

# SELF-FUNDING CONSIDERATIONS

*A Position Paper by Conrad Siegel Actuaries*



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In today's constantly changing world of medical benefits, it is *critical* for an organization to evaluate and plan effectively for the future. A medical plan can account for as much as one third of an organization's administrative expenses, or upwards of 10% or more of payroll. The medical plan chosen by an employer touches each employee as well as their family. Mistakes can be costly.

Every entity must decide how much risk it is willing to undertake in the delivery of medical benefits to its employees. Insured plans offer some cost stability in that rates are often guaranteed for 12 months at a time, sometimes regardless of claims experience for a group. Meanwhile, self-funded plans offer cost sensitivity, as the cost to the sponsoring organization is more directly and immediately tied to the group's claims experience. These are the extremes of the continuum – there are many intermediate funding arrangements balancing some combination of cost stability and cost sensitivity.

Understanding the risks involved in the various funding arrangements can help to make for better decision-making. Even though some of the risks cannot be quantified in advance, we present in this paper some of the main considerations that should be investigated and discussed when considering a move to self-funding. We also urge the Organization to openly review and discuss the goals and objectives for moving to a self-funded plan. Absent such discussion, it would be impossible to evaluate the relative advantages and disadvantages of self-funding to the current arrangement.

### **What is needed to help make a decision on whether self-funding is viable?**

The first step to a complete analysis of self-funding is to truly assess and understand your organization's needs. Self-funding should be approached with a *long-term* strategy and a *long-term* commitment in mind. Any entity sponsoring a self-funded program is assuming risk in exchange for some financial reward. Part of answering the question of the viability of a self-funded plan is to evaluate whether the assumption of that risk indeed has some benefits. That is, can the same or better benefit program and service to your employees be delivered in a more cost-effective way?

Secondly, there are many questions that need to be asked and answered before the ultimate viability of a self-funded plan can be judged. We suggest that the easiest way to begin this analysis is to compare a self-funded plan to a fully-insured plan. We have identified several areas of comparison below, and split the remainder of the report into sections related to these considerations. Within each section we highlight questions to ask yourself regarding each of these topics, as well as provide an outline of the general advantages and disadvantages of a self-funded program within each topic. Market considerations play a part in the viability of a self-funded program, so these are addressed where appropriate.

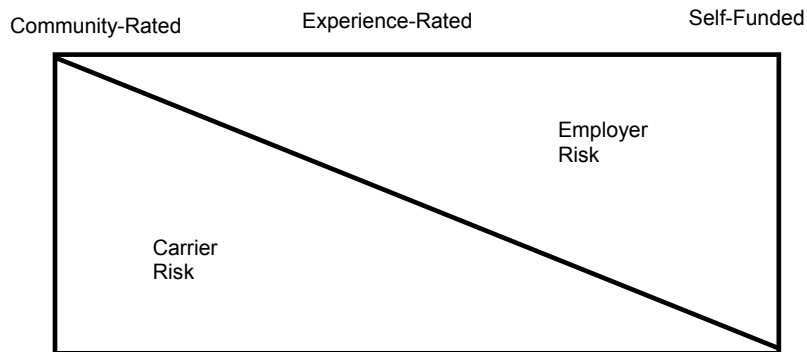
When comparing a self-funded plan to an insured plan, we recommend breaking down the analysis into the following categories:

- A. Risk
- B. Provider Network
- C. Cost Components and Cash Flow
- D. Administration
- E. Benefit Design

There are undoubtedly additional issues and considerations that should be pursued in more detail as an organization goes down the path toward self-funding.

## A. Risk

As you move out of a fully-insured arrangement and into a self-funded plan the level of risk assumed increases proportionally. Consider this - the rationale behind community rating is that "better than average" groups subsidize "worse than average" groups. As you move into experience rating, a group can benefit from having favorable claims experience, resulting in lower costs than community-rated groups. Conversely, they can have costs higher than community-rated groups should their experience not be favorable.



