Self-Funding Health Benefit Plans

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Employer-sponsored health plans are frequently divided into two categories: (1) insured plans and (2) self-insured or self-funded plans. Sponsors of insured plans pay money (premiums) to an insurance company (the insurer) in exchange for transferring the risk of potential health care claims from plan participants. The insurance company is responsible for covering participant claims as specified in the insurance contract or policy. Self-insurance and self-funding are strategies used by tens of thousands of plan sponsors across the country.

The purpose of this chapter is to introduce how health plans are funded—providing a foundation for understanding the other chapters in this book. In addition, this chapter explores the evolution of self-funded plans and the reasons these plans are gaining popularity. The chapter concludes with practical advice on deciding whether a plan is a good candidate for self-funding.

Self-Insurance and Self-Funding

The subject of this book presents a definitional difficulty. Neither self-funding nor self-insurance is entirely accurate. With self-insurance, a benefit plan sponsor (i.e., an employer or benefit trust) sets aside a pool of money in case an unexpected loss occurs. In reality, not all plan sponsors who self-insure employee health care benefits set aside separate funds for this purpose—some pay for incurred health costs through general assets.

1. Funded plans use a trust instrument to fund the cost of claims as well as accrued but unpaid claims. The trust instrument most often used by a funded plan is a voluntary employees’ beneficiary association (VEBA) trust, also called a 501(c)(9) trust since this is the section of the Internal Revenue Code (IRC) that exempts VEBAs from income tax.

2. Unfunded plans have no specific trust instrument to cover benefit claims. Rather, cash benefits are paid when due from an employer’s general assets.

With the alternative term, self-funding, a plan sponsor determines the amount of risk associated with plan participants. The predicted claim costs are treated as expenses. The sponsor deposits the expected maximum costs into an account each month (funded) or pays expenses as they come due (unfunded). If there is a reserve fund, it is usually kept separate from an organization’s other funds and invested so the money will be available when needed.

Self-funding suggests a plan sponsor assumes all of the losses associated with the risk of participant claims—there is no insurance arrangement. This is also not true for all plans. Plans that assume all of the risk and associated losses are said to be fully self-funded. The plan sponsor essentially acts as its own insurer determining what will be covered by the plan and paying claims directly. There are many sponsors, however, who modify the self-funding approach—They purchase an insurance policy to cover catastrophic losses above a specific dollar amount. Such plans are considered partially self-funded.

Various insurance contract arrangements are available to provide coverage for losses experienced beyond the covered claim limit established by the plan sponsor. The 1995 Government Accounting Office (GAO) Report HEHS Sections 95-167 recognizes these modified arrangements—
referring to plan sponsors that bear a large portion but not all of the risk for participant health claims as self-funded rather than self-insured.

For regulatory purposes, both self-insurance and self-funding are used. The term *self-insurance* has legal meaning with respect to the regulations on self-insured medical reimbursement plans. The term *self-insurer* also has meaning in several state laws. The “insurance” part of this term is applicable in determining whether state regulations are preempted by the Employee Retirement Income Security Act of 1974 (ERISA). The term *self-funding* is also used when determining the applicability of an Idaho law enacted in 1974.

The most accurate term for plans that are not fully insured is the cumbersome phrase “self-funding or self-insurance.” For simplicity in this book, plans that maintain a sig-

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**A Comparison of Fully Insured and Self-Funded Plans**

<table>
<thead>
<tr>
<th></th>
<th>Fully Insured</th>
<th>Self-Funded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paid Claims</strong></td>
<td>The dollar amount of paid claims does not change significantly under either program.</td>
<td>The dollar amount of paid claims does not change significantly under either program.</td>
</tr>
<tr>
<td><strong>Claim Reserves</strong></td>
<td>The insurer has a contractual obligation to pay claims incurred within a given liability period, but only a part of these claims are paid within this period. The insurer must set aside adequate reserves to provide for both “incurred but not reported” and “in process but not completed” claims.</td>
<td>Setting aside funds in a claims reserves is not necessary as claims are paid as received; however, the amount of claims incurred but not yet paid remains a plan liability and many plan sponsors do set aside reserves.</td>
</tr>
<tr>
<td><strong>Inflation (Trend)</strong></td>
<td>In a conventional insured plan, the insurer requires the insured group to prepay projected inflation.</td>
<td>The plan pays actual inflation.</td>
</tr>
<tr>
<td><strong>Profit</strong></td>
<td>No insurance company can grow or, in fact, exist without profit; hence, it is a necessary cost of operation.</td>
<td>The plan is providing an employee health benefit program—its purpose is to provide savings versus profit.</td>
</tr>
<tr>
<td><strong>Premium Tax</strong></td>
<td>The insurer must pay a premium tax to both the state and the federal governments. The state tax is typically about 2.5% of the total insurance premium, but it varies by state. Health care reform added a new federal premium tax that is also about 2.5% of the total insurance premium.</td>
<td>Premium taxes are not assessed on self-funded plans.</td>
</tr>
<tr>
<td><strong>Overhead</strong></td>
<td>Insurance companies have costs for equipment, office space, employees, marketing, etc. These expenses are considered when establishing a plan’s insurance premium.</td>
<td>Plans that are self-administered have equipment, office space, employee and other operating costs. When a plan contracts administrative services, these costs are reflected in the contract fees.</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Virtually all conventional insurers pool claims in excess of a given point. Theoretically, claims in excess of this amount are not charged to a specific group. The insurer applies an excess risk charge to all groups.</td>
<td>The plan sponsor is responsible for all claims. To avoid exposure to catastrophic loss, the plan sponsor can purchase stop-loss coverage.</td>
</tr>
<tr>
<td><strong>Margin</strong></td>
<td>Virtually all conventional insurers add a margin to their premiums in case their estimate of claims is too low.</td>
<td>The plan sponsor is responsible for all claims, so adding a margin to the budget may be advisable. However, no cash is disbursed until a claim is paid.</td>
</tr>
</tbody>
</table>
ificant portion of the risk for participant health claims and meet the ERISA standards for preemption are referred to as “self-funded.” Exhibit 1.1 summarizes the similarities and differences between fully insured and self-funded plans.

An Historical Perspective

Self-funding of health care benefits first appeared around 1930 with the formation of VEBAs. These organizations provided benefits to needy members of the association—replacing the informal employee practice of passing the hat.

