

SLBA Advisory

A Primer on Self-Funding Student Health Benefit Plans

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I. History and Description of Self-Funded Health Plans

Self-funding of health care expense liabilities is a relatively old concept. The first self-funded employer-sponsored health insurance plans were developed in the 1930s, closely following the implementation of the first group health insurance plan at Baylor University in the late 1920s (the precursor to the Blue Cross and Blue Shield plans). Two major events, however, caused self-funding to gain widespread acceptance as a financing vehicle for employer-sponsored group health plans in the late 1970s and early 1980s. The first event was the passage of the Employee Retirement Income Security Act of 1974 (ERISA). A key provision established that employer-sponsored health plans subject to ERISA could self-fund their claims liability, and that such plans would not be subject to state insurance regulations. While federal court decisions have clarified and refined this provision, medium-sized and large employers that have self-funded their health plan claims liability have been able to avoid significant regulation and state mandated benefits.

The other event that caused employers to self-fund their health insurance programs was the combination of large premium increases and limited sophistication of traditional health insurance carriers in providing financial systems that rewarded favorable consumption of health care resources. To understand this point, Figure One on the following page illustrates the two cost components of a traditional fully insured health insurance plan covering 500 employees with an annual premium of \$1,000,000. The first component is health care claims that cost \$750,000. The second component is insurance carrier *retention* charges (i.e., any expense that is retained by the insurance carrier for purposes other than benefit payments). The components of retention include the insurance carrier's profit charges, cost for claims administration, premium tax paid to the state where the plan is domiciled, risk charges, and other miscellaneous expenses, such as agent/broker commissions, fixed overhead, printing, legal expenses, etc.

Minimum Premium and Retrospective Premium Arrangements

The length limitations of this document precludes discussion of all alternative funding arrangements, such as minimum premium and retrospective premium. These forms of alternative financing arrangements are becoming increasingly available among certain health insurance carriers working in the student marketplace, as well as provider unbundling (i.e., creating separate contracts with the entities that indemnify the risk, administer claims, and provide the managed care network).

