

Professional Benefit Services, Inc. Self-Funded Health Plan Administration

What is a self-funded medical plan?

A self-funded plan is one in which the employer group takes the place of the insurance company and assumes the financial risk for providing health care benefits to its employees. The group, not the carrier, is responsible for the claims costs incurred by its plan members. The employer’s plan is administered by a Third Party Administrator (TPA) or by an insurance carrier functioning in an Administrative Services Only (ASO) capacity. The employer utilizes various tools, including stop loss, to help control overall losses by improving their ability to reduce plan expenses and premiums.

Why consider a self-funded medical plan?

- Reduce Costs (Potential Cost Reduction of 30% or More!)
 - Employer has opportunity to capitalize on good plan year (low claim loss)
 - Out-of-network savings can be attained reducing overall cost
 - Less taxation than fully insured plans (minimum of 2% ACA tax savings on premiums alone, states add another 1.75% on average)
 - Small employers (<100 FTE’s) utilizing self-funded medical plans are not subject to community rating requirements
 - Self-funded plans are not subject to the Essential Health Benefit (EHB) Requirements which allows plans to exclude certain types of coverage that fully insured plans cannot

Who is currently using self-funded medical plans?

- Employers as small as 50 employees with stable claim history
- Employers that desire flexibility and customization from their health plans
- 61% of all employees were covered by self-funded/partially self-funded plans, compared to 44% in 1999

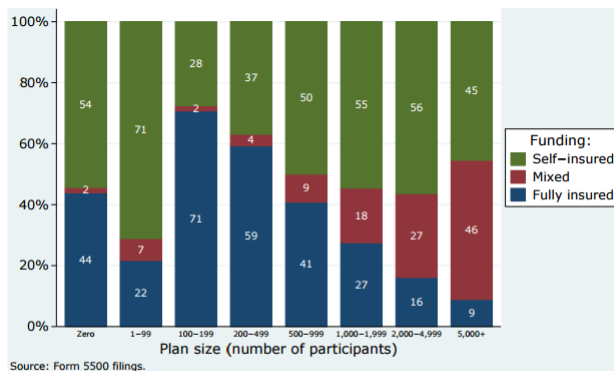


Figure 4. Distribution of Funding Mechanism, by Plan Size (2012)

Table 6 shows the numbers underlying Figure 4. It also shows the participant-weighted distribution of funding mechanism by plan size, which is similar to the plan-weighted distribution.

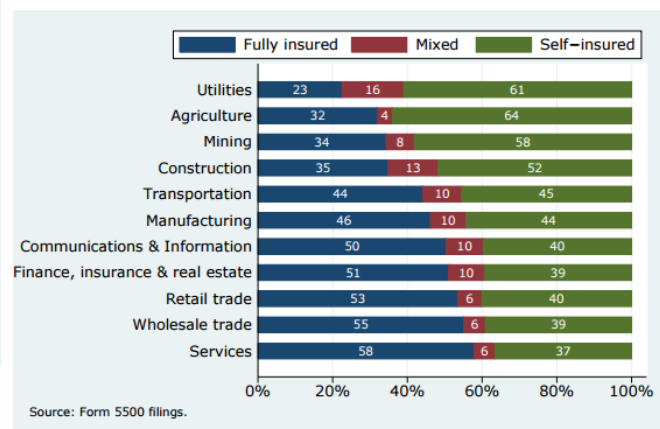


Figure 6. Distribution of Funding Mechanism, by Industry (2012)