An Introduction to Partial Self Funding
**Fully-Insured**

What is a fully insured health plan?

A fully insured health plan is one where the employer pays a premium to an insurance company for health coverage. The insurance premium is due in advance of the coverage and is actuarially projected to cover anticipated claim costs, insurance company overhead, broker commissions, reserves, various risk charges and taxes. In exchange for the premium, the insurance company assumes the risk of providing health coverage and performs various tasks such as processing claims and printing of employee certificates of coverage and Summary Plan Descriptions.

Fifty years ago, almost all plans were fully insured and this type of funding was considered the norm. But today, roughly 68% of U.S. workers in mid-size to large firms are covered by either partially, or completely self-funded plans.

**Self-Funded**

What is a self-funded health plan?

A self-funded (or self-insured) health plan is one in which the employer assumes some of the risk for providing health care benefits to employees. The employer purchases high-deductible insurance to cover catastrophic claims, holds and invests the assets of the plan, premium taxes and substitutes lower cost administration from an independent third party administrator for the higher cost insurance company administration.

The employer can completely design/redesign the plan to meet the specific needs of the employer and employees. In a sense, the plan becomes unbundled. The employer can assemble best of class pieces to construct a custom plan.
Partial Self-funding

Near Term Perspective

In recent years, employers have driven down their health care costs primarily by directing employees into managed care plans and by cost shifting. Those who have relied primarily on this strategy may be facing a new reality. Managed care companies are now facing tougher competition, shrinking profit margins and reduced profits from Medicare risk contracts, once a bonanza for HMOs. Providers, who are pressing for increased payments are facing huge cost issues such as earthquake retrofitting and updating network and communications systems. Health care consumers are resisting restrictive treatment plans and demand expensive new drugs and technologies. Government is getting involved to curb abuses by mandating minimum lengths of stay, mental health parity and other benefits that are adding to already increasing costs.

Self-funding is a simple concept with many attractive features for employers. Self-funded plans have been growing rapidly with the majority of larger employers in America now choosing to self-fund their employee benefits plans.

There are many reasons why employers choose the Partial Self-Funding approach to manage their health plan costs and administrative burdens. Increasingly, mid-size and large employers are choosing self-funding. The following chart is based on the findings of the 2009 KAISER Health Benefits Annual Survey and illustrates that self-funding is the dominant method of funding for the mid-size and large employer.

Furthermore, the KAISER survey reported that between 1999 and 2009, the percentage of partly or completely self-funded plans increased from 62% to 80% among large employers, and increased from 62% to 88% among jumbo employers. The percentages will vary depending who is doing the survey because self-funding is defined differently by many professionals. However, all surveys support the conclusion that self-funding is the dominant method of funding for the mid-size and large employer.

This summary should help give you the perspective necessary to decide if self-funding should be of interest to you.
Although there are many variations, there are three basic methods of funding the cost of group insurance contracts. Each has its own advantages and disadvantages.

**FULLY INSURED** contracts are commonly known as “fixed premium” or “fixed cost” policies, “prospectively rated” policies, “guaranteed cost” contracts or “fully insured” policies. This is the traditional method of funding group insurance for small to medium sized employers. The primary advantage is that cost is guaranteed and it is simple.

**ALTERNATE FUNDING MAXIMUM COST** contracts provide employers with cash flow benefits while sharing some minimal risk in return for the possibility of cost reduction. These contracts include “premium delay”, “reserve reduction”, “dividend paying”, “retrospective rating”, and “minimum premium” plans. Although, they include an element of risk sharing and possible cost savings, they are considered fully insured policies.

**SELF-FUNDED** plans involve a higher degree of risk to the employer along with the opportunity for significant cost savings. For smaller employers, these plans normally involve the purchase of stop loss coverage to protect against catastrophic claims. Administrative services are normally purchased either through a Third Party Administrator (TPA) or through an insurer under an Administrative Services Only (ASO) contract. The employer pays claims from its own funds as claims are presented for reimbursement.