I. History and Description of Self-Funded Health Plans

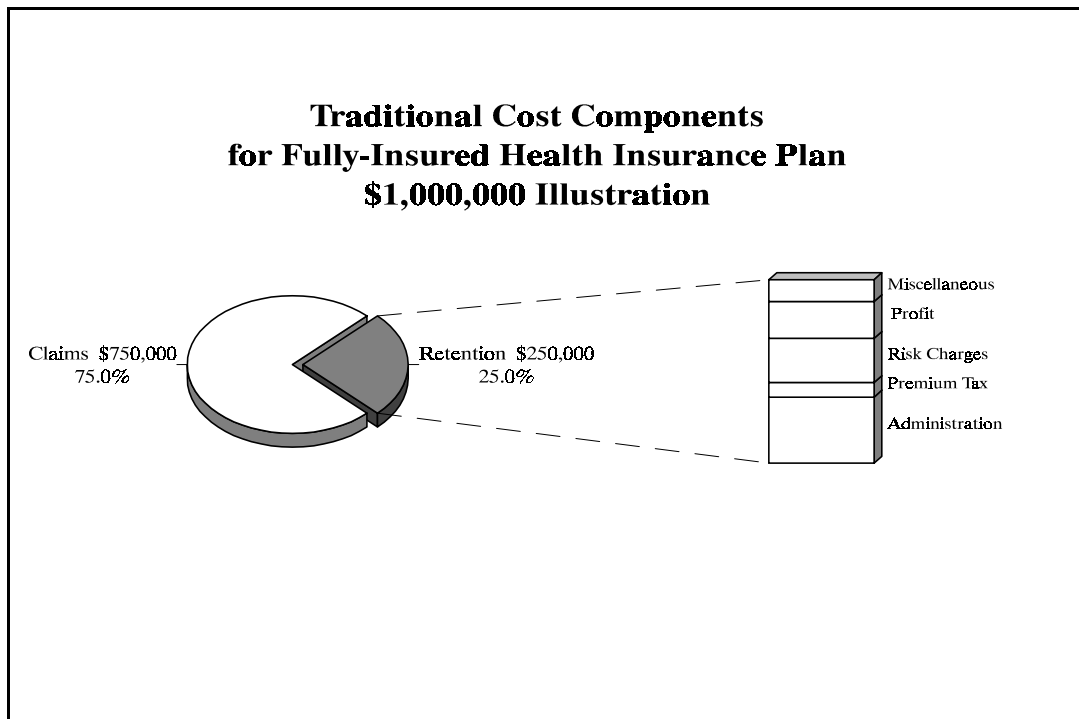


Figure 1

II. Principles and Objectives

The underlying risk management principle for self-funding is to avoid purchasing insurance for a known risk. If a health insurance plan has a large enough populace to have a predictable risk (i.e., claim costs do not significantly fluctuate each year, and there is a trend for increases that reflects the local medical care economy), then there is no need to send premium monies to an insurance carrier to be reduced by retention expenses before they are used to pay claim costs.

The objectives for self-funding are usually four-fold:

P Reduce Retention Charges

Expenses such as premium tax and insurance carrier profits are eliminated or significantly reduced under self-funding. Claims administration expenses are often reduced as third party claims administrators have traditionally had charges that were one-half to two-thirds less than the cost of claims administration from insurance carriers. In addition, many insurance carriers charge retention expenses as a percentage of total premium rather than on a fixed fee basis. Accordingly, retention expenses have often increased at the same rate as health care claim costs rather than the true cost of providing the service or assumption of risk.

II. Principles and Objectives

P Cash Flow Interest Income

A second objective of self-funding is to take full advantage of interest income on premium monies collected but not yet expended for claim payments, and interest income on the two reserve funds for terminal claims liability and claims fluctuation under partial self-funding (see operational definitions in Section III).

P Access to Surplus Funds

Even when insurance carriers offer financial arrangements that include dividend accounting arrangements, plan sponsors have experienced difficulty in obtaining a timely return of surplus funds. In addition, retention charges and interest income rates are often difficult to set at fixed levels and frequently become an issue for dispute in determining the existence of surplus funds. Self-funding allows the plan sponsor to have immediate access to surplus funds (for the purpose of lowering plan costs or indemnifying additional risk) and to have certainty as to when a surplus exists.

P Control of Plan Design

In addition to avoiding state mandated benefits (for plans that are subject to ERISA), self-funding often allows the plan sponsor to provide benefits that would otherwise not be available or that would have an artificially high cost from an insurance carrier.

There are numerous disadvantages and costs associated with self-funding that are often not readily apparent. These concerns will be discussed under the sections for employer and student experience.

III. Self-Funding Operationally Defined

There are four types of self-funding that are common for health plans. These methods are defined as follows:

P Full Self-Funding

Plan sponsors with 10,000 or more participants are often able to self-fund their claims liability completely because they have a highly predictable risk. This means they do not purchase stop-loss coverage or reinsurance to provide a maximum liability point. For these plan sponsors, the predictability of the claims risk is almost a certainty, and the worst case scenarios for the health claims liability represents a relatively small portion of their overall operating budget. Thus, expenditures for stop-loss coverage or reinsurance do not make sense from a cost perspective. Finally, a plan sponsor of this size may retain a third party claims administrator or perform claims administration services in-house.

III. Self-Funding Operationally Defined

P Full Self-Funding

The claims administrator would perform all of the services normally provided by the claims department of the insurance carrier (e.g., determination of medical expense eligibility under the plan document, issuing benefit checks and explanation of benefit forms, producing utilization data for plan assessment and claims cost forecasting, etc.).

P Partial Self-Funding

The plan sponsor under partial self-funding limits the claims liability by purchasing two forms of stop-loss coverage. *Aggregate stop-loss coverage* establishes a maximum plan-year liability, usually set between 115 percent and 125 percent of expected paid claims. Thus, if the expected paid claims were \$1,000,000, the plan sponsor's maximum liability would be \$1,115,000 or \$1,250,000. The plan sponsor maintains a claims fluctuation reserve to fund the liability between expected paid claims and the fiscal protection level established by the aggregate stop-loss coverage. This protection level is commonly referred to as the attachment point.