Self-funding, as it is known today, was established and experienced rapid growth after World War II. One reason for the substantial growth in the postwar era was the passage of the Labor-Management Relations Act (LMRA) of 1947 (also known as the Taft-Hartley Act). LMRA made it possible for employers to contribute money into a joint trust established for the sole and exclusive benefit of employees and their dependents. These tax-exempt trusts—more commonly referred to as multiemployer benefit plans—functioned as conduits for the payment of insurance premiums as well as vehicles for the direct payment of benefits without an insurance contract (i.e., the self-funding of benefits).

During the 1970s, another federal law in combination with rising health care costs further stimulated the growth of self-funded health plans. As health care costs increased, so did the cost of health insurance premium payments. Plan sponsors sought ways to contain these benefit costs and ERISA offered a means to do so.

Prior to the passage of ERISA, some states prohibited self-funding of health and welfare benefits. ERISA made it clear that self-funding of these benefits is permitted. The law exempted many self-funded plans from state benefit mandates—giving plan sponsors more control over the design of their health benefit plans and a way to avoid state requirements that helped raise benefit costs. Self-funding became an attractive alternative to purchasing health insurance for workers.

Be aware that while ERISA preempts state laws relating to employee benefit plans, there are limits to its powers. The Act does not supersede state laws regulating insurance or multiple employer welfare arrangements (MEWAs). It also does not preempt Hawaii’s Prepaid Health Care Act. Furthermore, ERISA does not apply to government plans or church plans; hence, these plans are subject to state laws.

In the early years, the number of plan participants was the primary factor determining whether a plan sponsor was a good candidate for self-funding health care benefits. By the 1980s, however, self-funding among small and medium-sized plans began to gain traction, largely because of the availability of stop-loss insurance. Today, plans with as few as 50 participants are routinely and comfortably self-funding. Plan sponsors now consider factors such as plan design, administration and cost containment as well as size when making the decision whether to self-insure health benefits.

The passage of the Patient Protection and Affordable Care Act of 2010 (PPACA) commonly called the Affordable Care Act (ACA) is now generating more interest in the self-funding of health care benefits. Self-funded plans are exempt from certain ACA requirements such as the medical loss ratio rebate rules. Moreover, self-funded plans do not have to pay the new health insurance tax. Health benefit plans of all sizes are considering self-funding as a means to retain control of plan features and costs.

Between 1999 and 2014, the proportion of public and private sector workers covered by a self-funded plan grew from 44% to 61%. Exhibit 1.2 reveals the growth in partially and fully self-funded employer-sponsored health plans by plan size. Growth has been most substantial among health plan sponsors with 1,000 or more workers.
The proportion of the smallest plans—those with less than 200 workers—using self-funding continues to be relatively rare, but there was a bump in coverage among these plans in 2010. Whether an upward trend will continue among smaller plans is not clear, however, the stop-loss insurance industry has shown greater interest in accommodating the small plan market.

Which Health Benefits Are Most Commonly Self-Funded?

Medical and Drug
Medical and prescription drug benefits consume most of the health care dollars and are discussed throughout this book; however, other health care benefits, such as dental, vision and hearing benefits can also be self-funded.

Dental Benefits
In recent years, there has been a trend toward self-funded or standalone dental plans. Some of these programs are essentially plan sponsor-administered dental plans. Dental benefits carry less risk for self-funded plan sponsors than medical benefits because dental benefits typically have annual maximums. Plans have an interest in these programs because:

- Employees are asking for dental benefits.
- Plan sponsors are dissatisfied with current plan costs.
- Plan sponsors realize the plan design can be streamlined so that they can administer the plan themselves.

Self-funded dental plans most often look like fully insured plans administered by insurers on an administrative services only (ASO) basis or by a third-party administrator (TPA).

For years, the American Dental Association (ADA) has been a strong promoter of self-funded dental plans. The standalone plan that the ADA has in mind is what it calls a direct reimbursement plan—The participant obtains dental care from any dentist, presents a payment receipt to the plan and is reimbursed for a percentage of the expenses up to a given dollar limit. From the plan sponsor’s perspective, the participant typically presents a payment receipt from the dentist’s office. The plan then verifies eligibility, calculates the benefit payment, issues a check and records the amount paid to the participant.

One advantage of the ADA system is that there are no claim forms. In addition, the participant knows in advance what the out-of-pocket expense will be, since there are no usual and customary or treatment limitations. It is up to the participant to choose a dentist that the participant believes will provide quality care at a reasonable cost.

The direct reimbursement plan is flexible in its reimbursement levels. In its simplest form, a reimbursement plan might pay 75% of dental expenses up to a maximum benefit of $750 per individual. Slightly more complex arrangements might vary the percentage of reimbursement after the first $100 or $200 of dental expenses.

If a direct reimbursement plan is set up in a typical fashion by an employer with no participant contributions, the employer does not have to establish a trust to segregate funds. However, the ADA points out that employers with 200 or more participants may realize tax advantages by setting up an IRC Section 501(c)(9) trust to fund their direct reimbursement programs.

The ADA offers substantial startup support, free of charge, for plan sponsors interested in setting up a direct reimbursement dental plan. This support includes:

- A detailed brochure describing how the plans work, along with commonly asked questions
- Assistance in developing an administrative system
- Actuarial estimates of the cost a plan will incur, based on its employee population and plan design
- Referral to a company that can help the employer set up a trust
- Referral to a TPA if the plan sponsor chooses not to self-administer the plan
- Sample explanation of benefits documents, enrollment forms and summary plan descriptions
- Answers about any other dental program concerns that plan sponsors have.

Some plan sponsors favor outsourcing dental benefits administration because of the special computer design challenges required, the need for super-rapid and efficient claim processors, the unique recordkeeping requirements and the subculture of dental care.

Vision Benefits
Like dental benefits, self-funding vision benefits carries less risk than self-funding medical benefits because vision benefits are limited. Many self-funded vision benefits use a benefit schedule that limits the plan’s liability.