Central to the theme of self-funding is the concept of risk management. Self-funded plans transfer risks too large for the employer to accept to an insurer. Generally, this is accomplished through the purchase of stop loss insurance either for specific claims (per person), aggregate claims (per group) or both. In most cases, a self-funded arrangement exposes the employer to the risk that total costs could be 10% - 15% higher (maximum) than a fully insured plan in return for the likely savings of 10% - 15% but also with the potential to save up to 40%. Self-funded plans can also pass through a significantly higher portion of the health spending savings achieved through wellness plans.

**STOP LOSS INSURANCE**

First, it is useful to comment on some industry jargon. 

*Incurred claims* is a term to identify eligible expenses that have been incurred by eligible members within the policy period. These claims, however, may or may not have been submitted for reimbursement. The concept of incurred claims therefore presumes that some, but not all
of these eligible expenses are submitted and reimbursed during the policy period. The difference between the eligible expenses that have been incurred during the policy period and the eligible expenses that have been both incurred and paid is referred to as **IBNR** (incurred but not reported) claims.  

*Paid claims* on the other hand, identify those eligible claims that have been processed and reimbursed during the policy period. The concept of paid claims presumes that some, but not all of these reimbursed expenses were incurred during the policy period (i.e. some were incurred during a previous policy period but were not processed until this policy period). Since the date claims are incurred may be many months prior to the date these same claims are submitted and processed, plans need to create **Reserves** to pay claims in future periods that are incurred during the current period.

Stop loss insurance transfers risks too large for an employer to assume to an insurance company who for a premium can more appropriately accept and spread the risk. Stop loss insurance is written in many forms. Most self-funded employers purchase stop loss coverage. Differences in stop loss coverage can be significant. Some of the common types are discussed below. For purposes of this discussion, the policy period will be from January 1 to December 31.

**SPECIFIC STOP LOSS**

A specific stop loss policy provides protection against high claims on account of any single covered person. Deductibles, sometimes called pooling points, typically range from $10,000 to $100,000 per person. Generally the smaller the employer, the lower the specific stop loss should be. For example, if an employer with 2,500 employees is self funded with a $250,000 specific stop loss, a $250,000 claim would represent an average of $100.00 of claims expense per covered employee. A $100,000 specific stop loss policy, however, would reduce the employer’s maximum claims expense to an average of $40.00 per covered employee. Naturally, the lower the specific stop loss, the higher the premium for this protection. A suitable balance between cost of protection and acceptable risk must be determined.

**AGGREGATE STOP LOSS**

An aggregate stop loss policy provides protection against high total claims (claims under the specific stop loss amount selected) during the policy period. Rather than a deductible, the protection is expressed in terms of an **Attachment Point**. An attachment point is the amount of total paid claims, minus reimbursements from your specific stop loss, after which the stop loss insurer will be responsible for reimbursing claims. Attachment points typically range from 110% to 125% of expected claims. Expected claims are forecast by an actuary based upon past experience, the group’s census, inflation and other factors. Again, the lower the attachment point the higher the premium for this coverage and the lower the risk to the employer. It is worthwhile to note that an attachment point of 125% of expected claims, for an employer that is large enough to be statistically credible) is commonly believed to be two standard deviations above expected claims. In other words, it should be a rare occasion that a company would collect on this aggregate stop loss plan (i.e. only about 5% of the time). Therefore, premiums for aggregate stop loss protection are low.
Stop loss contracts also vary as to the period covered. The most common periods of coverage are 12/12, 12/15, 12/18, 12/24 and “incurred”. In each case the first number represents the number of consecutive months beginning with the policy effective date during which covered claims must be incurred. The second number represents the number of consecutive months beginning with the policy effective date during which covered claims must be paid.

