**APPENDIX A1: Plan Funding Classification**

The majority of the U.S. population receives their health insurance coverage through their employer. In 2016, employer-sponsored health insurance covered 56 percent of the U.S. population.[[1]](#footnote-1) There are a variety of ways in which plan sponsors (usually employers) may fund the health insurance coverage they offer their workers.[[2]](#footnote-2)

# What Is a Self-Insured Group Health Plan?

Sponsors may purchase a group insurance policy from a state-licensed insurance carrier or similar organization and pay premiums directly to the insurer. Plans may set aside assets in a dedicated trust to fund the health plan, an arrangement known as a “funded” arrangement for Form 5500 reporting purposes. Alternatively, plan sponsors may pay the plan’s benefits directly out of their general assets, an arrangement known as “unfunded” for Form 5500 reporting purposes. In addition, these funding arrangements – insured, funded, and unfunded – may be combined in multiple ways. For example, a group insurance policy may cover a subset of the plan’s health benefits, but the plan’s remaining health benefits may be paid out of the plan sponsor’s general assets. Plans may use assets held in a dedicated trust to pay insurance premiums or to pay plan benefits directly. Whether a plan is considered to be self-insured, fully insured, or a mixture of both is a function of how the benefits are provided under the plan.

Fully insured – A fully insured plan provides health benefits by purchasing a group health insurance policy or contract from a state-licensed insurance carrier or similar organization, such as Blue Cross Blue Shield or a health maintenance organization. The insurance carrier then assumes financial responsibility for the covered health benefit claims of the plan’s participants and associated administrative costs.[[3]](#footnote-3) An employer with a fully insured health plan chooses how to transfer insurance premiums[[4]](#footnote-4) to the insurance carrier. The plan either establishes a trust for the express purpose of receiving contributions for the payment of insurance premiums or pays the premiums directly from the plan sponsor’s general assets.

Self-insured – In the case of a self-insured health plan, the sponsor generally assumes the financial risks associated with covering the health benefit expenses of the plan’s participants. Benefits in a self-insured plan may be paid, as needed, directly from the general assets of the sponsoring employer or paid from a trust[[5]](#footnote-5) to which employer and/or employee contributions have been made. While some self-insured plans are self-administered, employers usually enter into a contract with a third party administrator (TPA) or use another outside entity to handle enrollment, pay claims, collect premiums, provide customer service, and perform other administrative duties.

The financial risk for self-insured benefit claims may be borne partially or entirely by the employer offering the self-insured plan. To protect against unexpectedly large claims, self-insured plans or employers sponsoring such plans may obtain stop-loss insurance coverage. Stop-loss coverage limits the liability (stops the loss) the plan or employer bears for each covered person’s health care costs (in the case of policies with individual or specific attachment points) or for the total expenses of the plan (aggregate attachment points), as the stop-loss carrier will reimburse the plan or employer for losses above the policies’ attachment points.[[6]](#footnote-6)

Mixed-insured – A mixed-insured plan contains both fully insured and self-insured components. For example, an employer may offer its employees a choice between a fully insured HMO option and a self-insured PPO option. If both plan components were reported on a single Form 5500 filing, the plan would be considered mixed-insured.

# Form 5500 Health Plan Filing Requirements

The Employee Retirement Income Security Act of 1974, as amended (“ERISA”), and the Internal Revenue Code of 1986, as amended (“Code”), establish certain reporting and filing obligations for private sector employee benefit plans.  Plans generally are required to file an annual return/report concerning, among other things, the financial condition and operations of the plan.

In 1975, the Department of Labor (the “Department”), the Internal Revenue Service, and the Pension Benefit Guaranty Corporation (collectively, the “Agencies”) jointly developed the Form 5500 Series to allow employers who sponsor an employee benefit plan for their employees to satisfy the annual reporting requirements under Title I and Title IV of ERISA and under the Code. The Agencies have changed the Form 5500 over time. Today, filing the Form 5500 together with any required Schedules and Attachments (the “Form 5500”) generally satisfies these annual reporting requirements.[[7]](#footnote-7)

The Form 5500 is an important source of information on ERISA-covered, private sector employer-sponsored benefit plans and their operation, funding, assets, and investments. The majority of Form 5500 reports are filed for employee pension benefit plans. Welfare benefit plans (which include plans providing benefits such as medical, dental, life insurance, severance pay, disability, etc.) are required to file a Form 5500, with certain exceptions tied to plans’ size, funding arrangement, and sector. These exceptions are listed below:[[8]](#footnote-8)