And as you move into self-funding, the risks and rewards increase as well. Overall costs become more sensitive to the group's claims experience, and therefore less stable. Some stability is gained as the size of the self-funded group increases, and individual catastrophic claims are buffered by the larger group. Protection from catastrophic claims can also come from purchasing "stop loss insurance," or reinsurance. The attachment point for stop loss insurance (*point where an employer is no longer responsible for claims*) will depend on how much risk an organization is prepared to assume, the size and experience of the group, and the levels available from the reinsurance carrier. The amount of risk appropriate for an organization to assume usually depends on the number of insured, history of claims, and the ability to fund the reserves needed to pay claims. Reinsurance carriers look at this same information and greatly control the type of product it is willing to offer a particular entity. The smaller the group, the fewer the number of alternatives available.

Some questions that an entity needs to discuss include: How much risk can we assume in the short-term? How much risk can we assume in the long-term? Can we transfer some of that risk to a reinsurance carrier? What is the cost to transfer that risk? Does the reinsurance carrier we select work well with the TPA handling our program? Is the reinsurance premium discounted in the first year to account for the "run in" of claims? Is there any back end exposure with reinsurance if we change back to an insured plan at any time? How competitive is the reinsurance market?

## A. Risk

Consider the information you have to determine this: How many years of data are there to analyze? How credible is your population? Are you aware of any serious medical conditions within your population? How stable is your group? What is the rate of employee turnover? What are the challenges of your industry? How fairly are we being treated in our experience-rated plan?

### **Advantages:**

- Opportunity for lower costs due to favorable experience (over community-rated plans).
- Opportunity for greater cash flow, and greater control over reserves and investment income.
- Ability to limit exposure through stop loss insurance (specific and aggregate).

### **Disadvantages:**

- Greater legal and fiduciary responsibility (employer responsible for payment).
- Monthly expenses dependent on actual claims which are difficult to budget and can be more costly than fully insured plans – certainly more volatile.
- Greater administrative burden to employer (tracking monthly costs, monthly funding of account/trust, monitoring TPA & reinsurance carrier).
- Possibility for higher exposure in second year if first year claim estimates are off the mark (adverse experience).
- Reinsurance (stop loss) premiums are on the rise (increases generally outpace even regular medical inflation, which continues in the double-digits); second year reinsurance contracts are often 10 to 15% higher than first year.
- Complexity of reinsurance contracts – Must pay close attention to details of stop loss contract. Oversights can result in unexpected and increased exposure to employer (i.e. non-guaranteed premium, cumbersome payment procedures, protection from run out claims, etc.).
- Possibility of advance funding of catastrophic claims required by employer if TPA and reinsurance carrier do not have a seamless relationship.

## B. Provider Network

Provider networks can vary greatly. Choosing a network that meets your employee's needs is vital to the success of your plan. Failure to give proper consideration to this can result in difficult employee relations issues and increased administrative burdens. Depending on the TPA you choose, you may have limitations in your provider network, or you may not receive the discounts that you are currently receiving under your insured arrangement. Since claims make up about 85% of the cost of the plan, any loss of provider discounts can greatly offset the other advantages of moving to a self-funded plan.

Questions to consider include: What are the provider discounts? What are the hospital discounts? How do the discounts compare to the current plan? Can the TPA provide a side by side comparison of discounts for the last year's worth of claim payments? How extensive is the network? Are employees limited to regional providers? What providers are available for tertiary care? With whom is the network affiliated? Where will referrals be sent?

### **Advantages:**

The number of networks available has increased over recent years, and increased competition usually benefits consumers.

Greater opportunity to negotiate with providers (fully insured plans typically insulate employers from providers while self-insured plans provide more opportunity to interact - some larger employers may even contract directly with a provider for specific services).

Greater flexibility in overall plan management (an organization can change networks and still continue to self-fund without changing plan designs, while fully insured plans must usually change carriers or the type of plan if a different network is desired).

### **Disadvantages:**

No guarantee for better discounts – insurance carriers typically have more leverage and expertise over TPAs and employers in negotiating discounts with providers.

Lack of key providers can result in greater expense to employees and employers.

Networks are often limited to a regional area (can raise issues for organizations with employees living in rural areas or different states).

Increased legal and fiduciary responsibility on the part of the employer (ultimately responsible for payment of services to the provider).

## C. Cost Components and Cash Flow

From a cost perspective, two of the major considerations when analyzing the feasibility of self-funding are network discounts and administrator retention charges. As mentioned in the prior section, claims make up roughly 85% of the costs of most medical programs, so any loss in discounts can quickly overshadow any retention savings on the remaining 15% of the program costs. Meanwhile, since the sponsoring entity is assuming some of the risk of the plan and perhaps some of the administrative responsibilities, there should be some savings to the group when moving to a self-funded plan.