How Common Are Self-Funded Health Plans?
As noted previously, 61% of workers with an employersponsored health plan are covered by a partially or fully self-funded plan. Nearly three-fourths (71%) of these participants are in a conventional and/or preferred pro-
provider plan (see Exhibit 1.3). Coverage by a self-funded high-deductible plan with a savings option is also substantial at 60%. In comparison, the proportion of persons covered in a self-funded HMO is relatively low at 32%. It is notable, however, this figure has doubled in the last 15 years. In 1999, just 16% of HMO participants were in a self-funded plan. 3

Self-funding is also more popular in some industries than others. Health plan participants most likely covered by a self-funded plan are those in transportation/communication/utilities (70%), state/local government (69%), manufacturing (69%), retail (68%), health care (67%) and finance (65%). 4

A 2013 survey of benefit plan sponsors by the International Foundation of Employee Benefit Plans (see Exhibit 1.4) examined the proportion of plans using partial versus full self-funding. Half (51%) of the plan sponsors that responded said they were partially self-funding their health benefit plans, while another 16% reported they were fully self-funding. Multiemployer plans were those most frequently reporting using one form of self-funding or the other (78%), but the strategy was also being used by a substantial portion of public sector employers (63%) and corporations (60%). 5

Why Do Many Self-Funded Plans Use a Partial Versus a Fully Self-Funded Approach?

Despite the economic advantages of fully self-funding a plan, the majority of funds use partial self-funding for these reasons:

• **Risk exposure.** Self-funding requires a sufficient number of participants to project annual benefit costs. As a result, most plans that fully self-fund are large plans. It can be difficult for small plans to predict costs confidently. Partial funding arrangements using stop-loss insurance allows smaller groups to pool some of the benefit risk. Stop-loss insurance has become so readily available in recent years that even small firms have no trouble obtaining coverage, although some states mandate minimum levels of stop-loss coverage that discourage smaller plans from self-funding.

• **Predictability.** Even with large groups, claim amounts fluctuate from year to year. Stop-loss coverage helps a plan stabilize annual benefit costs and plan finances.

What Are the Benefits of Establishing a Reserve Account When Self-Funding?

Some plan sponsors who self-fund do not establish a reserve for claims unpaid. The reason they are self-funders is

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**Exhibit 1.3**

Percent of Covered Workers in Self-Funded Plans by Plan Type, 2014

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional/Preferred Provider Plan (PPOs)</td>
<td>71%</td>
</tr>
<tr>
<td>High-Deductible Plan with Savings Option</td>
<td>60%</td>
</tr>
<tr>
<td>Health Maintenance Organizations (HMOs)</td>
<td>32%</td>
</tr>
<tr>
<td>Point-of-Service Plan (POS)</td>
<td>22%</td>
</tr>
</tbody>
</table>


**Exhibit 1.4**

Health Care Plan Funding*

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Corporations</th>
<th>Public Employers</th>
<th>Multiemployer Plans</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Insured</td>
<td>40%</td>
<td>36%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>Fully Self-Funded</td>
<td>11%</td>
<td>27%</td>
<td>20%</td>
<td>16%</td>
</tr>
<tr>
<td>Self-Funded with Stop Loss Coverage</td>
<td>49%</td>
<td>36%</td>
<td>58%</td>
<td>51%</td>
</tr>
</tbody>
</table>

* Due to rounding, not all totals equal 100%.
to avoid maintaining a reserve. Of those that do establish a reserve, it is usually done within the guides of an IRC Section 501(c)(9) trust. The advantages to establishing a reserve include the ability to:

- Measure and monitor the financial integrity of the program
- Provide a basis to periodically test the financial advantages of continuing to self fund
- Obtain accurate and current distribution of loss costs by operating division
- Monitor severity and frequency trends by location and product lines
- Provide cash-flow forecasts.

**How Are Self-Funded Plans Administered?**

Three basic approaches exist for the administration of a self-funded health benefits plan:

1. **Self-administered.** With self-administration, specialized personnel are needed to:
   - Perform a variety of recordkeeping, risk management, claims and compliance duties
   - Handle actuarial issues such as setting contribution levels and reserve attestations
   - Conduct its utilization reviews (i.e., precertification, concurrent and retrospective reviews).

2. **Administrative services only (ASO).** An insurance company provides services such as maintaining eligibility information, billing and claims processing under an ASO contract. In addition to serving as the plan administrator, the ASO might provide a network of providers and utilization review services. If services are limited to paying claims, the agreement may be called a claims services only (CSO) agreement. Stop-loss coverage may be provided by the same insurer or an unaffiliated stop-loss carrier. Often the insurer brings a strong managed care presence to the plan through its provider network. ASO arrangements can offer one-stop service for the self-funded health benefit plan.

3. **Third-party administrator (TPA) or specialty firm.** An outside party other than an insurance company is contracted to provide the self-funded plan with services such as collecting premiums and claims processing. The TPA may provide these services directly or arrange for them through another vendor. Stop-loss coverage may be arranged by the TPA or, less often, by a consultant, risk manager or broker.

For more information on these options, see Chapter 22 on plan administration.

**What Types of Plans are Good Candidates for Self-Funding?**

Exhibit 1.5 describes two employers with characteristics that may help in the decision whether to self-fund. Employer A might be a good candidate for self-funding while Employer B is probably a poor candidate.

**What Factors Must Be Considered When Choosing Self-Funding?**

Before a decision is made to self-fund versus fully insure health benefits, a plan sponsor must carefully consider a number of factors beyond cost. A risk manager is essential to addressing many of the issues. Regrettably, some plan sponsors choose self-funding for the wrong reasons. They want to capture the reserves, run the plan at minimum costs and hope that large claims do not happen. The following general guidelines have been prepared to assist organizations in evaluating the self-funding option.

**Claims Predictability**

- **What are the risks?** A risk is the chance a person or other entity will be injured or suffer a loss. For health benefit plan sponsors, the risk is that one of their plan participants will present a claim for the provision of health care goods and services.
- **How frequently do these risks occur and what is their potential severity?** Risks that have high frequency but low severity are those most appropriately covered through self-funding because such claims are most predictable. Of the primary health and welfare risks—hospital, medical, surgical, dental, vision and short-term disability—are better candidates for self-funding. Claims for long-term disability, death and dismemberment have lower frequencies and the potential for a higher cost per claim—factors that reduce the predictability of claims and financial stability.
- **Is the participant group large enough to spread the risk sufficiently?** Self-funding is a better fit for groups that have a consistent claims experience from one year to the next. Larger groups are more likely to have this consistency.
- **Does the group have a claims history?** Older organizations with a claims experience track record are better candidates for self-funding than new organizations with no history.
- **What outside influences (e.g., economic changes) might influence risks?** A plan sponsor in an indus-
try expected to take a downturn is not a good candidate for self-funding.

**Finances**

- **What is the organization’s overall financial situation?** A strong asset base increases the feasibility of self-funding because a plan is better able to deal with random fluctuations in claims experience. The need for asset strength may be reduced if the plan purchases stop-loss insurance. A plan sponsor for whom bankruptcy is a real possibility is not a good candidate for self-funding.

