**APPENDIX A1: Plan Funding Classification**

The majority of the U.S. population receives their health insurance coverage through their employer. In 2022, private employer-sponsored health insurance covered roughly 54 percent of the U.S. population.[[1]](#footnote-1) There are a variety of ways in which plan sponsors (usually employers, and less often, unions) may fund the health insurance coverage they offer their workers.[[2]](#footnote-2)

# How Do Sponsors Fund Group Health Plans?

Sponsors may “fully insure” benefits through the purchase of a group insurance policy from a state-licensed insurance carrier or similar organization and premium payments directly to the insurer. Plans may also 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.

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 while the plan’s remaining health benefits are 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 mixed-insured 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 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 to the insurance carrier.[[4]](#footnote-4) The plan sponsor may either establish a trust for paying insurance premiums or pay premiums directly from its general assets.

Self-insured – In the case of a self-insured health plan, the sponsor generally assumes the financial risks associated with covering the benefits of the plan’s participants. Benefits in a self-insured plan may be paid directly from the general assets of the plan sponsor or from a trust to which employer and/or employee contributions have been made.[[5]](#footnote-5) While some self-insured plans are self-administered, employers usually enter into a contract with a third-party administrator or other 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 of 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). The stop-loss carrier reimburses the plan or the employer for losses above the policy’s attachment points.

Some insurance carriers offer more complex arrangements, often called “level-funded” plans, that are nominally self-insured but allow the plan sponsor to pay a set dollar amount to cover a portion of expected claims cost, a stop-loss insurance premium, and plan administration costs. These arrangements have recently become more prevalent among smaller employers.[[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 Group Health Plan Filing Requirements

The Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (the Code) establish certain reporting and filing obligations for private sector employee benefit plans. Plans are generally 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) developed the Form 5500 Series for employers who sponsor a benefit plan for their employees. This satisfies certain annual reporting requirements under ERISA and the Code. As statutory and regulatory requirements changed, the Agencies changed the Form 5500. Today, filing the Form 5500 with any required Schedules and Attachments generally satisfies a plan’s 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 operations, 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 based on plan size and funding arrangement. These exceptions include:

* Welfare plans maintained outside the United States that serve mostly nonresident aliens
* 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.[[8]](#footnote-8) Plans are not unfunded if they use a trust or separately maintained fund (including a Code section 501(c)(9) trust) to hold plan assets or act as a conduit for the transfer of plan assets during the year and generally must file a Form 5500. Also, plans with contributions from employees or former employees during the plan year are not unfunded or insured for this purpose unless (1) those contributions are used to pay insurance premiums within 3 months of receipt by the employer or (2) it is a plan associated with a cafeteria plan under Code section 125 with the employee or former employee contributions held in the general assets of the plan sponsor and used to pay benefits instead of insurance premiums.[[9]](#footnote-9)
* Governmental plans
* Unfunded or insured welfare plans maintained only for a select group of management or highly compensated employees
* 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
* A welfare benefit plan maintained solely for (1) an individual or an individual and his or her spouse, who wholly own a trade or business, whether incorporated or unincorporated, or (2) partners or the partners and the partners’ spouses in a partnership

# 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 2022. However, the following filings are excluded:

* 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 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 total assets, liabilities, net assets, income, and expenses;
* Plans that filed the Form 5500 or Form 5500-SF with zero participants as of the beginning and the end of the plan year;
* Plans that report health benefit features but appear not to actually provide health benefits based on the plan and sponsor name;[[10]](#footnote-10)
* Direct Filing Entities (other than Group Insurance Arrangements); and
* Duplicate filings or filings that were subsequently amended.

For purposes of this report, group health plans that file the Form 5500 are categorized as being self-insured, fully insured, or mixed-insured. The Department used information from the 2021 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. In general, plans are classified based on whether their filings include evidence of health insurance and/or evidence of a trust.

*Evidence of Health Insurance.* Schedules A filed as part of the Form 5500 that specify “Health (other than dental or vision)” benefits or reflect an “HMO contract,” “PPO contract,” or “Indemnity contract” are considered evidence of health insurance. For classification purposes, Schedule A insurance contracts are not considered health insurance policies or contracts if the per capita annualized premium amount reported is less than 30 percent of the average cost of single health coverage in the United States.[[11]](#footnote-11)

*Evidence of a Trust*. Information on a plan’s trust, if any, should be reported on a Schedule H or Schedule I. In addition to assets and liabilities, the Schedule H or I lists contributions and expenses (such as benefit payments directly to participants and payments to insurance carriers). For classification purposes, Schedules H or I filings that include at least some information on assets, liabilities, income, or expenses are considered evidence of a trust. A Schedule H or I that is blank (not common since the introduction of electronic filing) or only reports compliance issues is not considered evidence of a trust.