When you unbundle the costs of a fully-insured plan, you find that it is basically comprised of money to cover claims and administration. Claims costs are based on actuarial projections to cover anticipated medical costs throughout the upcoming contract year. Administrative costs are based on a number of components including reserves, various risk charges and taxes, commissions, profit and company overhead. Administrative costs and claims costs combined, form the fully-insured premium that is prepaid each month to an insurance carrier.

Self-funding provides advantages by eliminating some of the fixed cost components found in a carrier's administrative, or retention charges. State premium taxes do not apply to self-funded plans - this alone can account for 2% of premium. Commissions and various risk and retention charges might also be eliminated.

Meanwhile, the cash flow advantages of a self-funded plan can be substantial. Upon making a move to a self-funded plan, premium payments under the insured plan cease. Concurrently, the submission and payment of claims which occur after the changeover to a self-funded plan often takes a few months to build to a steady-state level. Thus, there is a significant cash flow break for the medical plan costs for the first few months. This break from payments can be viewed in two ways: 1) an opportunity to use the money in some other fashion, or 2) a chance to build up some reserves to keep the program fiscally sound (since the liabilities are incurring even if the payments are not yet being made).

With this increased cash flow, the employer can control the reserve amounts and any derived investment income. Some organizations may be tempted to reduce or eliminate reserves - *this can be a serious oversight*. If an organization decides to transition back to a fully insured plan, they will be responsible for paying several months of runout claims in addition to their fully insured premium - potentially doubling or even tripling their costs. And smaller organizations with less credibility must have adequate reserves set aside to account for monthly fluctuations in claims. It is important to remember that with the advantages of increased control come increased responsibility. Whereas an insurance company automatically performs monthly budgeting and reserving, an employer must have the understanding and discipline to do so as well. This means analyzing and clearly understanding the data, as well as the risks and the impacts of their decisions.

## C. Cost Components and Cash Flow

More often than not, the marketplace providers of self-funded plans convince the employer of the “savings” of a self-funded plan due to this phenomenon of the “run in” of claims taking several months to become mature. At the same time, the “run out” liability is almost always overlooked and goes unmentioned. We strongly recommend the recognition of this liability, and promote the setting aside of reserves to help maintain a fiscally sound benefits program.

Questions to ask regarding the cost components and cash flow include: What are the expected costs for a full year (mature) of claims under a self-funded plan? What are the appropriate reserves levels to be held? How should we invest the reserves? How often do we need to adjust the reserves? What are the retention savings under the self-funded plan? What are the tax savings?

### **Advantages:**

- Greater control over reserves and investment income.
- Opportunity for increased cash flow.
- Tax Incentives.
- Avoid additional retention costs (commissions, risk charges and profit).

### **Disadvantages:**

- Increased financial risk (monthly fluctuations in budget).
- Transition back to fully insured plan costly if reserves not accumulated.
- Increased legal and fiduciary responsibility.
- Increased administrative burden (tracking, analyzing data or TPA reports).

## D. Administration

When it comes to administration of the plan, service is the name of the game. Employers can choose from many different types of third-party administrators (TPAs). About two out of three are privately owned and the rest are corporate-owned firms, commercial insurers, HMOs and PPOs, and even some hospital organizations. The role of the TPA is to process and pay claims, assist with employee claims issues, provide reporting, and many of the same services provided by the carrier under a fully-insured plan. In fact, some carriers offer TPA services for employers who want to self-fund under an "administrative services only" (ASO) contract.

Under these arrangements, employers can pick and choose to pay for the specific services that are desired. Good TPAs will have current statistics available on their performance and provide a high level of customer service to back it up. Some will even negotiate "performance guarantees" complete with financial rebates. Once a decision to self-fund has been made, the selection of a TPA is of utmost importance. The types of questions to ask when doing research on TPAs should include: What percentage of claims are processed within a two week period? Are they submitted electronically or on paper? What is the process for claims exceeding the stop-loss insurance? How are run out claims handled if the contract is canceled? What is the average answer time for customer service calls? Who is answering the phone, an actual person or a computerized menu? What types of services can be provided to help manage costs? Can the TPA administer a managed care plan? Is there an anti-fraud program? What reports will be produced and how often are they produced? Can they write and produce the SPD booklets and plan documents? Who will manage the account? How often will we meet each year? How many other accounts do they have to manage? What standard reports are available?