**12/12 CONTRACTS**

The 12/12 contract (incurred in 12 months and paid in 12 months) is the type of stop loss most commonly illustrated. It is the lowest cost contract because this type will only protect against claims that are both incurred and paid during the 12 month contract period. Graphically, this contract type looks like the following:

<table>
<thead>
<tr>
<th>Incurred Period</th>
<th>Paid Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2011</td>
</tr>
<tr>
<td>Jan</td>
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<tr>
<td>Feb</td>
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</table>

Although the policy period is for 12 months, this contract provides only roughly 9 months of protection. This is because of **Claims Lag**. When an employee goes to the doctor and incurs an expense, this expense is rarely submitted for reimbursement immediately. Submission and processing is usually delayed for a variety of reasons including but not limited to: the care provider’s billing cycle, mail delivery delay, patient procrastination and normal processing delays which may themselves be up to 30 days. On average, claims are processed 60-90 days following the date they are incurred. This is what is referred to as claims lag. In the 12/12 contract only 9-10 months of protection is afforded because on average, the claims that are incurred in October, November and December will not be paid until after the policy period expires.

It is imperative for the employer to understand that this contract can leave the employer in an extremely risky situation following the expiration of the initial policy period because there is no protection at all for **Claims Runout**. Claims runout is a term used to describe those claims incurred during the 12 month incurred period that were not actually paid during the paid period. This type of contract is unsuitable for smaller employers, employers in volatile industries, employers who may not be totally committed to self-funding and those who cannot afford to pay for a large loss in addition to the specific and aggregate stop loss maximums. However, these contracts are often illustrated because they offer the lowest premium (about 75%-80% of a 12/15 contract) and are therefore more attractive from a premium cost perspective. This is not to say that this contract is unsuitable for everyone or there are not available methods to deal with and protect against claims run out.
### PAID-IN-12 CONTRACTS

The **Paid-in-12 contract** will reimburse eligible claims that are paid during the 12 month policy period regardless of when the claims were actually incurred. The Paid-in-12 contract normally replaces the 12/12 contract in the second and successive policy years. Graphically, this contract type looks like the following:

<table>
<thead>
<tr>
<th>Incurred Period</th>
<th>Paid Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan - Dec 2010</td>
<td>Jan - Dec 2011</td>
</tr>
<tr>
<td>Jan - Dec 2011</td>
<td>Jan - Apr 2012</td>
</tr>
</tbody>
</table>

The paid-in-12 contract normally is renewed successively following year 2. However, this contract does not address the issue of claims runout upon termination of the self-funded plan. There remains the danger that large claims may have been incurred and not yet paid by the end of the paid-in-12 policy period. In the event of a significant claim, an employer may be prevented from changing insurance carriers. Further, in the event of a non-renewal, it may not be possible to secure coverage at all for such a claim.

An attractive alternative to the above approach is the purchase of the **12/15 contract**. This contract allows the employer to address the issue of claims runout prospectively, prior to the occurrence of a large claim, while the employer is in an attractive bargaining position.

### 12/15 CONTRACTS

The **12/15 contract** (incurred in 12 months and paid in 15 months) is a more expensive but more comprehensive stop loss policy. A 12/15 contract will reimburse eligible claims that are incurred during the 12 consecutive month period beginning with the policy effective date and which are paid within 15 consecutive months following the policy effective date. Graphically, this contract looks like the following:

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<thead>
<tr>
<th>Incurred Period</th>
<th>Paid Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan - Dec 2010</td>
<td>Jan - Dec 2011</td>
</tr>
<tr>
<td>Jan - Dec 2011</td>
<td>Jan - Apr 2012</td>
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</table>

With this type of policy, claims lag is addressed by allowing claims incurred during the incurred period to be reimbursed for up to 3 months following the end of the incurred period. In renewal years this policy works similarly thereby allowing a 3 month runout period following each contract year and at termination. The result is protection for a full 12 month year assuming claims lag is not substantially in excess of normal patterns. An added benefit is that the employer may be in a much better position to shop for and negotiate a replacement and more competitive stop loss protection in renewal years.