The second form of stop-loss coverage is called *individual or specific*. This coverage limits a plan sponsor's liability for catastrophic claims. For example, a claim of \$400,000 would be paid as follows under a \$50,000 specific policy: stop-loss carrier liability = \$350,000, and plan sponsor liability = \$50,000. Specific stop-loss coverage is important to protect the plan sponsor's cash flow and reserves established for claims fluctuations. A common maxim used to be that specific stop-loss coverage should be set at six percent to eight percent of annual expected paid claims (the specific stop-loss point would be \$60,000 to \$80,000 under an annual expected paid claims of \$1,000,000). This theory is no longer prevalent among benefit consultants because the cost trends of specific stop-loss coverage has been sporadic in recent years. Today, the specific stop-loss protection amount is set to reflect: (1) the optimum mix of risk to the plan sponsor versus the cost of coverage; and (2) the plan sponsor's comfort level with exposure to adverse trend increases in claim costs due to catastrophic expenditures.

Both aggregate and specific stop-loss coverage commonly include provisions that establish periods for when a medical expense claim is eligible under the stop-loss coverage. The two provisions are referred to as *incurred* and *paid*. For example, the stop-loss coverage could be written on a 12/18 basis, which means the medical expense must be incurred during the 12 month policy period, but may be paid by the claims administrator during an 18 month period. Thus, run-out claims liability is covered under the stop-loss coverage for up to six months after the end of the plan year.

III. Self-Funding Operationally Defined

P Partial Self-Funding

Another important feature of partial self-funded plans is the catastrophic case management services that are provided many by stop-loss carriers. Claims for head trauma, spinal injuries, severe burns, premature births, and other common catastrophic claims can often be managed to obtain the most medically effective and cost efficient care.

Conversion policies (i.e., policies that students may purchase with no pre-existing condition limitation upon termination of their participation in the student health benefits plan) are also often purchased from stop-loss insurance carriers. Depending upon state regulation, and how student health insurance plans are being regulated under the Health Insurance Portability and Accountability Act (HIPAA) in a specific state, the need for a conversion privilege may now be significantly diminished.

Claims administration is almost always performed by a third party claims administrator rather than in-house.

P Component Self-Funding

Component self-funding means the plan sponsor is self-funding a limited part of the claims liability. For example, a small employer may wish to self-fund the difference between a \$200 and \$1,000 deductible. Another increasingly common example of component self-funding is a college or university retaining a portion of the student health insurance premium to fund the fee-for-service charges the insured student populace will incur at the student health service. Under this example, \$60 of a \$250 semester premium does not reach the insurance carrier but is retained on-campus. Monies are transferred periodically from the student insurance account to the health service based on the insured students' actual usage of medical care that is not covered by the health fee and charged on a fee-for-service basis.

P Direct Self-Funding

The most common example of direct self-funding is health services on college campuses and the growing number of large employers providing employee health services and wellness clinics at the work site. These health services are funded by the plan sponsor, with contributions from student fees or employee funds, and their objective is to render as much of the primary health care as possible for the commonweal of need in the covered populace. They are also important as these services can effectively blend health education with primary care. Another way to think of employee or student health services is that they are ambulatory health maintenance organizations.

IV. Experience of Employer-Sponsored Partial Self-Funded Health Plans

A recent survey conducted by William M. Mercer, Inc., found that for employers with more than 500 employees, over half self-funded their health care plans in 1997. An increasing percentage of HMO plans are moving into self-funding (13 percent compared to 10 percent for 1996).