- **Will there be sufficient cash flow and/or liquid assets to cover claims throughout the year?** If not, the plan sponsor is definitely not a candidate for self-funding. When first making the transition from a fully insured contract to self-funding, most plan sponsors are able to build adequate reserves with a favorable cash flow.

- **Is management comfortable with the claims volatility typical of self-funded plans?** Not all plan sponsors are willing to accept the financial ups and downs that can occur with self-funding over time. Conventional insurance arrangements are more stable and predictable. A plan sponsor that is overly concerned with claim cost volatility may not be a good candidate for a self-funded plan. On the other hand, many stop-loss carriers provide a monthly benefit leveling device to protect the plan sponsor from one month’s claims being excessive in relation to the average monthly payout.

- **What about extraordinary losses?** Unless a plan sponsor has aggregate stop-loss insurance with monthly limits, it must be prepared to handle unusually high losses periodically.

- **Is stop-loss coverage available in the marketplace?** Risk managers are comfortable when insurers are chasing prospective buyers and uncomfortable with the reverse. Also, risk managers favor insuring when insurers are underpricing the estimated inflationary factor.

- **What self-funding structure will be used?** Options include trusts, MEWAs, stop-loss coverage, captives, etc. Each of these is discussed in detail in other parts of this book.

- **What amount of losses is the plan sponsor willing to assume?** Perceptions of what is an acceptable risk vary widely. For this reason and others, there is no magic formula for setting the maximum loss the plan sponsor should assume. There are, however, some practical rules of thumb that plan sponsors use when establishing the maximum loss amount they are willing to accept:
  - Rule 1: 1% to 3% of working capital
  - Rule 2: 1% of surplus plus 1% average annual earnings
  - Rule 3: 1% of revenues.

Stop-loss coverage is used to protect the plan sponsor from claims that exceed the loss limit established. This maximum loss is fixed by the stop-loss carrier and is generally in the range of 115% to 125% of the expected claims as estimated by the carrier.

- **Are there any upsides to setting the maximum higher?** Yes. The more risk a plan sponsor is willing to assume, the lower the plan’s fixed costs will be.
However, only plan sponsors that have the resources to absorb the greater risk and are willing to accept the risk should set higher limits.

**Administration**

- **Who will administer the plan?** A plan administrator screens, processes and audits claims. A decision is needed whether plan administration will be done internally or outsourced. Large plan sponsors with a well-staffed personnel department may have the facilities and expertise to administer a cost-effective health plan. Sponsors of most small and medium-sized plans are more likely to employ a TPA or have an ASO contract with an insurance company. The scope of services contracted out varies from plan to plan. When there is a family of plans—health and welfare, pension, vacation and 401(k)—established by a set of collective bargaining agreements, the plans jointly employ staff to administer all of the plans. Typically, self-funding appeals to sponsors because they can transfer administrative problems from their staff to the TPA or the ASO. An outside administrator is a way to pass the “bad guy” role of administration to an external party while the plan sponsor functions as the “good guy.”

- **Is the organization capable of taking on additional responsibilities outside its core competencies?** Employers who are in the widget business and want no part of being in the insurance business are not candidates for self-funding. Plan sponsors selecting to pay more to enjoy total freedom from plan worry or responsibility are not good candidates for self-funding. Many plan sponsors know intuitively that they are unable to assume even the smallest amount of responsibility that attaches to a self-funded plan.

- **Is access to competent external plan administration available?** TPAs and insurance companies with ASO contracts are, for the most part, reliable and excellent administrators. Still, plan sponsors are advised to select carefully external administrators with a prior track record as there are those who fail to meet high standards.

- **Is bonding required?** If an employer pays claims from its general assets, no bond is needed. If there are plan assets, as is the case with a multiemployer plan or a plan funded through a trust, then a bond will be required.

- **Who will generate the necessary reports?** Various personnel associated with the plan sponsor need a variety of reports related to the plan. Determining which reports are needed and who will provide them are necessary steps—as is making sure the data necessary to generate reports is available on a timely basis.

- **Who will conduct audits?** Sponsors of self-funded plans should conduct periodic audits and request a copy of Statement on Standards for Attestation Engagements (SSAE) No. 16 Report on Controls at a Service Organization. When stop-loss coverage is used, the insurance company providing the coverage is subject to audits by insurance commissioners. These companies also have internal audit departments.

- **Will there be a plan supervisor?** All ERISA plans must have a formal plan administrator; many also choose to have a subordinate layer of management under the control of a plan supervisor, who may be a staff person of the plan sponsor or an outside entity, such as the TPA or ASO contractor.

- **Who will be responsible for resolving claim problems and appeals?** All ERISA plans must name fiduciaries that make final decisions on appeals and designate agents for service of legal process (the individual designated to receive legal documents). It is also advisable to determine in advance who will handle problem claims before they reach the level of an appeal or lawsuit.

- **How will legal issues be handled?** Does the plan sponsor have the resources to pay for legal counsel? If not, the plan sponsor is not a good candidate for self-funding. Even those with the resources must budget for legal fees and have an idea of who will be used for different legal situations. The lawyer drafting documents is probably not the same lawyer that will defend lawsuits.

- **Who has fiduciary liability for the plan?** If the plan is an ERISA plan, the plan sponsor is the fiduciary—The sponsor owns the liability regardless of whether the plan is fully insured or self-funded. Some TPAs are willing to assume fiduciary responsibility and make all claim decisions—relieving self-funded plan sponsors of some liability.

To the extent self-funders may move with greater speed and flexibility, their ability to respond thereto in an efficient and productive manner, such method will have some advantage over fully insured plans. The reverse is also true; a burdensome federal mandate might be more harmful to a small plan with a small TPA than to a large plan with an ASO arrangement.

While federal mandates (COBRA, HIPAA, etc.) affect all plans the same, the ability to administer such mandates is
mixed. Because the smaller TPAs, in total, are so dominant in self-funding, their struggle to accommodate the federal mandates has lessened the dominance of self-funding. The expansion of state mandates and the new federal premium tax, however, have increased interest in self-funding. Also, the NAIC-promulgated stop-loss model law has had a negative impact on the small group self-funded markets.