1. Evidence of a trust; no evidence of health insurance
   1. All plans with filings with evidence of a trust and no evidence of health insurance are classified as **self-insured**.
2. Evidence of a trust; evidence of health insurance
   1. Plans reporting payments both directly to participants and to insurance carriers
      1. Plans filing a Schedule A that reflects a level-funded plan contract or that indicates experience-rated charges but no premiums are classified as **self-insured**.
      2. Plans reporting payments directly to participants that are more than 30 percent of the average cost of single health coverage in the United States are classified as **mixed-insured**.
      3. All other plans are classified as **fully insured**.
   2. Plans that *do not* report payments both directly to participants and to insurance carriers
      1. Plans reporting trust payments to insurance carriers within 20 percent of total premiums for all insurance contracts are classified as **fully insured**.
      2. All other plans are classified as **mixed-insured**.
3. No evidence of a trust; no evidence of health insurance
   1. Plans filing the Form 5500-SF with fewer than 100 participants as of the beginning of the plan year are classified as **self-insured**.
   2. Plans filing the Form 5500-SF with 100 or more participants as of the beginning of the plan year and reported nonzero total assets, liabilities, or net assets are classified as **self-insured**.
   3. Plans filing a Schedule A that indicates stop-loss coverage or payments to a third-party administrator are classified as **self-insured**.
   4. Plans with filings indicating that the plan funding or benefit arrangement is through a trust or general assets of the sponsor are classified as **self-insured**.
   5. All other plans are classified as **fully insured**.
4. No evidence of a trust; evidence of health insurance
   1. Plans with filings indicating that 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* that the plan funding or benefit arrangement is through a trust or general assets of the sponsor are classified as **mixed-insured**.
   2. All other plans are classified as **fully insured**.

Private sector, employer-sponsored health plans were also divided into six distinct categories based on the Form 5500 filing requirements.

1. Small plans 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 plan 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.[[12]](#footnote-12) All large welfare plans that fully insure or self-insure benefits without a trust must file only the Form 5500 and the Schedule A to report information about insurance contracts.

The tables in this document summarize Form 5500 data for group health plans that file. In a limited number of cases, the filed information has been edited. For example, certain plans did not indicate that the plan was terminating and reported zero participants as of the end of the plan year (or left the field blank) 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. Any plans deemed to be mixed-insured or fully insured 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 are tabulated without adjustment.

1. U.S. Department of Labor, Employee Benefits Security Administration calculations using the March 2023 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<https://www.bls.gov/ebs/factsheets/pdf/definition-of-health-insurance-terms.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. Kaiser Family Foundation has estimated that 38 percent of firms with fewer than 200 workers that offer health benefits used a level-funded plan in 2022, which is similar to the 42 percent estimated in 2021, but up from 13 percent in 2020. See: *2022 Employer Health Benefits Survey,* Kaiser Family Foundation (Oct. 27, 2022),<https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey>. [↑](#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 2022 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 answer a question whether there were any fees and commissions paid with respect to the purchase of insurance, and if so, provide the total amount. *See*, 2022 Form 5500-SF, Line 10e. [↑](#footnote-ref-7)
8. 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. See 2022 Form 5500 Instructions. [↑](#footnote-ref-8)
9. *See* DOL Technical Release 92-01, 57 Fed. Reg. 23272 (Jun. 2, 1992) and 58 Fed. Reg. 45359 (Aug. 27, 1993). [↑](#footnote-ref-9)
10. For a more detailed explanation of this exclusion criterion, see the current Form 5500 Group Health Plan Research File User Guide, available at <https://www.dol.gov/agencies/ebsa/researchers/data/group-health-plan-data>. [↑](#footnote-ref-10)
11. *2022 Employer Health Benefits Survey,* Kaiser Family Foundation (Oct. 27, 2022),<https://www.kff.org/health-costs/report/2022-employer-health-benefits-survey>. [↑](#footnote-ref-11)
12. 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-12)