However, what does the employer do when a change of stop loss insurance carrier is necessary, the prior contract did not afford protection during the claim runout period and the amount of claims runout is unknown?
15/12 CONTRACTS

The 15/12 contract (incurred in 15 months and paid in 12 months) was created to answer the above question. This policy extends the claims incurred period retroactively 3 months from the policy inception date in order to dovetail the old contract’s IBNR claims with the new contract. In this way claims that were incurred during the last three months of the prior 12/12 or paid-in-12 contract, but not yet paid, can be submitted for reimbursement under the new contract. Graphically, this contract type looks like the following:

<table>
<thead>
<tr>
<th>Incurred Period</th>
<th>Paid Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 1998  - -</td>
<td>Jan 1999  - -</td>
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This concept goes a long way toward protecting the employer against unexpected losses as a result of high claims runout. However, such coverage may not be available if large known claims exist and in any event, significant claims may have been incurred but not paid 4 or more months prior to the 15/12 policy inception date.

THE 12/18 AND INCURRED CONTRACTS

The 12/18 and 12/24 contract takes the 12/15 contract a step further. It extends the period of time during which eligible claims may be submitted for reimbursement an additional 6 or 12 months beyond the incurred period rather than only 3 months as in the 12/15 contract. This type of contract reduces the possibility further that a large claim may have been incurred and not submitted for payment for an extended period of time.

The “incurred” contract goes all the way by providing for stop loss protection for all eligible expenses incurred during the incurred period regardless of when the expenses are actually submitted for payment. Is it necessary to go this far with stop loss protection? Perhaps not. However, consider the current situation with respect to Medicare reimbursements made in error during the period of 1987 to 1989.

Department of Health and Human Services (HHS) Secretary Louis Sullivan announced April 2, 1991 that letters would be sent to 800,000 employers in the first phase of a program designed to recover Medicare payments that should have been paid by employer-sponsored health insurance plans. HHS announced it expects to recover $600 million to $1 billion from employer health plans, many of them self-funded, that should have been the primary payers of claims which Medicare mistakenly paid. This action likely involved thousands of catastrophic claims for which self-insured employers may not seek reimbursement from their stop-loss insurers.
**Accumulation Methods:** Stop loss contracts may also vary in other ways. One variation has to do with how specific stop loss claims accumulate. Most specific stop loss policies are written on a per individual basis (i.e. when claims for any one individual exceed the deductible amount, reimbursement begins). However, some contracts are written on a per occurrence basis (i.e. reimbursement begins when claims for any one illness or injury for any one individual exceeds the deductible amount.). Another variation is that contracts may be written on a per family basis.

**Actively at Work Provisions:** There is some disagreement as whether or not stop-loss coverage, that protects the employer, is not subject to HIPAA’s non-discrimination or portability provisions. This will mean that your stop loss carrier may impose an actively at work provision. This clause provides that an individual is not covered if he or she is not actively at work for reasons such as sickness or injury. Fully insured plans are protected by HIPAA. Every self-funded employer should insist on a waiver of this provision for all employees employed on the effective date of the stop loss contract.

**Deductible Carryover:** A deductible carryover provides that claims incurred during the last three months of the stop loss policy incurred period may be carried forward and credited toward the stop loss deductible for the following policy year.

**501 (c) (9) Trust Fund:** The establishment of a trust that is qualified under section 501 (c) (9) of the Internal Revenue Code is usually advantageous if not specifically mandated. All employer and employee contributions flow into the trust instead of being paid as premiums to the insurance company.

Within limits established by the I.R.S., all reasonable employer contributions to the trust are tax deductible in the year in which they are made. All earnings within the trust are tax exempt and there are no employee tax consequences. Tax deductible employer contributions can be added to the trust as reserves for future claims. Earnings from the trust can be used to reduce corporate contributions, subsidizing the cost of the plan in future years. The trust accounting will need to be audited. The employer gains complete control of the funds, eliminating unnecessary insurance company overhead, risk charges, reserves and expenses.

**Extension of Benefits:** An extension of benefits provision extends the stop loss benefit period for covered employees and dependents that are totally and permanently disabled. Generally, the extension is available for up to 12 months for expenses related to the disabling condition only. This option can be of great value as it may allow an employer to shop for new more competitive stop loss protection when otherwise the high claims associated with disabling conditions may prevent the employer from doing so.