Taxes

- **What are the federal tax implications?** The self-funding of health care benefits has federal income tax consequences for the plan sponsor, plan participants and the participants’ beneficiaries. There may also be estate tax consequences for a deceased plan participant. Benefits received from a self-funded benefits plan are, in general, subject to the same income tax treatment as conventionally insured benefits. An exception is a self-funded life insurance benefit. While life insurance benefits paid by an insurance company are not taxed, self-funded life insurance benefits in excess of $5,000 are taxable as income. Health care reform created a new health insurance tax, which is a federal premium tax. Self-funded plans are exempt from this tax, which has made self-funding more attractive.

- **What are the state tax implications?** Chapter 6 discusses the premium taxes assessed against minimum premium plans where claims under the trigger point are held to be premiums.

Plan Design

- **What benefits will be provided and who will be eligible for benefits?** Self-funded plans have more flexibility than plans purchased through an insurance company that may only offer “off-the-shelf” plan options. With a large number of participants, however, insurance companies and health care service providers are more likely to build a benefits package tailored to the desires of a plan sponsor. Federal and state mandates also place some limits on choices—Various laws and regulations require health plans and insurers to provide coverage for certain benefits, care providers and persons.

- **What delivery systems will be used to provide these benefits?** When considering the delivery of health care benefits, some plans purchase all services and programs from one provider in an effort to create a fully integrated health care system for participants. Other plans elect to contract with more than one provider—choosing those providers that are most efficient in providing a specific program or service. Some plans carve out specific benefits and provide them on a separate basis. It is quite common for pharmacy, dental, vision and voluntary benefits like hospital indemnity or critical illness policies to be carved out and fully insured while medical benefits are self-funded. Mental health and substance abuse have also been carved out and separately managed by health plans. Transplant services are another area where a carve-out has been used.

Costs and Cost Containment

- **How much will self-funding the plan cost?** A self-funding decision should include an actuarial analysis (cost-impact study) estimating the potential gain or loss expected under a self-funded plan. Self funding can yield cost savings due to the elimination of premium taxes, sales commissions, profit and risk charges, in combination with the retention of a reserve. The magnitude of the cost savings, however, can be overstated if not properly balanced against the costs of self-funding. Self-funded plans have costs that do not exist with conventional insurance.

  It cannot be assumed claim costs will remain the same if a plan is switched from insured to self funded. A self-funded plan that liberally interprets its benefits may find it has higher total claim costs than a conventional insured plan with strict interpretations. Self-funded plan personnel may also lack the sophistication to interpret benefits as detailed in the policy, which results in borderline claims settled to a plan’s disadvantage. There is also the potential for coverage by another plan resulting in payment duplication.

  Exhibit 1.6 offers a comparison of three situations. Situation A favors a fully insured approach be-

| Exhibit 1.6 |

| Cost Comparison of Coverage Options |
|-------------------|-----|-----|-----|
|                  | A  | B   | C   |
| Fully Insured    | $100 | $100 | $100 |
| Self-Funded      |     |     |     |
| Fixed costs      | $60 | $40 | $30 |
| Best estimate of total costs | $100 | $85 | $70 |
| Maximum costs    | $150 | $110 | $95 |
cause the best estimate of total costs ($100) is the same as the insurance premium ($100), but maximum costs are significantly higher ($150). Situation C favors self-funding because the maximum cost ($95) is less than the insurance premium ($100). The normal situation is Situation B, where the maximum additional cost of $10 is unlikely (e.g., one chance in 12, but the expected savings of $15 is very likely (e.g., eight chances in 12). In general, plan sponsors in low-cost areas are better candidates for self-funding because insurance premiums are likely to be overstated.

- **What will be the start-up costs associated with converting to a self-funded plan?** Implementation costs are unavoidable; they include rewriting plan documents and summary plan descriptions. They may also include such things as establishing a trust.

- **What cost-containment programs are needed?** Cost containment is a must when a plan is self-funded. Assuming risk and making no effort to reduce risk goes against the basic principles of risk management. Chapter 21 is devoted to health care cost management.

- **How concentrated are plan participants?** Plan sponsors with a large concentration of employees in one area are in a better position to direct contract with health care providers—making these plans better candidates for self-funding.

- **Are participants primarily in urban or rural areas?** Urban areas are more likely to have multiple hospitals providing service. This makes it possible for a plan sponsor to negotiate with one of the providers for better discounts in exchange for directing patients there.

**Making the Transition**

- **How will workers respond to the change?** Workers can often sense when a plan is moving to self-funding for the wrong reason or at their expense. Some may resent having the strong backing of XYZ Insurance Company replaced by what they view as a weak employer or trust. Workers may also dislike aggressive cost-containment programs implemented by a new self-funded plan if they have had an insured plan with few cost-containment programs. If a cost-containment program is aimed at avoiding abuses, workers are more likely to accept them and, hence, the new self-funded plan.

- **How are gaps in coverage avoided?** With fully-insured plans, transfer problems are erased because the plans are written on an incurred basis and nearly always provide for disability extension. Self-funded plans are commonly written on a paid basis with no extension whatsoever. Making the transition between two funding options can be done, but it must be handled carefully to avoid gaps, lost coverage and surprises. For an additional price, stop-loss coverage may be written similar to insured plans.

**Communication and Employee Relations**

- **How will the plan be communicated?** A self-funded plan—particularly one with cost-containment provisions—must be properly communicated to be effective. Communication strategies must meet legal requirements such as plan booklets, summary plan documents and notices. Other messages might be delivered via handouts, videos, emails, etc. Communications are particularly crucial in situations where a union contract is involved and during the period of transition from a fully insured to a self-funded arrangement.

- **Is collective bargaining required with any unions?** Some bargaining agreements specifically refer to “insurance.” When this is the case, the agreement must be modified to allow self-funding.

**Can a Small Group Self-Fund?**

Many myths have developed around small groups of participants and self-funding. While larger plan sponsors are better candidates for self-funding, it is possible to successfully self-fund a smaller plan. Plans with as few as 50 participants are viable self-funding candidates.

**Myth 1** Only large plans can afford to self-fund. Actually, plans with as few as 50 participants can comfortably self-fund with predictable cost savings.

**Myth 2** Self-funding fails when a very large claim occurs. The reality is that a specific deductible amount protects the plan against such very large claims.

**Myth 3** Self-funding fails when a bad claims experience occurs. In fact, self-funding is a long-run proposition with fat as well as lean years.

**Myth 4** Financially unsound external administrators service most self-funded plans. Contrary to this belief, TPAs do a professional job of plan administration in most instances.

**Myth 5** Self-funded plans cannot provide protection against claims incurred before plan termination but submitted after termi-
nation of the plan. True, but stop-loss is obtainable to cover these runoff claims.