The continued use of self-funding, is due a number of independent causes: (1) self-funding is not mutually exclusive with adoption of a managed care program; (2) HMOs have not been cost competitive in many areas because of high retention charges; (3) the cost advantages of many HMOs have been derived in large part by attracting the youngest and healthiest workers; (4) employers have gained confidence with self-funding in at least being able to determine the claim costs versus administrative expenses (many HMOs do not provide any form of dividend accounting or reliable cost data for the employer); (5) many large employers have been able to replicate the most important advantages associated with HMOs (easy access to primary care and health prevention programs) by establishing on-site employee health services; and (6) for employers subject to ERISA, avoiding the costs associated with certain state mandated benefits is only possible through self-funding, as HMOs are subject to state insurance regulation and mandated coverage.

The most common difficulties for employers providing self-funded health plans have been as follows:

P Indirect Time Costs

The time costs for key manager involvement in the decision making process associated with plan funding levels and benefit design issues are usually not adequately considered when a self-funded program is developed. While these activities represent indirect costs to the employer, they can be substantial.

P Volatility of Stop-Loss Coverage Costs

Stop-loss coverage is provided by many insurance companies through their property and casualty divisions. Accordingly, the cost of such coverage can fluctuate based on the performance of other product lines or interest income rates. Many employers have experienced difficulty with cost trends that do not reflect actual claim consumption.

IV. Employer-Sponsored Partial Self-Funded Health Plans

P Appropriate Stop-Loss Coverage Provisions

More than a few employers have selected stop-loss policies that did not have adequate protection for run-out claims liability (see previous comments about incurred and paid claims provisions in stop-loss coverage). Inappropriate stop-loss policies can create an excessive cash flow and claims liability for catastrophic health care expenses.

P Failure to Develop and Maintain Appropriate Plan Documentation

Self-funded programs require considerable attention to summary plan description booklets and plan documents that are usually provided by insurance carriers. Liability can arise for employers that fail to develop and maintain communication materials as specified by ERISA. Reporting to the Department of Labor is also required for plans subject to ERISA and for 501(c) trusts that are established for many self-funded plans. Many employers have created considerable liability for themselves by failing to pay careful attention to plan documentation and reporting requirements.

P Selection of Poor Quality Claims Administrator

Advances in computer software and reduced hardware costs have led to the development of a large number of third party claims administrators. The ability to process health care claims accurately and cost effectively is often overlooked by employers in establishing self-funded health plans. The cost of the services rendered is often overrated in relation to expertise and organizational stability. Unfortunately, organizational stability in all facets of health care and employee benefits services organizations is becoming increasingly difficult to determine. The recent volatility of the managed care field is now characteristic of all other parts of the group health insurance field.

The advantages of various self-funding mechanisms have already been discussed earlier in this document. The large number of employers that continue to provide health care coverage for their employees through various self-funding vehicles is testimony to the relative simplicity and security of this funding methodology. In fact, when properly established and maintained with prudent reserves, self-funded health plans should have no greater financial risk than fully insured programs.

V. Student Health Plan Self-Funding

A number of large public and private institutions have adopted self-funded student health plans in the past decade. Universities that have partial self-funding programs include Dartmouth College, Princeton University, Case Western Reserve University, the University of Massachusetts at Amherst, and the University of California at Berkeley. Universities that have developed component self-funding systems for their student health service charges include Ohio State University, the University of Minnesota, and the University of Colorado at Boulder.

The motivations for moving to self-funding have often been linked to service needs more than cost advantages. The quality of claims service from a number of fully insured health plans has not been acceptable as the need for student health insurance programs has risen due to the increase in the number of uninsured and under-insured students. The need for effective student health insurance programs is also increasing as employers continue to shift the cost of health insurance to their employees.

From a cost perspective, partial self-funded plans have been able to reduce their administrative and risk charges from the normal range of insurance carrier retention charges. Many large self-funded student health insurance plans are able to return over 85 percent of the collected funds to covered students in the form of benefit payments. This objective of percentage return of plan funding is known as the *target loss ratio* for both fully insured and self-funded plans. The target loss ratio for the majority of the student health insurance marketplace, using some form of mandatory enrollment system, ranges from 70 percent to 80 percent of premium. It should be noted, however, that there are a small number of Blue Cross and Blue Shield plans and other regional insurance vendors that have target loss ratios of 85 percent to 90 percent of premium. In some cases, these insurance carriers have a mutually beneficial relationship with the university that creates marketing and other advantages for the insurance carrier to offer an unusually favorable target loss ratio.

