THEKEMPTONGROUP

SELF-FUNDING 101

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Historically, employers have turned to the self-funding of their health plans when traditional insurance programs failed to meet their cost expectations. The many thousands of employers in the U.S. that have implemented self-insured medical programs later discovered the other advantages such as coverage flexibility and client-specific benefit plan administration.

A self-funded, or self-insured plan, is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for claims out-of-pocket as they are presented instead of paying a pre-determined premium to an insurance carrier for a fully-insured plan.

Self-Funding Myths and Facts

Learn about common self-funding myths and the facts that accompany them in this informative and helpful document from the Society of Professional Benefits Administrators (SPBA).

How Self-Funding Works

1. Usually with the help of a third party administrator (TPA), the employer designs its medical plan, which can be similar to a plan currently insured or it can be altered to meet employee or budget needs.
2. Rather than obtaining medical coverage from an insurance carrier, the employer funds the risk directly from the employer's assets. The employer becomes directly responsible for benefits covered under the plan and is subject only to federal regulation (e.g. ERISA).
3. Stop-loss insurance is arranged to limit the employer's loss to a specified amount to ensure that catastrophic claims do not upset the financial integrity of the self-funded plan. The amount of risk to be reinsured is a function of the employer's size, nature of its business, financials, and tolerance for risk.
4. A Summary Plan Description (SPD) is prepared (usually by the TPA) and distributed to covered employees. The SPD contains all the provisions of the plan, including eligibility, coverage descriptions, and plan exclusions and limitations. The TPA typically prepares the plan booklets, ID cards, provider directories, and other employee materials.
5. The TPA administers the plan. Its responsibilities include maintaining eligibility, adjudicating and paying claims, customer service, utilization management, preparing claim reports, plus arranging for services such as provider network access and implementation of a Pharmacy Benefit Management program.

Benefits of Self-Funding

1. Elimination of Most Premium Tax: There is no premium tax on the self-insured claim expenditures. Premium tax is applied only to the stop-loss premium, which is a fraction of a fully insured premium.
2. Lower Cost of Administration: Employers find that administrative costs for a self-insured program administered through a TPA are significantly lower than those included in the premium by an insurance carrier or HMO.
3. Carrier Profit Margin and Risk Charge Eliminated: The profit margin and risk charge of an insurance carrier/HMO are eliminated for the bulk of the plan.
4. Claims/Administration: The TPA should provide fast, efficient claims service. The employer should be provided an electronic enrollment option. ID cards should be provided within 72 hours of request.
5. Customer Service: The employee should have access to a toll-free telephone number and a dedicated customer service team. Claims and eligibility information should be available over the Internet.

6. Cash Flow Benefit: The employer's cash flow is improved when money formerly held by the insurance carrier in the form of reserves, for unreported and pending claims, is freed for use by the employer.
7. National Provider Network: The TPA should offer a national integrated program of PPO networks for multi-state employers.
8. Control of Plan Design: The employer has complete flexibility in determining the appropriate plan design to meet the needs of the employer and employees. The employer can redesign its plan at any time.
9. Mandatory Benefits are Optional: State regulations mandating costly benefits are optional because self-funding is regulated by federal legislation only.
10. Cost Reporting: The TPA should provide a monthly detailed reporting of costs, by department or location, and by type of medical service. Utilization and lag reports should also be available. Fund disbursement journals should be provided electronically.

STOP LOSS 101

Stop-Loss insurance, sometimes called reinsurance, is a product designed to protect employers and self-funded health plans from catastrophic losses. There are two types of coverage:

1. Specific - employer protection against a large expenditure by an individual
2. Aggregate - employer protection against excessive claim expenditures for the entire group

Specific Stop-Loss

Specific Stop-Loss provides catastrophic protection to the self-funded plan. Medical benefits only may be covered, or prescription drug claims can additionally be covered. The client chooses the Specific stop-loss deductible. The stop-loss deductible is the amount for which the client is responsible on each individual employee or dependent claim in the policy year.

Typically, the larger the group, the greater the risk that is taken by a plan. For example, a group of 1,000 employees may select a specific deductible of $125,000 per claim, while a group of 300 may decide on a specific deductible of only $50,000 per claim. Health plan budgets will also be a factor in these determinations. The Specific Stop-Loss premium is paid monthly.

Aggregate Stop Loss

Aggregate Stop-Loss provides protection for an excessive amount of claim expenditures for the entire group for the policy year. The Aggregate premium is paid monthly.

Coverage is based on a floating Aggregate Attachment Point. To calculate the annual Aggregate Attachment Point, the monthly enrollment is multiplied by a pre-established aggregate retention factor and aggregated for each of the (12) months in the policy year. The policy retention factors are influenced by the claim and/or premium experience of the group, expected medical costs in that geographic area, the contract terms, and a medical trend component. The Aggregate factor is usually established at 125% of expected claims. The premium for aggregate coverage is low; correspondingly, the retention factors are calculated conservatively.

The maximum amount applied to the Aggregate contract per individual are the claims under the deductible (not reimbursed under the Specific stop-loss contract). Any amount in excess of the Specific stop-loss deductible is reimbursable only under the Specific contract. The client determines the benefits they wish to have covered under the Aggregate contract. Covered benefits usually include medical and prescription drug. Dental, vision and weekly disability can also be included.