What Is Dual Funding and How Does It Work?
The dual funding of a benefit plan combines self-funded coverage for a plan’s “front end” with fully insured coverage for the “back end.” A plan sponsor of this type of dual-funded plan purchases fully insured major medical coverage with a high deductible (e.g., $5,000 per person), then self-funds the deductible. Coverage of the deductible is sometimes referred to as a gap plan. A self-funded gap plan may have its own set of copays, coinsurance and deductibles—adding complexity to the overall plan design. However, when communicating with plan participants, the plan sponsor can focus on how the plan’s benefits and claims processing appear to employees versus the existence of the high deductible and how the plan is funded. Nonetheless, take note that the summary plan description (SPD) must describe both the insured and self-funded aspects of the plan.

When considering a dual-funded program, be aware that some insurers refuse to allow their policies to be part of plans like this. If it is possible to self-fund a gap, there are a number of advantages for plan sponsors and participants, including these:

- **Lower cost.** Dual funding is essentially individual stop-loss coverage at the chosen level—$5,000 in the example provided. Stop-loss insurers consider this level low and, as a result, would price coverage starting at this point quite high. In contrast, medical insurers view a $5,000 individual deductible as high and would price coverage lower.

- **Certainty of stop-loss payment.** Under a typical stop-loss arrangement, stop-loss insurers sometimes disagree with the medical insurer regarding the eligibility of claim items that have been paid. The insurer might deny payment on the basis that the trigger activating the stop-loss coverage has not been reached. With dual funding, the medical insurer is essentially the stop-loss insurer, which means there can be no disagreement.

- **Improved cash flow.** With stop-loss coverage provided via an insurance company, a plan sponsor can face a lengthy delay before receiving reimbursement. When a plan is dual funded, the plan participant receives the funds via the normal claim processing period, which can be as few as 10 to 14 days.

- **Ease of administration.** Sponsors who self fund face the decision who will administer their plan. Self-administration is impractical for most small or mid-size plans. A plan sponsor can certainly engage a TPA to process the self-funded portion of a dual-funded plan, but there is little need to do so. In fact, hiring a TPA may be more cumbersome.

- **Self-administration.** With dual funding, a plan sponsor can submit claims to the insurance company as they occur. The insurance company reviews the claim and determines which expenses are covered. Next, the insurer issues an explanation of benefits (EOB) detailing which expenses are not covered and, most importantly, which expenses are being applied toward the deductible. The plan sponsor then issues payment to the participant from the self-funded portion of the plan to cover the expenses identified by the EOB as they apply to the insurance company’s deductible. If there is a deductible, copay or coinsurance to be satisfied by the participant, the sponsor considers this in calculating how much to pay the employee. One downside of this approach is that it delays reimbursement for out-of-pocket costs incurred by the claimant.

Another option is to hire the insurance company providing coverage to administer the self-funded portion of the plan. This allows seamless administration.

Are Self-Funded Plans Subject to Federal and State Insurance Laws?
Under current law, sponsors of group health plans may provide coverage through an insurance contract or self-funded. Section 514(a) of ERISA generally preempts state laws that relate to “employee benefit plans,” as defined by ERISA Section 3(3). What this means is that self-funded private sector employment-based group health plans are not subject to state health insurance laws, which includes coverage laws, rating policies and certain other consumer protections.

Self-funded plans are also not subject to some of the requirements under the Affordable Care Act applicable to health insurance issuers. However, they are subject to the consumer protections in the group market reform provisions such as the prohibition on lifetime and annual limits, the prohibition on preexisting condition exclusions and coverage of dependents to age 26.

States have been uncertain of their ability to regulate the use of stop-loss insurance by self-funded group health plans governed by ERISA because the federal legislation
prohibits states from deeming employee benefit plans to be insurance companies in order to regulate them under insurance laws. The National Association of Insurance Commissioners (NAIC) adopted a model law for states that prohibits the sale of stop-loss insurance with a specific annual attachment point below $20,000.

- For groups of 50 or fewer, the aggregate annual attachment point must be at least the greater of (a) $4,000 times the number of group members, (b) 120% of expected claims or (c) $20,000.
- For groups of 51 or more, the model law prohibits an annual aggregate attachment point lower than 110% of expected claims.

The U.S. Department of Labor (DOL)—the agency primarily tasked with administration of Title I of ERISA—announced in Technical Release 2014-01 that it takes the view that states may regulate insurance policies issued to plans or plan sponsors including stop-loss insurance policies. A state law that prohibits insurers from issuing stop-loss contracts with attachment points below specified levels would not, in the DOL’s view, be preempted by ERISA. Thus far, about ten states have enacted laws using the same approach as the NAIC model. For example, California prohibits specific stop-loss policies for small employers (no more than 50 employees, increasing to 100 in 2016) with an attachment point of less than $35,000 and aggregate stop-loss policies with attachment points less than the greater of:

- $5,000 times the total number of group members
- 120% of expected claims
- $35,000

There are no comparable rules in California for large employers.

The DOL has said it is not aware of any challenges to such laws based on ERISA preemption. This Technical Release is likely to encourage states to enact legislation limiting stop-loss insurance policies and, therefore, discourage self-funding for small plans.

What Are the Advantages and Disadvantages of Self-Funding?

Advantages

Self-funding provides plan sponsors a combination of economic, administrative and legal advantages. From an economic perspective, self-funded plans are significantly less costly than fully insured plans. Proponents say self-funded plans can realize savings of as much as 20% over a fully insured plan; however, it would take an aggressive strategy to achieve that level of savings.

Many plans choose to keep plan designs the same when converting from fully insured to self-funded, which limits the immediate savings that might result from avoiding state-mandated benefits. Cash flow advantages are small when interest rates are low. Savings from unbundling services vary significantly.

- **Benefits and funding flexibility.** Health insurers are burdened with a substantial number of state-mandated benefits—over 2,200 according to the Council for Affordable Health Insurance. Some state laws mandate coverage of certain individuals (e.g., newborns), while other state laws mandate coverage of specific types of services (e.g., chiropractic care) or certain diagnoses (e.g., autism). ERISA preempts self-funded benefit plans from these state laws. Likewise, ERISA preempts state laws regulating the financial management of plans. These preemptions give sponsors greater flexibility when designing and funding benefit programs.

  Preemption is especially important to plans that serve participants in multiple states. Sponsors of multistate benefit plans can establish one plan for all workers—avoiding the expense and complexity of meeting requirements in each state. Sponsors can choose which mandates they will meet and which they will disregard.