The ability to have complete control over surplus funds has also been a major factor in pushing college and universities toward self-funding. As noted previously, dividend accounting, minimum premium, and retrospective premium arrangements are becoming more common in the student health insurance marketplace. The introduction of such arrangements to the student health insurance field should help facilitate the transition of colleges and universities from fully insured arrangements to partial self-funding. The following is a brief summary of common pitfalls universities have experienced with self-funding:

P Conflict with University Culture

Proper management of self-funding requires development and maintenance of at least two reserves for claims fluctuation and terminal claims liability (the purpose of both reserves is discussed earlier in this document).

V. Student Health Plan Self-Funding

Many universities do not have a strong culture for maintaining reserves, or they have not been able to successfully encumber funds for long-term liabilities (see Section VI for a complete discussion of the ethical tests for developing and maintaining reserve funds).

Another conflict with some university cultures occurs over price sensitivity. Fully insured products allow the university to conduct a periodic public request for proposal process to determine student insurance costs, whereas self-funded plans require the institution to set its own funding rate for the health plan. This must be accomplished using claim cost trend forecasts and spread of risk enrollment projections that are highly speculative. Temptations to develop overly optimistic funding assumptions that will yield politically acceptable student health plan increases must be consciously avoided. *Successful student health plan management requires the institution to manage the funding requirements with the same fiscal success objectives that drive insurance carriers.* The cost for student health plans must be measured against marketplace alternatives, both on an individual product basis and as compared to other student health plans of comparable quality.

P Inappropriate Stop-Loss Coverage

Institutional cost sensitivity is linked directly to the level of stop-loss coverage that should be purchased for protection from catastrophic claim expense. The trend is clearly toward more catastrophic coverage (\$250,000 to \$500,000 maximum benefits) in benefit designs, reflecting the fact that the majority of insured students are no longer purchasing student health insurance as a plan that is supplemental to parental insurance. Self-funded student health plan managers have often struggled with the quandary of known premium expenditures versus the savings produced through a higher deductible amount for specific stop-loss coverage. For example, a deductible increase from \$50,000 to \$150,000 may produce a savings of \$50,000 in stop-loss premium. That may be an appropriate trade-off, but some student health plan managers have erred by not setting up a third reserve account for the premium savings to be dedicated to catastrophic claim protection. Student health plan managers should work under the assumption that the worst possible case scenario for plan funding will happen.

The end result of purchasing stop-loss coverage is that it will probably be a financial loss for the plan. That is, the benefit payments are not likely to exceed or equal premium payments over an extended period. In fact, aggregate stop-loss coverage set at 125 percent of expected paid claims has a very low probability of producing a return for the plan. Stop-loss coverage is correctly viewed as peace of mind protection for either widespread adverse claims cost trend, epidemic illnesses, or multiple catastrophic injury claims that could create an extraordinary liability for the institution.

V. Student Health Plan Self-Funding

P Request for Proposal Processes

Universities that are interested in self-funding often try to evaluate its feasibility while also pursuing fully insured alternatives. This usually results in a less-than-enthusiastic response from vendors specializing in both markets. If self-funding is feasible and desired, it should be pursued as the primary course of action. A request for proposal process for a fully insured product should be developed as a fall-back strategy if self-funding is not workable following an attempt to select a stop-loss carrier and claims administrator.

P Conflict of Interest between Vendors

The advantages of self-funding can be negated or diminished if the institution selects vendors that have a conflict of interest. Ideally, the institution should work with four different vendors with no financial or other ties to each other: stop-loss carrier, claims administrator, consultant/actuary, and legal counsel.

