

SELF-FUNDING IN THE WAKE OF PPACA

By Chris Marren

While larger employers have been self-funding for years, it is now also becoming an increasingly popular option for small- and mid-sized companies. According to PricewaterhouseCoopers data, the percentage of self-insured employers with fewer than 1,000 people in their health care programs has almost doubled – from 29% in 2008 to 48% in 2010 (*M. Frey, BenefitsPro, Feb. 2011*).

Under self-funded arrangements, an employer establishes a budget and sets aside funds to pay the medical expenses of workers and their families from current cash flow as claims arise, based on analysis of prior claim expenditures and underwriter's projections. By purchasing stop-loss insurance on the population, an employer is able to limit risk by assuming only a certain dollar amount of claim liability on each covered individual (called a "specific deductible").

Depending on the organization's size and risk tolerance, the employer can purchase a specific deductible ranging from as low as \$25,000 to \$125,000 or higher. Additional mitigation of financial risk is available via aggregate stop loss which will reimburse an organization whose aggregate claims exceed a particular threshold at the end of the plan year. Aggregate stop loss coverage is more common with smaller populations, where a comfort level with anticipated claim experience may not be as high as with larger populations.

In addition to the enhanced cash-flow opportunities, employers with self-funded plans are not subject to state health insurance regulations and benefit mandates, allowing for flexibility in plan design, especially for those with multi-state locations.

Under PPACA and the creation of state health benefits exchanges, several provisions are designed to avoid adverse selection, such as standardization of plan designs and risk adjustment methods applied to premiums.

As noted in *Issue Brief #840 from the National Health Policy Forum, December 2010*, self-insured plans are exempt from some requirements, even though the term "self-insured" is not defined in PPACA. Some exemptions for self-insured plans:

- They are not required to provide coverage with minimum essential benefits
- They are not required to participate in a risk-adjustment system
- They are not subject to provisions such as medical loss ratio requirements and review of premium increases.

While the Issue Brief noted that data is not available to assess the availability, premiums, or terms of stop-loss for small employers, it indicated that the stop-loss marketplace is developing different types of products for smaller firms who may consider switching to self-insurance in the future.

As an aside, if a trend begins to develop where smaller businesses with healthier populations find a way to become self-insured via new products in the coming years, a situation could arise where less healthy populations are insured via the exchanges, causing premiums within the exchange to rise and ultimately challenging the viability of the exchange.

PPACA mandated the Secretary of HHS to partner with the DOL to study fully-insured and self-insured markets, and their 180-page report was sent from the DOL to the Secretary of HHS for review on April 20th. The TPA and stop-loss marketplace is no doubt anxiously awaiting the results to see what the future holds for self-insured plans.

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