While the passage of ACA in 2010 places some new limits on this flexibility, self-funded plans continue to have some latitude that is not available to fully insured plans.

- **Stability.** An often unsung advantage of self-funding is stability. A self-funder may change TPAs, stop-loss carriers, consultants, brokers and so forth frequently and never have to reenroll participants. Self-funded plans have lives of their own independent of their vendors. Such is not the case with a fully insured plan. It has been reported that once a plan self-funds, it rarely goes back to being fully insured. Furthermore, self-funded plans are insulated from insurance cycles that can cause fluctuations in insurance premiums.

- **Capturing favorable claims experience.** Insurance companies use historical claims experience and a variety of other factors to predict the future claims experience and premium due for a group insurance plan. If the prediction is higher than the actual claims experience of the insured group, the insurance company often keeps the difference. In contrast, when
actual costs are lower than those anticipated by a self-funded plan, the plan sponsor keeps the difference. The recapture of a favorable claims experience has the potential for some of the greatest savings with a self-funded plan. Of course, there is also the possibility that a plan’s claims will be greater than what was projected. In such a case, self-funding could yield an unwelcome surprise. Such surprises can be reduced or eliminated through stop-loss insurance coverage for plan claims above specified limits.

Under health care reform, insurance companies are required to use community rating for small groups. In 2015, states have the flexibility to define small groups as being under either 50 or 100 employees. Starting in 2016, all states must define small groups as being under 100 employees. This lack of flexibility for insurance companies could make self-funding even more attractive for groups under 100 employees that have healthy workforces.

• **Reduced expenses.** With an insured funding arrangement, the money a plan sponsor pays to the insurance company must cover a variety of expenses beyond plan participant claims (e.g., insurance risk charges and broker commissions). Self-funded plans do not necessarily incur these expenses and can purchase services on an unbundled basis. In addition, the administrative and underwriting expenses incurred by a self-funded plan are typically less than those in an insured arrangement.

• **No profit margin.** For-profit insurance companies are expected to provide shareholders a competitive return on their investments. There is no such expectation of self-funded plans, although each of the plan’s service providers does expect to make a profit.

• **Avoiding premium taxes.** An important source of revenue for states is the insurance premium tax. Insurance companies pass on the cost of these taxes to those they insure. To the extent their plans are self-funded, plan sponsors have historically been able to avoid most insurance premium taxes. The laws governing insurance premium taxes vary from state to state, but the tax savings for self-funded plans have been in the 1.5% to 3.5% range. On average, the savings from avoiding both the state and the new federal premium tax is around 5%.

• **Commissions.** Another savings is the elimination of commissions paid to an insurance agent or broker. Self-funding does not involve the sale of a product by an agent paid a commission by an insurer. Self-funded plans usually pay consultants to provide some or all of the services typically provided by an insurance broker; however, these services can be purchased and negotiated on an unbundled basis with a lower cost.

• **Cash flow.** Self-funded plans always create a cash flow advantage when a plan is first self-funded. Rather than paying premiums monthly in advance, claims are paid after the services have been rendered and billed. Many, but by no means all, plan sponsors prefer the pay-as-you-go option that self-funding offers versus paying fixed monthly premiums to an insurance company. Some sponsors establish a side fund to even out the fluctuations. As interest rates have declined in recent years, it is important to recognize that savings from self-funding have decreased.

• **Improved investment return.** Reserves for incurred-but not reported (IBNR) claims are often equal to two or three months of claims. To the extent a plan sponsor can get a better investment return than an insurance company would credit, there is improved investment return.

• **Vendor choice.** Many services (e.g., claims processing, recordkeeping, utilization review, risk management) are needed when managing a health benefits plan. With a fully insured plan, the insurance provider provides a package of services that may or may not fit the particular needs of the plan. With self-funding, a plan sponsor has the ability to bring together a collection of vendors that best suits plan and plan sponsor needs.

**Disadvantages**

• **Vendor package.** An advantage for one plan is sometimes a disadvantage for another. Some sponsors welcome the fact that with a fully insured plan, the insurer puts together the package of vendors serving the plan. Sponsors of self-funded plans must choose from a plethora of vendors. Coordinating and monitoring the services of vendors also falls on the shoulders of the plan sponsor. Not all sponsors are willing or able to fulfill these responsibilities.

• **Additional services.** An insured arrangement offers additional underwriting, legal and administrative services not available to a self-funded plan. Self-funded plans need to set their own budgets and reserves and may not have all the expertise needed for proper administration.
• **Participant reassurance.** Plan participants may have concerns regarding the financial security of their health care benefits.

• **Claims buffer.** A self-funded plan is responsible for settlement of its claims. In contrast an insurance company provides a third-party buffer with employees. The sponsor of a fully insured plan can maintain the persona of the “nice guy” promoting payment of difficult claims while the insurer takes on the role of the “tough guy” refusing payment. (Self-funded plans with stop-loss coverage avoid this problem to some extent because there is an insurer involved for the large and, more likely, difficult, cases.)

• **Liberal claims settlement.** Self-funded plans—regardless of whether they are administered internally or via a third party—tend to have a more compassionate attitude towards claim settlement. While participants may appreciate this compassion, such decisions are detrimental to plan finances.

• **Community rating.** With an insured arrangement, a plan sponsor may be able to capture the lower costs of a community rating versus the expected actual costs of the participant group based on its demographics, health status and previous claims experience.

• **Contractual restrictions.** Collective bargaining stipulations may prohibit or restrict the value of self-funding.

• **Less premium volatility.** Stop-loss premiums have greater volatility than fully insured premiums. The risk assumed with stop-loss protection is at the high end, which statistically has greater dispersion than fully insured coverage. The latter includes both the high- and low-end risk.

• **Benefits discrimination.** IRC Section 105(h) forbids discrimination by self-funded plans, but no such prohibition applies to fully insured plans. A nondiscriminatory technique using a high/low benefit option (where employees are offered both a rich plan and a less expensive plan) open to all participants is practiced by many self-funders and accomplishes in a permissible manner what the insured plans do directly. Health care reform requires fully insured plans to abide by the same nondiscrimination rules; however, as of press time, no regulations have been issued and enforcement with regard to fully insured plans is suspended until after regulations are issued.

• **Liability.** Unless a TPA or ASO contractor assumes responsibility for the plan. Typically, the plan sponsor’s burdens with a self-funded plan exceeds those of a fully insured plan. Fully insured plans are subject to DOL audits; however, self-funded plans have greater exposure.