The nuances of the stop-loss market often require that the RFP for claims administration and stop-loss coverage be commingled. This is particularly true for student health insurance where plans with participation levels that are usually much lower than the common range for employer-sponsored health plans. Accordingly, the stop-loss market is not as open for student health plans compared to large employer-sponsored plans. The influence of a large claims administrator, who has favorable relationships with one or more insurance carriers, may be critical to obtaining stop-loss coverage.

P Poor Student Health Service Quality

The coexistence of high quality student health services and student health insurance programs is increasingly difficult to achieve. Effective student health insurance programs require a strong element of managed primary care. This means that successful student health insurance plans usually require the existence of a high quality student health service capable of rendering comprehensive primary care. As college health services become increasingly difficult to manage, and traditional pre-paid funding is reduced or stagnates, the likelihood for successful student health insurance management is greatly diminished. A key facet of evaluating the viability of student health plan self-funding must include an assessment of the fiscal stability and quality of care of the student health service.

V. Student Health Plan Self-Funding

P Time Constraints and Student Involvement

As is the case with employer-sponsored health plans, college and university administrators often fail to recognize the amount of time required to manage a self-funded health program. For public universities, the issue of management time is often directly linked to developing and maintaining student involvement in the management of the program. This creates an added challenge that is part of the overall student affairs division culture of the institution.

VI. Ethical Tests for Developing and Maintaining Reserves

As noted previously, successful long-term performance of a partial self-funded plan requires the plan sponsor to manage the program with the same fiscal success objectives that would drive an insurance organization. This inherently means that reserve funds must be established that allow for error in claims forecasting and conservatively fund the terminal liability that will exist if the partial self-funded plan is discontinued. Many colleges and universities have difficulty with the concept of developing and maintaining reserves because it suggests that currently enrolled students will pay more than their fair share of the cost of the program. SLBA recognizes this concern and recommends that four ethical tests should be applied to the development and maintenance of reserve funds.

P Comparison with Insurance Industry Standards

Insurance carriers usually include a factor for error known as *margin* in the calculation of expected paid claims, even though this reserve funding may not be formally acknowledged. Under common student health insurance contracts, the insurance carrier is responsible for all of the terminal claims liability when either a change of carriers is made, or the plan is terminated. This liability also requires the insurance carrier to maintain reserves. Thus, under fully insured scenarios, currently insured students usually make a contribution to the cost of the plan (or insurance carrier profits) that promotes premium rate stability. As previously noted, such contributions are rarely returned to the plan sponsor through dividends.

Colleges and universities operating partial self-funded health plans are on ethically solid ground to the extent their development and maintenance of reserves does not exceed the levels charged under fully insured plans, or if contributions to reserves can be made through reductions in retention charges that would have otherwise occurred if the plan had been maintained on a fully insured basis.

VI. Ethical Tests for Developing and Maintaining Reserves

P Comparison with Individual Health Insurance Marketplace Alternatives

Another test for the appropriateness of reserves is to determine if the existence of such funds creates a situation whereby individual health insurance products are available to students in the local community at a lower cost. It may be possible in some situations to develop reserves that are advantageous compared to charges under fully insured products but that are still excessive.

P Integrity of Institutional Funds

Costs charged to students for health care financing must ultimately be expended for that purpose. Colleges and universities that are unable to create encumbered reserve funds should not enter into partial self-funding arrangements. At a minimum, there should be a clear expression of policy intent regarding the establishment and use of reserve funds, even though such funds cannot be placed in a formal trust or other encumbered account.

P Interest Income

A slightly separate test from the integrity of institutional funds is to make certain that large reserves benefit the covered student populace. Such reserves should receive interest income at a level similar to other institutional reserve funds. This interest income should be used to build reserves or to reduce plan administration and risk charges.

VII. Conclusion

While there are pitfalls that must be carefully studied, self-funding of health benefits plans is a widespread and reliable method of funding health insurance coverage for either employer-sponsored group health insurance programs or student health benefit plans. The adoption of a self-funding program can also be accomplished in conjunction with implementation of an effective managed care benefit design. It is also noteworthy that college health professionals have much more experience in operating self-funding programs than often perceived. Many college health services operated as self-funded ambulatory health care maintenance organizations.