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Is Level Funding on the Level?

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Editor's note: This article compares and contrasts the various forms of employee benefits funding available to smaller employer groups.

The Affordable Care Act (ACA) was designed with several desired outcomes: to increase the number of people covered by insurance to spread health care risk over a greater base of individuals, to make insurance more affordable and to modify or eliminate certain underwriting and pricing practices for individual and group policies. One of the outcomes of ACA health care reform is an increased interest by employer groups of all sizes to consider self-funding their benefit programs. Although self-funding has been a common approach for many larger employer groups, smaller employers are also now increasingly considering self-funding. This article focuses on small group employer stop-loss market product design issues (defined here as 15–100 employee lives).

ACA rating and underwriting requirements produce incentives for groups to consider moving from insurance to self-funding.

Potential advantages of self-funding (regardless of group size) include improved cash flow from employer responsibility for funding and favorable experience thereon, flexibility in benefit design, elimination of most premium tax and lower cost of operation due to elimination of most insurance carrier risk and profit margin. Potential disadvantages of self-funding include assumption of risk due to adverse claim fluctuation and more time spent overseeing the benefit plan and not on the core purpose of the business. The increased risk can be partially mitigated by purchase of employer stop-loss "specific and aggregate" coverage.

These advantages and disadvantages for self-funding exist regardless of the ACA. However, the ACA provides additional incentives to consider self-funding as ACA rating and underwriting requirements produce incentives for groups to consider moving from insurance to self-funding. Prior to ACA reform, modified community rating allowed a variety of demographic factors to be considered in setting appropriate rates for small employer groups. These include age-sex factors, family size, occupation, duration of coverage, geographic location, tobacco use and even credit-worthiness. Proposed ACA reforms limit these types of features to age, geography, tobacco and family size. In addition, the result of the age banding limitation is that younger, healthier groups are subsidizing older/less healthy groups under such mandated rating requirements. These subsidization requirements are eliminated when a group is self-funded and ACA insurance laws and regulations do not apply.

Smaller employer groups interested in self-funding currently have two different employer stop-loss product design approaches for consideration. The first, often called level funding or aggregate only, provides a maximum aggregate liability to the employer group while incorporating no specific deductible per member. In that regard, it looks and feels more like a fully-insured employee benefits plan with a different maximum benefit limitation. In contrast, a traditional employer stop-loss policy provides both a specific deductible per covered member (above which all claims per member are covered by the employer stop-loss carrier) as well as an aggregate claim limit protection for all claims not subject to the specific individual deductible. This aggregate protection is often set at 125 percent of expected non-pooled claims, but this limit is often reduced to 115–120 percent for small groups and related to all claims if there is no specific individual deductible involved.

Most employer stop-loss carriers prefer issuing policies to larger groups (200+ employees) for several reasons. These groups typically have claims experience from a current insurance carrier or may be currently self-insured and more likely to have steady employee enrollment than smaller groups. Given the possibility of availability of experience from the incumbent insurance carrier, this facilitates rating the specific individual deductible coverage via a pricing manual and the aggregate coverage utilizing group experience.

Level funding costs are typically made up of several components—Administrative Services Only/Third Party Administrator (ASO/TPA) fees, stop-loss coverage and claim funds (paid claims plus reserves). The ASO/TPA fees will cover administrative costs for administering the self-funded benefit plan and broker commissions. Stop-loss provides a risk protection for specific individual catastrophic claims and/or claims in excess of an aggregate expected amount. The claims fund is typically the largest component of the level funding premium payment amount. Amounts not utilized to pay claims may be refunded to the group or provided as a credit for following year's costs or settlement at termination.

Level funding is designed to maintain the advantages of stability and efficiency of the fully insured coverage while providing the flexibility and advantages described above for self-funded plans. Level funding is a stop-loss product designed to facilitate an existing fully insured plan to transition to self-funding. Here's how it works:

Funding—The TPA sets up an employer benefit plan account for each employer at the bank of its choosing. The carrier sets up a funding account that can transfer funds via Automated Clearing House (ACH) to the employer's benefit plan account. At the beginning of each month, the employer deposits its monthly funding (based on the group's rating factors) into its employer benefit plan account. The TPA cannot process any claims until the employer has made this monthly deposit. The employer's monthly funding is used to pay any eligible medical claims. At any time during the month, if the cumulative paid claims amount exceeds the employer's account balance, the Third Party Administrator (TPA) calculates the excess amount and sends a request to the carrier. The funds are then sent by ACH transfer to the employer's benefit plan account. The TPA then releases any pended claim payments. At any time during the month, if the employer's cumulative paid claims exceed its cumulative funding balance, all claim payments for the remainder of the month would be reimbursed by the carrier.

Premium—The employer's premium payments and the funding factors must be submitted by the first of each month. The funding factors would be deposited into the employer benefit plan account and the premium will be sent to the insurance carrier. If the employer's premium is not received, the TPA must hold all claim payments until it is received.