• **Keeping current.** With a self-funded plan, considerable time and effort must be spent to ensure plan benefits remain competitive with the current employee benefits market. Substantial staff time and effort may be required to remain up to date on changes associated with technology, health care practices and government regulations.

• **Gaps in stop-loss coverage.** Plan sponsors with stop-loss insurance may have caps in coverage, such as for claims not filed in a timely manner, exclusions and lasering. See Chapter 6 on stop-loss insurance for more information.

• **Misuse of funds.** In addition to the risk of fraud, self-funded plan sponsors are sometimes tempted to use reserves for other purposes, leading to a cash flow crunch later.

### How Are State-Sponsored Self-Funded Plans Structured?

According to the National Conference of State Legislatures, 46 of the 50 states self-funded at least one health benefit plan as of 2010. Antigovernment spending sentiment in some states is increasing interest in the potential savings that might be generated by self-funding.

• **Creation.** Before a public employee plan may be self-funded, either enabling legislation or an opinion of the state’s attorney general is usually required.

• **Plan choice.** Most state plans are multiple option plans, that is, employees are offered more than one health plan.

• **Participation.** Most state plans permit other government entities within the state to become participating members, such as:
  - Independent state agencies
  - Counties
  - Cities, towns and municipalities
  - Principalities
  - Public universities
  - Water districts.

• **Funding.** The plans are usually funded as a general asset plan. Since public employers are tax-exempt, no trust is needed. Stop-loss agreements are typical with these plans.
• **Governance.** Self-funded plans are usually managed as soundly as the political environment will permit. A board or committee that includes employee representatives typically governs the plan. With substantial employee representation, the need for a claims buffer may be greater for a public than for a private plan.

• **Administration.** Administration of state plans (e.g., claims, consulting, risk management, utilization review, disease management and prescription drug cards) is generally provided by outside vendors—just like most other self-funded single employer plans.

• **Regulation.** Public employee plans are not subject to ERISA, hence, they do not have to meet federal reporting and few disclosure requirements. Since they do not have ERISA preemption, the plans must meet any applicable state rules and regulations.

**What Options Are Available When Multiple Employers Want to Jointly Self-Fund a Health Care Plan?**

Consider the five employers in Exhibit 1.7. Each has its own health care plan. How many different ways might these employers share a plan between two, or more, of them?

1. **Controlled group.** Because A and B are part of a controlled group within the meaning of the Internal Revenue Code, they may share a plan (i.e., losses of A may be borne by B or vice versa.) Were A’s ownership less than 25%, the plan would be a multiple employer welfare arrangement (MEWA).

2. **MEWA.** Any two or more of the five (except A and B) may share a plan as a MEWA. Under ERISA, MEWAs are regulated by the states and some states prohibit self-funded MEWAs.

3. **Common document, vendor service, etc.** Any two or more of the five may have what might appear to be a single plan with a common document, booklet, TPA, managed care rules, stop-loss protection and so forth except for two critical distinctions:
   - Each employer’s plan remains a single plan as contemplated by ERISA.
   - Each employer is responsible for its own claims (i.e., the losses of one must not affect any of the others).

4. **Nonassociation Veba.** The employees of A and C may become members of a Veba sponsored by A and C because geographic and employment commonality provisions are met. Employers B, D and E fail one or both of such tests.

5. **Association Veba.** The employees of A, C and D may become members of a Veba sponsored by A, C and D, not as employees, but as members of a national trade or industry association. A geographic test is not applied if a trade or industry association sponsors the plan.

**What Happens When There Is an Acquisition or Merger?**

Before finalizing an acquisition or merger, each party should examine its respective health care plans to avoid postclosing surprises. Some of the questions to ask before finalizing a merger or acquisition are:

- Have the reserves been verified?
- Is there a captive involved?
- Will the new group be included in the existing group?
- Have all potential liabilities been identified and properly evaluated?
- Is either plan self-funded?
- Are there any plan administration difficulties?
- Is a merger possible from a legal perspective?

**What Sources of Information Are Available to Help Self-Funded Plans and Those Considering Self-Funding?**

**Health Care Administrators Association**

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www.hcaa.org
The Health Care Administrators Association (HCAA) is a not-for-profit organization that supports health care third-party administrators (TPAs) by providing educational opportunities, information and resources from leading industry experts. HCAA is also a legislative advocate, working to increase its influence with policymakers and the media in order to transform the TPA industry and its role in health care. Nationwide, its members include TPAs, insurance carriers, managing general underwriters, audit firms, physician hospital organizations, broker/agents, human resource managers and health care consultants. HCAA sponsors the Certified Self-Funding Specialist® (CSFS®) designation.

International Foundation of Employee Benefit Plans
18700 W. Bluemound Road
Brookfield, WI 53045
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www.ifebp.org

The International Foundation of Employee Benefit Plans (IFEBP) is a nonprofit organization dedicated to providing the diverse employee benefits community with objective, solution-oriented education, research and information to ensure the health and financial security of plan beneficiaries worldwide. Foundation members include 33,000 individuals across the U.S. and Canada. These members are from a range of sectors including multiemployer (management and labor trustees), public employee, professional service providers and corporate. The Foundation cosponsors the Certified Employee Benefit Specialist® (CEBS®) program with the Wharton School of the University of Pennsylvania.

Self-Insurance Institute of America
P. O. Box 1237
Simpsonville, SC 29681
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www.siiia.org

The Self-Insurance Institute of America, Inc. (SIIA) is a member-based association dedicated to protecting and promoting the business interests of companies involved in the self-insurance/alternative risk transfer (ART) industry, both domestically and internationally. Membership includes self-insured entities and professional service providers. To complement its role as the “umbrella” association for the self-insurance/ART industry, SIIA operates four membership sections to facilitate more targeted membership benefits: health care, alternative risk transfer, workers’ compensation and international.

Society of Professional Benefit Administrators
Two Wisconsin Circle, Suite 670
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The Society of Professional Benefit Administrators (SPBA) is a national association committed to promoting the interests of third-party administration (TPA) firms. It provides information and insights related to existing and proposed legislation, regulations and guidance affecting employee benefit plan administration. SPBA also communicates member views about proposed legislation and regulations to federal policymakers. Membership is available only to TPA firms, but the organization offers service partner status to stop-loss carriers, managing general underwriters (MGUs), reinsurers of stop-loss and relevant technology firms.

Endnotes
2. Ibid.
3. Ibid., pp. 176-177.
4. Ibid., p. 178.