The more homework you do and details you hammer out in the contract, the better your needs will be met throughout the year. You **do not** want oversights turning into delays and problems for your employees and their families. Prompt service is essential, otherwise your company could get very bad publicity.

Some questions to consider regarding claims administration that should be asked prior to a decision on self-funding include: Who are the Third-Party Administrators (TPA) that can deliver our program? What is the cost of the TPA's service versus the insurers retention charge and are the services provided comparable? What networks and discounts can this TPA bring to us? What administrative burdens do we want to keep within our organization? How much legal and fiduciary responsibility is our organization prepared to handle? Can we find expertise elsewhere to assist in the administration of our plan and/or the selection of the TPA?

## D. Administration

### **Advantages:**

Ability to select only the services desired from the TPA – allowing the organization to perform some of the administrative tasks, resulting in some cost savings.

TPA is service-oriented.

Contracts can build in financial incentives for performance.

Greater access to information.

### **Disadvantages:**

Very complex and varied supply in the marketplace - potential for oversight during TPA comparison.

Cannot assume that TPA will perform all the services that an insurance carrier would under an insured arrangement. A TPA's business is service, not insurance.

Services not as global as insurance carrier (administration of claims only).

Transition back to fully insured plan difficult and costly.

May be difficult to find a “seamless” TPA / Reinsurer combination at a cost-effective price.

## E. Benefit Design

When self-funding, an organization has increased control over the level of benefit provided. If desired, self-funded programs can be written to be identical to your current insured program. However, state mandated benefits can be completely avoided -- an attractive advantage to multi-state organizations. Greater control over benefit design can be a first step towards greater understanding of benefit/cost relations and make for more effective long-term planning.

Questions to consider regarding benefit design include: What benefit levels do we want to offer? Do we want to monitor and maintain our plan to incorporate and future mandated benefits? Are there any high cost areas of the program where benefits should be reduced? Do we want steerage into a particular network or facility (where discounts are higher)?

### **Advantages:**

An organization is not limited to insurer benefit designs and provisions (i.e. mental health, alcohol substance abuse, day and/or dollar limitations).

Opportunity for global understanding of health care costs and better tracking of these costs.

Greater control in influencing employee behavior through plan design (i.e. offering specific wellness benefits, or steerage - incentive to use certain providers who offer greater discounts).

More consistent benefit administration for organizations with collective bargaining arrangements and multiple state locations – helping to avoid carrier differences and state mandated benefits.

### **Disadvantages:**

Responsible for paying close attention to benefit detail (changes in benefit designs, benefit maximums, etc...).

Additional legal and fiduciary responsibility.

Employee relation risks (i.e. denied services/benefits, late payments, cost increases).

Overall greater administrative burdens (communicating changes, summary plan descriptions (SPDs), plan design decisions, etc.

## Summary

The major difference between fully-insured programs and self-funded programs is that when self-funding, an organization is assuming the risk for the claims, and therefore, the claims should be somewhat predictable. Most entities consider self-funding because they think there is an automatic cost savings associated with doing so. That is certainly the wrong approach to take. In order to properly evaluate any self-funded proposal, you should take the time to investigate all of the areas mentioned in the above sections.

Analyzing the pros and cons of moving to a self-funded plan is difficult. Some of the more important items that we suggest the Organization consider when weighing the option to investigate self-funding are the following:

- The goals and objectives of the current benefit program.
- Specific areas of satisfaction and dissatisfaction with the current insurance carrier.
- Level of discounts obtainable in the marketplace from TPAs relative to current discounts.
- Other alternatives to self-funding.

A thorough discussion of these items and some of the detail outlined in this report should provide you with enough information regarding whether you want to continue exploring this alternative. Next steps would involve outlining your service needs from a TPA, sketching out benefit design and network requirements, and soliciting quotes from the marketplace.

We look forward to discussing the goals and objectives of the benefits program and providing recommendations for your consideration as you move forward.

For more information on self-funded health care benefits, please contact:

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