**Monthly Aggregate:** The concept of the monthly aggregate is that it is theoretically possible for an entire year’s worth of claims to show up in the first month of the plan. This is not likely, but claims will not be incurred evenly throughout the year and more claims than
anticipated could be submitted early in the year. This feature insures against this possibility by limiting the employer’s claim liability in any one month to 1/12 the annual attachment point times (X) the number of months elapsed minus (-) employer paid claims year to date. This option is important to employers with limited cash flow or limited credit. This rider does not lower the employer’s liability. Its purpose is only to limit the maximum amount of monthly cash flow. In addition, in the absence of this provision, claims in excess of the aggregate attachment point are often not reimbursable until the policy’s paid period ends. Therefore, hypothetically, an employer with a $500,000 aggregate maximum stop loss may need to fund $1,000,000 in claims early in the year and wait until the policy paid period ends to receive reimbursement.

Alternatively, the stop loss carrier may only require that the employer fund claims up to the specific stop loss deductible amount and then make payment directly on the balance. This is called the “indemnity method”. However, before indemnity carriers will begin claim payments, they will want to review the underlying claims files for accuracy and appropriateness. This method may therefore be subject to its own delays. In most cases stop loss insurers are forwarded the files of potential stop loss claimants well before the stop loss is actually exceeded.

Deficit Carry-forward and Deficit Repayment: When your stop loss carrier loses money, one of three results will occur. The first and most desirable result is that you will neither owe anything upon termination nor will any amount of this year’s loss will be carried forward and used to net out savings in future renewal years. Some contracts will specify, however, that any losses from the current year will be carried forward into future years and first used to offset any savings made in those future years before a refund or dividend may be made. In the worst case you may even be asked to pay to the insurance carrier the remaining losses accumulated upon policy termination. Obviously, the most desirable contract is one with neither a loss carry-forward nor a deficit repayment provision.

Finally, it is imperative that the stop loss contract be reviewed to determine that the coverage is not more restrictive than your health plan document. Otherwise serious gaps in coverage may exist despite other risk management efforts.
SELF-FUNDED PLAN SUITABILITY

Small Employer Issues

Typically, self-funded plans are thought to be most suitable for employers with a minimum of 200 employees. The goal of self-funding is to control cost increases, provide benefit design flexibility, and standardize benefits across state lines and to save money. Smaller employers are often not able to achieve the promised financial benefits. Usually, this is because the fixed cost of smaller self-funded plans is high relative to fully insured plans, making it extremely difficult for the employer to net significant savings over time. This does not mean that the smaller employer cannot save money by assuming risk through self-funding. It’s just harder to achieve a meaningful savings over a long period of time. Often these smaller plans seem to show a savings over the short run, only to experience severe difficulties later. This is because smaller companies can expect to experience wild swings in claims from year to year. The smaller company does not have the ‘law of large numbers’ working for it to prevent these wild swings. For example, a $100,000 catastrophic claim in a 100-life firm is $1,000 in claims ($83.33 per month) for each employee. However in a 500-life firm it is only $200 in claims ($16.67 per month) for each employee. A small self-funded plan can seem to save money for several years while claims are low due to the normal swings in claims experience of small plans. Then significant losses may be incurred when the inevitable run of large claims finally hits.

Financial Considerations

Naturally an employer must be financially able to pay claims under a worst-case scenario without risking its financial integrity. Aside from the risks to the employer, employees of self-funded employers are ineligible to receive benefits from state-sponsored guarantee funds that cover claims against bankrupt insurance firms. Another consideration is employment stability. Businesses which are cyclical in nature or which may be subject to substantial layoffs should be extra careful to obtain good insurance coverage to cover claims run out liability. Should layoffs cause the employer to fall below the number of insureds needed to run an economical self-funded plan, plan termination may be desired, but not financially possible unless stop loss insurance was purchased to cover the claim run out liability. In extreme cases the employer may find their stop loss insurance canceled leaving no protection against catastrophic run out claims. In addition, many aggregate stop loss insurance contracts specify a minimum attachment point based upon from 85% to 90% of enrollment at contract inception. A significant layoff may render the aggregate stop loss protection irrelevant. For the same reason, mid-year terminations leave the employer virtually totally at risk since attachment points are calculated on an annual basis.
### Adverse Selection

