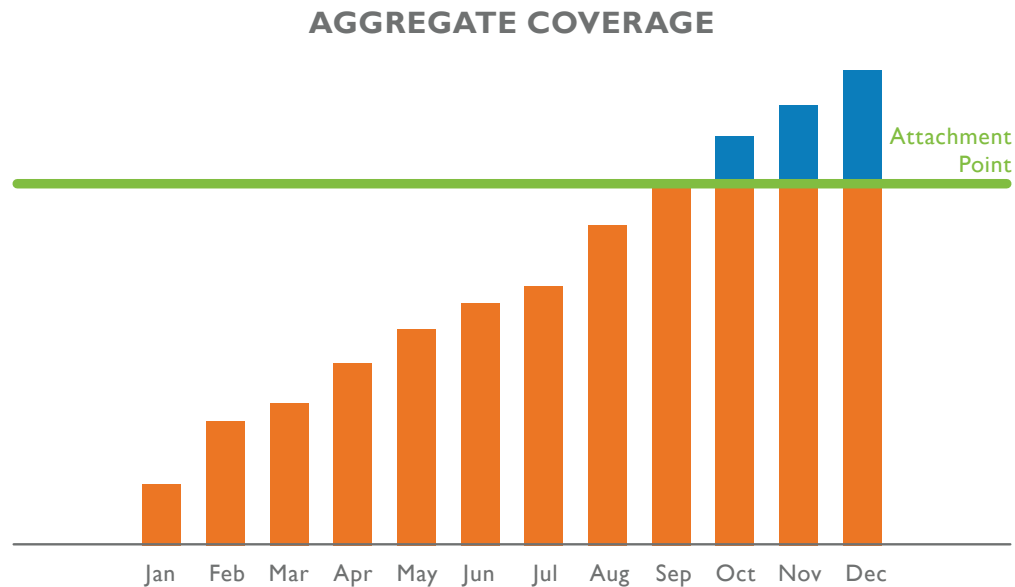
Stop-loss insurance protects the self-insured employer against “shock claims” - catastrophic claims that can drain the employer's self-funding reserves and put the plan at risk. Stop-loss coverage reimburses an employer for claims above the threshold established in the insurance policy.

There are two types of stop-loss insurance:

- Individual stop-loss insures against any individual's claims exceeding a certain deductible amount in a particular year. For example, the stop-loss policy may cover expenses incurred by any individual in excess of \$150,000.



- Aggregate stop-loss insures against claim costs for the plan as a whole that exceed a certain amount (called the “attachment point”). For example, an employer may purchase insurance that reimburses the plan for claims in excess of 125% of the expected plan costs for the year.



An employer may purchase individual or aggregate stop-loss coverage, or both.

Considerations When Deciding to Self-Fund

Although self-funding a group health plan has the potential to significantly reduce a company’s health care costs, plan fiduciaries should carefully consider the company’s financial fitness before making the decision to self-fund.

When making a funding decision, employers should look at:

- Premiums and reserves. Employers must calculate projected costs to ensure adequate budgeting and calculation of employee and employer contributions.
- Risk tolerance. Employers should evaluate whether they’re prepared for the variability in costs associated with self-funding. Regardless of whether claims are funded through general assets or through a trust, adequate reserves must be available to pay claims – including unexpectedly high claims – as they occur.
- Insurance (e.g., the cost of stop-loss insurance) and plan administration costs.

Establishing a Self-Funded Plan

Once a decision has been made to self-fund its health plan, there are several steps an employer should take, regardless of whether it is establishing a new plan or transitioning from a fully-insured plan.

1. Appoint fiduciaries who will act in the best interest of the plan and its participants.
2. Secure stop-loss coverage. Stop-loss coverage is essential to protect the company's (or, if applicable, the trust's) assets against catastrophic claims.
3. Prepare a health plan document.
4. Contract with a TPA. When selecting a TPA, consider whether the vendor:
 - i. Can provide the necessary reporting and data to allow you to make informed decisions regarding plan design changes and to evaluate any cost control measures in place.
 - ii. Can provide all the services the company will require, such as:
 1. Accurate and timely processing of claims, including systems for detection of errors, duplicate charges, fraudulent charges, and a comprehensive auditing and recoupment process.
 2. Access to a broad network of medical providers.
 3. Quality and cost data that allows members to make informed choices.
 4. Cost control programs, such as case management and disease management.
 5. Compliance support, such as drafting and distribution of summary plan descriptions (SPDs) and summaries of benefits and coverage (SBCs).
 6. Non-discrimination testing.
5. Consider fiduciary liability insurance to protect your assets in the event of error, breaches of federal law, or fraud on the part of your fiduciaries or administrative agents.

Find out how Pinnacle Claims Management can help you control your employee health care costs.

Contact us today!

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