* Welfare plans (other than plans required to file the Form M-1) with fewer than 100 participants as of the beginning of the plan year that are unfunded, fully insured, or a combination of insured and unfunded [[9]](#footnote-9)
* Welfare plans maintained outside the United States that serve mostly nonresident aliens
* Governmental plans
* Unfunded or insured welfare plans maintained for a select group of management or highly compensated employees only
* Plans maintained only to comply with workers’ compensation, unemployment compensation, or disability insurance laws
* Welfare benefit plans that participate in a group insurance arrangement that files a Form 5500 on behalf of the participating plans
* Apprenticeship or training plans meeting certain conditions
* Certain unfunded welfare benefit plans financed by dues
* Church plans
* Welfare benefit plans maintained solely for only the owner and/or spouse who wholly own a trade or business or the partners and/or spouses of partners in a partnership

A small plan that receives employee (or former employee) contributions during the plan year and does not use the contributions to pay insurance premiums or uses a trust or separately maintained fund to hold plan assets or act as a conduit for the transfer of plan assets during the year is required to file. An exception to this rule is a small plan associated with a cafeteria plan under Internal Revenue Code section 125 with employee contributions that are used to pay benefits instead of insurance premiums. This type of plan may be treated for annual reporting purposes as an unfunded welfare plan if it meets certain Department requirements.

# Data Used for this Report

The data included in this report consists of all Form 5500s filed by welfare plans providing health benefits that had plan year ending dates in 2016. Certain filings are excluded in order to reflect the filing requirements described above:

* Plans filing the Form 5500 with fewer than 100 participants as of the beginning of the plan year that filed without a Schedule H or I or with a Schedule H or I that have zero or blank values for each of total assets, liabilities, net assets, income, and expenses;
* Plans that filed the Form 5500-SF with fewer than 100 participants as of the beginning of the plan year that have zero or blank values for each of total assets, liabilities, net assets, income, and expenses;
* Direct Filing Entities; and
* Duplicate filings.

For purposes of this report, Form 5500 health plans are categorized as being self-insured, fully insured, or a mix of both self-insured and fully insured (mixed-insured). The Department used information from the 2016 Form 5500 on plans’ funding arrangements, together with information from Schedule A “Insurance Information,” Schedule H “Financial Information,” and Schedule I “Financial Information - Small Plan” to categorize the plans as follows:

1. Self-insured. The plan does not include information on a health insurance policy or contract in any Schedule A filed as part of the Form 5500. For classification purposes, Schedule A insurance contracts are not considered health insurance policies or contracts if the per capita premium amount reported is less than $2,000 or the filing also indicates that the policy could be for stop-loss coverage or for payments to a TPA.[[10]](#footnote-10) The filing must also either:
   1. indicate the plan is funded through a trust or general assets of the sponsor;
   2. include a Schedule H or Schedule I and report benefit payments;
   3. be filed on the Form 5500-SF and report nonzero total assets, liabilities, or net assets; or
   4. be filed on the Form 5500-SF with fewer than 100 participants as of the beginning of the plan year and report zero total assets, liabilities, and net assets with a nonzero amount for income or expenses.
2. Mixed-insured. The plan does not meet the requirements in (1) and either:
   1. the number of individuals covered under insurance contracts as reported on the Schedule A is less than half of the total number of participants as of the end of the plan year, and the filing indicates that the plan is funded through a trust or general assets of the sponsor; or
   2. the filing has an attached Schedule H that indicates benefit payments directly to participants or beneficiaries; or
   3. the filing has an attached Schedule H that indicates benefit payments but *does not* indicate benefit payments directly to participants or beneficiaries *and* both
      1. Premiums paid for all insurance contracts as reported on the Schedule A are *not* within 10% of total payments to insurance carriers for the provision of benefits as reported on Schedule H, and
      2. Premiums paid for all *health* insurance contracts as reported on the Schedule A are *not* within 10% of total payments to insurance carriers for the provision of benefits as reported on Schedule H; or
   4. the filing has an attached Schedule I that indicates benefit payments *and* both
      1. Premiums paid for all insurance contracts as reported on the Schedule A are *not* within 10% of total benefits paid as reported on Schedule I and
      2. Premiums paid for all *health* insurance contracts as reported on the Schedule A are *not* within 10% of total benefits paid as reported on Schedule I.
3. Fully insured. The plan does not meet the criteria in (1) or (2).