Accounting—Each month, the employer deposits its funding factor amount into its employer benefit plan account. Both the plan's attachment point and paid claim amounts accrue on an aggregate basis. During any month, if the employer benefit plan account reaches $0.00, the TPA will hold all checks and request funds from the carrier. At any time during the policy year, if the employer benefit plan account has a large balance and the carrier had previously issued prior reimbursements, a refund may be requested prior to plan year-end final settlement. For every group, a full accounting of the employer's attachment point, funding and paid claims must be done at plan year end. If the carrier **did not** reimburse any claims throughout the year and the year-end total paid claims amount is less than the year-end attachment point, the outstanding balance in the employer benefit plan account remains in the employer benefit plan account. If the carrier **did** issue reimbursements throughout the

year, any amount remaining in the employer benefit plan account must be refunded to the carrier. The amount of the refund would be limited to the amount(s) reimbursed by the carrier. If the year-end total paid claims amount exceeds the employer's year-end attachment point and the employer benefit plan account has a balance of $0.00, the carrier would have reimbursed all eligible excess amounts and no refunds would be due.

In some situations, carrier reimbursement is via a "sweep" account. The employer's bank account is attached to the carrier's account and when the employer's bank account becomes negative, the carrier account automatically funds the difference.

Claims—Notification of potential large claims mirrors a traditional specific and aggregate stop-loss policy approach. Notification typically occurs for individuals that exceed some dollar threshold in total paid claims, claims with a potentially catastrophic diagnosis, inpatient admissions, outpatient surgeries, and individuals in a catastrophic case management setting.

Table 1 provides a brief comparison of a fully-insured employer benefit plan to the level funding and traditional employer stop-loss alternatives for a smaller employer group.

The underwriting of risk for smaller groups typically involves usage of a short form medical questionnaire or risk assessment tool to predict future high claimant claim costs. Health plans may already have existing individual underwriters and small group rating capabilities to utilize in this regard.

In 2016, the senate passed the Protecting Affordable Coverage for Employees (PACE) Act. The PACE act stopped the ACA small group definition from expanding from 50 to 100 subscribers and lessened the immediate demand for small group self-funding. However, incentives remain for the better risk small groups to consider level funding products or traditional employer stop-loss.

Programs will also need to consider NAIC model stop-loss laws which have been adopted in many states and require minimum

Table 1
Program Features

	Fully Insured	Aggregate Only Level Funding	Traditional Specific & Aggregate
Specific deductible per member	No	No	Yes
Cash funding calls to employer	No	No	Yes
Fully funded liability	Yes	Yes	No
Level monthly budget	Yes	Yes	No
Maximum cost	Lowest	Medium	Highest
Flexible plan design	No	Yes	Yes
Participation in favorable experience	No	Yes	Yes
Individual medical underwriting	No	Usually	Sometimes
Added risk for poor experience relative to fully insured	No	Yes	Yes

Both self-funding programs have advantages and disadvantages and Table 2 summarizes these.

Table 2
Pros Versus Cons

	Aggregate Only Level Funding	Traditional Specific and Aggregate
Advantages	1. Feels more like a traditional insured program 2. Simpler administration 3. Lower maximum aggregate corridor 4. Participation in favorable experience	1. Specific deductible protection specifically provided 2. Participation in favorable experience
Disadvantages	1. Higher portion of total cost paid in fixed costs 2. Higher risk assumed by employer	1. Higher risk assumed by employer for adverse experience

specific deductibles (e.g., $30,000–$40,000) and aggregate stop loss corridors (e.g., 120 percent).

HMOs and other managed care organizations (i.e., health plans) are increasingly developing small employer group self-funding products. This is a natural fit for their marketplace given that health plans have knowledge of the current employer group risk profile (if currently a fully-insured group), and health plans often have experienced individual medical underwriters on staff. Health plans also have a rating model which takes into account their service area, preferred provider arrangements and managed care programs.

Health plans' considering offering small group self-funding have decision points:

- Traditional or level-funding type small group self-funded product,
- minimum group size,
- lowest specific stop-loss deductible available,
- available aggregate corridor (e.g., 115–125%),
- use of individual medical applications and small group medical underwriter,
- health plan filed policy or use an external stop-loss carrier fronting arrangement,
- level of risk assumed by health plan either directly or via reinsurance, and
- small group rating model and medical underwriting capabilities at the health plan.

In conclusion, regardless of size, employers simply want health care benefits that provide peace of mind, control, flexibility and value. These remain interesting and challenging times for those who purchase and provide health care coverage to their employees and the health plans that provide them on a fully insured or self-funded basis. Traditional specific and aggregate coverage and level-funding are increasingly becoming attractive value propositions for smaller employer groups due to ACA requirements. Employee benefits plans which include both properly managed care and self-funding have a winning formula for success. ■

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