Employers subject to adverse selection should also consider carefully the potential additional risks assumed under self-funding. For example, Dual Choice plans (HMO, PPO & Indemnity) often subject the PPO/indemnity plan to higher than normal claims as a percentage of premiums. It is presumed that the younger, healthier employees on average are attracted into the HMO plans while on average the older and sicker employees are attracted to the PPO/indemnity plans. This would potentially leave the self-funded plan with higher than anticipated claims.

In such cases, it is desirable to convert HMO coverage to EPO coverage in order to take advantage of the lower claims per capita associated with HMO enrollees. An EPO (Exclusive Provider Organization) resembles an HMO plan as to coverage, but premiums and claims are handled under the self-funded plan. In this way the young, healthy participants normally lost to the HMO remain in the employer’s risk pool. Absent this approach, the employer will pay the higher than normal per capita costs of the traditional plan and receive no offsetting savings from the managed care plan. It is generally best from a financial perspective for the self-funded plan to retain the entire risk.

### Stop Loss Insurance Quality

Many stop loss contracts have potential gaps in coverage that can leave employers without reinsurance for potentially significant claims. Avoid cheap but ineffective stop loss. Insist on the following:

- Run-in and run-out contract options
- Terminal liability coverage
- Guaranteed renewal offer
- Guarantee of “no laser” coverage at renewal for employees and dependents
- No insurer right to terminate coverage off-anniversary without cause
- No insurer right to change your specific or aggregate stop loss premiums or factors during the contract year, except for a change in plan design
- No exclusion of disabilities incurred between when insurer accepts the risk and the plan anniversary or effective date
- Eligible expenses are defined by your plan document, not by the insurer (including experimental treatment)
- No denial of claims found to be payable by court decision after expiration of the timely filing period
- Claims eligibility is determined for experimental or alternative treatment plans during pre-certification, not after claim is incurred
- No actively at work provision
- No late entrant exclusion
- No act of war exclusion
- No medical necessity limitation or exclusion
- No internal experimental/investigational limitation or exclusion
- No transplant limitations or exclusions
- No reasonable and customary limitations
- No coordination of benefits reductions
- No exclusion of benefits incurred outside the U.S.
- Pooled renewals
- No internal benefit limits
- Prescription drug benefits covered under stop loss
- Unlimited lifetime maximum
**ADVANTAGES OF SELF-FUNDING**

**Flexible Plan Design:** One of the advantages of self-funding is the flexibility in plan design that is available. Virtually any benefit design may be created. Special needs may be met that cannot be administered on fully insured plans. Many self-funded plans are finding creative ways that are not yet possible in fully insured plans to slow the increase in health spending while maintaining or even improving quality. Value-based plan design is one example. Another is a new concept called cost-plus.

**Avoid State Mandated Benefits:** Further, self-funded plans generally are not subject to state mandated benefits. If a plan wishes to exclude certain benefits otherwise required by state laws under insured plans, the employer will be free to do so. This is particularly important to employers with locations in multiple states where it is desirable to have uniform benefits throughout the country. This also offers the plan additional opportunities for cost containment.

**Avoid State Premium Taxes:** Self-funded plans in most states are free of State premium tax. This represents in most states a minimum 2% savings. In addition, self-funded plans are free of most other State insurance regulation as regulation is pre-empted by ERISA (the Employee Retirement Income Security Act of 1974).

**ERISA Limitation of Liability:** ERISA regulation also offers the self-funded plan some limitation of liability not available to insured plans. Most states allow insurance firms to be sued in state courts for bad faith or negligence, which can result in large monetary damages. However, under ERISA, employees at self-funded firms may only file suits in federal court where employees can only seek payment of medical claims and attorney’s fees.
Open Architecture: Another advantage of self-funded plans is that changes can be nearly transparent to insured employees and dependents. For example, if service should become a problem, the TPA may be changed without affecting the plan design or PPO network. If stop loss insurance with one insurer becomes noncompetitive a change can be made without requiring employees to learn a new insurance carrier’s systems. The modular approach of the typical self-funding plan offers great flexibility in the design, price negotiation and selection of all its components.