For purposes of this report, private sector employer-sponsored health plans were also divided into six distinct categories based on the Form 5500 filing requirements.

1. Small plans (covering fewer than 100 participants as of the end of the year) that fully insure their health plan
2. Small plans that self-insure but do not have a trust
3. Small plans that self-insure their health plan and use a trust to hold the plan assets
4. Large plans (covering 100 or more participants as of the end of the year) that fully insure health plans
5. Large plans that self-insure and use a trust to hold the plan assets
6. Large plans that self-insure but do not operate a trust

Generally, small group health plans that fully insure benefits or self-insure benefits but do not have a trust are not required to file a Form 5500.[[11]](#footnote-11) All large welfare plans that fully insure or self-insure benefits without a trust must file, but are only required to file the main Form 5500 and the Schedule A to report information about insurance contracts.

The tables in this document summarize Form 5500 data for health plans that file. In a limited number of cases, the filed information has been edited to better reflect the universe of Form 5500 filing health plans. For example, certain plans that did not indicate an intention to terminate submitted filings that reported zero participants as of the end of the plan year but a positive number of participants at the beginning of the year. In these cases, the beginning of year participation count has been used for the end of year count and all of these participants have been classified as active participants.

The statistics reported within this document also contain one important imputation. Namely, any plans deemed to be mixed-insured or fully insured as defined previously are assumed to have at least one health insurance contract even when a Schedule A has not been appropriately filed to provide details on insurance contracts purchased by the plan. Otherwise, all figures reported herein are tabulated without adjustment.

1. U.S. Department of Labor, Employee Benefits Security Administration calculations using the March 2017 Current Population Survey Annual Social and Economic Supplement. [↑](#footnote-ref-1)
2. Upon establishment of a welfare plan, the plan sponsor decides how the plan will be structured – including how the plan benefits will be paid. [↑](#footnote-ref-2)
3. Definitions of Health Insurance Terms, at[*http://www.bls.gov/ncs/ebs/sp/healthterms.pdf*](http://www.bls.gov/ncs/ebs/sp/healthterms.pdf). [↑](#footnote-ref-3)
4. The premium payments could be paid entirely by the employer, entirely by employee contributions, or partly from the employer and partly from employee contributions. [↑](#footnote-ref-4)
5. Some employers may invest plan assets in a separate insurance company account instead of holding plan assets and investing through a trust. [↑](#footnote-ref-5)
6. An employer may also purchase a “minimum premium” arrangement in which the employer pays a fraction of the fully insured premium to cover non-claim expenses, such as administration and claims processing, and pays claims up to an agreed-upon limit, after which the insurance carrier is responsible. Under a minimum premium arrangement, the insurance carrier usually is also responsible for processing claims and administrative services. [↑](#footnote-ref-6)
7. See ERISA Section 101, 29 U.S.C. 1021 and accompanying regulations. The data used for this report were taken from the Form 5500 data for plan years 2016 and earlier. For plan years beginning on or after January 1, 2009, certain eligible small plans are able to file the Form 5500-SF “Short Form Annual Return/Report of Small Employee Benefit Plan.” Small plans using the Form 5500-SF include information about total fees and commissions paid with respect to the purchase of insurance. [↑](#footnote-ref-7)
8. 29 C.F.R. 2520.104-1. [↑](#footnote-ref-8)
9. An unfunded welfare benefit plan has its benefits paid as needed directly from the general assets of the employer or employee organization that sponsors the plan. A combination unfunded/insured welfare benefit plan has its benefits partially as an unfunded plan and partially as a fully insured plan. An example of such a plan is a welfare benefit plan that provides unfunded medical benefits and life insurance benefits. [↑](#footnote-ref-9)
10. Although Schedule A health insurance contracts reporting a per capita premium of less than $2,000 are not considered as such to determine the plan funding classification, they are ultimately counted as health insurance contracts in the event that the plan is deemed fully insured. [↑](#footnote-ref-10)
11. Large plans that use a trust to hold the plan assets to self-insure health benefits are required to file a comprehensive Form 5500, including a Schedule H to report financial information about the plan’s operations. Generally, those small plans that use a trust to self-insure their health benefits are not required to file a Schedule H. These filings include more abbreviated financial information about the plan’s operation as filed on Schedule I or the Form 5500-SF. [↑](#footnote-ref-11)