Self-Funded Toolkit

What Does it Mean to Be Self-Funded?

Employers who are self-funded assume the financial risk and reward associated with providing health care benefits to their employees. Rather than paying a fixed premium to their insurance carrier, the employer pays for medical and pharmacy claims as they are incurred, typically up to a predetermined amount.

Important Players in a Self-Funded Arrangement

TPA
A self-funded employer typically partners with a third-party administrator (TPA) to manage the day-to-day operations of their self-funded health plan. The TPA provides services such as provider network access, claims processing, provider reimbursements, reporting, and customer service.

Network
Offers employers "in-network" access to providers (doctors & hospitals) for their employees. It also provides a discount off the services the providers charge.

Stop Loss Insurance
Provides protection against large, unexpected claims. The Stop loss insurance establishes a limit for the amount an employer is responsible for paying. The level of protection is based on group case characteristics and risk tolerance. There are two types of Stop loss:

- **Individual**: limits an employer's liability when an individual employee's medical claims exceed a specific amount (specific deductible). This coverage protects employers against high claims from any one individual (each belly button).
- **Aggregate**: limits the employer liability from the total sum of health claims for an entire group of employees rather than an individual (ally belly buttons). This is typically set at 125% of expected claims for that year.

PBM
A self-funded health plan partners with a Pharmacy Benefit Manager (PBM) to manage the prescription drug plan. The PBM is responsible for establishing the pharmacy network, negotiating drug prices, setting the formulary, processing prescription drug claims, and providing utilization reporting.

How it Works
After an employee sees a doctor, the doctor's office prepares the claim based on the services provided and submits the claim to the TPA. The TPA then adjudicates the claim, which involves identifying what portion of the cost will be covered by the plan, as well as what portion of the bill the employee will be responsible for. Next, the TPA will request payment from the employer's bank account to pay for the medical service. The TPA will then send the payment to the doctor who rendered the service.

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Pros and Cons of Self-Funding Your Health Plan

Pros	Cons
Greater plan flexibility	Greater financial risk
Greater transparency (access to more data)	Increased administrative burden
Reduced State Premium Tax	Cash flow volatility
Avoidance of State-Mandated Benefits for ERISA Groups	

Self-Funded Compliance Requirements

- **PCORI**: A fee that ACA imposes on sponsors of self-insured health plans to help fund the Centered Outcomes Research Institute (PCORI). The fee must be reported once a year on the second-quarter Form 720. This fee must be paid by July 31 of each calendar year.

- **RxDC Reporting**: Group health plans and health insurance issuers must annually submit detailed information on prescription drugs and health care spending to the Centers for Medicare and Medicaid Services (CMS). This is comprised of several files, some of which might be submitted by your issuer, TPA, or PBM. You should check with your plan partners to see which information they will submit on your behalf. This reporting is due June 1st to report the data for the prior calendar year.

- **Form 5500**: ERISA-covered welfare benefit plans are required to file an annual form 5500. Plan administrators are required to file an annual return/report with the Department of Labor regarding the plan's financial condition, investments, and operations. This is generally satisfied by filing the Form 5500.

- **Gag Attestation**: A federal transparency law prohibits health plans and health insurance issuers from entering into contracts with health care providers, TPAs, and other service providers that contain gag clauses (clauses restricting the plan or issuer from providing, accessing, or sharing certain information about provider price and quality). Plans and issuers must annually submit an attestation of compliance with the gag clause prohibition to the federal government.

- **HIPAA Privacy Notice**: Employers are responsible for informing covered individuals of their privacy rights under their health plan. Employers are required to provide notices at the following times:
  - The time of enrollment for new employees
  - Upon request
  - Within 60 days of a material change to the Notice
  - No less frequent than every 3 years
  - If applicable, verify controlled group status.

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