Savings on Administration: Administration of self-funded plans is competitively priced. Insurance company overhead, margins and reserves typically add significant costs to insured plans that self-funded plans avoid. Good TPAs often can be found locally and may be inclined to offer more personal service. Large, nationally recognized insurers can also provide superior levels of service at competitive prices.

Savings From Specialty Networks and On-Site Clinics: Unit costs for many health services can be significantly lowered because of the unbundling of services. For example, the cost of specialized scanning services and some prescriptions from specialty networks can be significantly lower than from PPO providers. Also, employers who can support on-site physicians can both save money and provide valued convenience for employees.

An Alternative for Employers in Challenging Industries: Employers in certain industries often have difficulty in obtaining competitive fully insured plans. Some industry examples would be: providers of health care, scrap metal recycling, attorneys, spas, hotels, vehicle dealerships, municipalities and restaurants. Employers in these industries with favorable claims characteristics may find self-funding especially attractive.

Non-discrimination Penalties are Lower: Under new health reform, penalties for discriminatory self-funded plans are significantly less than for discriminatory fully insured plans. Employers who wish to maintain plans that are discriminatory as to benefits, eligibility or contributions in favor of key employees should consider self-funded plans.
Colorado decided to move from a fully-insured environment to self-funding beginning in its fiscal year 2006 (July 1, 2005 – June 30, 2006). The primary reason it changed was to gain control of the design of medical and dental plans. Self-funding affords the state the flexibility to change plans to meet its needs and the needs of its employees. And while immediate and direct cost reductions were not the goal, the increased adaptability and improved value of its platform marginalized nationwide increases and has begun to translate into future cost avoidance.

Colorado’s experience can be broken-down and exemplified through the following generic case study example:

**Case Study**

XYZ Company is an Industrial Contracting Company located in Georgia. The Company has 168 employee’s and a total of 344 members enrolled in their medical plan. They were looking to move to a self-funded plan and they were comfortable they could manage the claim volatility. By moving to a self-funded plan, they were able to design a benefit plan that better matched their employee’s needs and the company’s philosophy on benefits.

The exhibit below shows how XYZ was able to save over five years but had to be able to absorb a year that was more expensive than a comparable fully insured plan.
You will need assistance in the careful transition from fully-insured to self-funded. Your administrator and consultant will:

- Assist the corporate attorney in preparing the necessary documents
- Prepare material required for government approval
- Prepare a summary plan description for the employees
- Assist with the establishment of a 501 (c) (9) trust
- Advise on and place stop-loss reinsurance
- Create funding procedures to maximize cash flow advantages to the employer
- Define all claims and administrative procedures
- Issue identification cards to each plan recipient
- Adjust claims and issue checks
- Produce a neat and concise Explanation of Benefits for each claim payment made
- Handles all claims service using our sophisticated computerized online claims system. This system provides immediate access to information for response to inquiries plus rapid turnaround claims service
- Prepare routine monthly, quarterly and annual claim reports organized to provide exceptional control over eligibility, coordination of benefits, utilization and providers
- Maintain constant contact with reinsurers to assure prompt and equitable settlement of stop-loss claims
- Consult on trends, funding levels, cost controls, benefit adequacy, reinsurance protection and modifications or improvements in plan design
- Provide tailor-made statistical reports, when requested, to aid in analysis of unusual situations
- Provide annual information required by the Department of Labor and the Internal Revenue Service

This is not intended to be an exhaustive treatment of the self-funding subject. We hope that you will find this piece a useful primer on the subject and that it will help you to identify relevant issues. Please feel free to discuss with us any issue. We would also welcome your feedback as well as your recommendations on how we can improve this document.

Thank you,
California Corporate Benefits