Employer’s Guide to
Self Funded Healthcare Plans

Most self-funded or self insured employers want flexibility in making key decisions on benefits, administration and funding, yet need to limit their liability. Partial Self Funding or Self Insurance with Stop Loss Coverage for employer group health insurance is an attractive alternative to the fully insured market for cost conscious employers.

Self-funding is an alternative that enables employers to control rising healthcare costs.

What is a Self-Funded / Self-Insured plan?

A self-insured healthcare plan, sometimes referred to as a partially self funded healthcare plan or partial self funding your healthcare plan, is a healthcare plan in which the employer assumes partial financial risk for providing health care benefits to its employees. The employer decides on a plan of employee benefits, which can be similar to or identical to the employer’s current fully insured plan, or the employer can create whatever benefits they desire. Rather than obtaining medical coverage from an insurance carrier, the employer elects to fund the risk up to a certain level where a Reinsurance or Stop Loss Insurance carrier is brought in. The Stop Loss is designed to limit the employer’s loss to a specified amount, to ensure that large, or unanticipated claims, do not upset the financial integrity of a self funded healthcare plan. The amount of risk to be insured is a function of the employer’s size, nature of their business, financial experience and tolerance for risk. A TPA administers the plan. Their responsibility includes maintaining eligibility, customer service, adjudicating and paying claims, preparing claim reports, plus arranging for managed care services such as network access and case management.

What types of benefits are self insured or self funded?

 Usually the group medical or health plan is the focus of a self funded program. Other benefits that are often self funded are dental, prescription drugs, vision and short term disability. Life Insurance, Accidental Death and Dismemberment and long term disability are usually not suitable for self insurance.

Self Funding – A Comparison to Fully Insured Plans

Basically, everything that is provided in a conventionally fully insured program is duplicated in the partially self funded health plan. Everything that the insurance company does when it offers a conventionally insured program takes place in the partially self funded healthcare program. The difference is that with the self funded healthcare plan the employer holds the cash needed to fund benefits, and instead of sending the fully conventional premium to the
insurance company, only a small fraction of the conventional premium is sent in to a reinsurance carrier. The employer purchases re-insurance for protection, holds the remainder of the conventional funds (claim funds), invests them, segregates them if desired, or uses them for general business purposes until they are needed for the funding of claims. The employer retains and keeps the funds when claims do not materialize, hence making a profit.

**Example A: (Fully Insured Example)**

Acme Company is fully insured with Fully Insured Carrier and pays a premium of $1,500,000.00 annually for their health insurance plan. Claims experience shows that Acme Company only had $1,000,000 in claims and admin expenses. The fully Insured Carrier keeps $500,000 in profits.

**Example B: (Self Funded Example)**

Acme Company’s group health insurance is self funded with a Third Party Administrator with reinsurance. Acme Company’s potential worst case scenario for the year is $1,600,000 annually. Acme company pays $20,000 a month in fixed premium costs and holds in claims reserves $1,360,000 for potential claims. The $1,360,000 is retained by Acme Company and it is theirs to utilize as they see fit until claims materialize. At the end of the year Acme Company’s claims are $1,000,000. Acme Company retains the $360,000 it reserved in a worst case scenario. Acme Company realizes a $260,000 savings by going partially Self Funded versus Fully insured.

The employer is protected by three facets of insurance protection, the specific deductible or (Specific Stop Loss) which protects against any one person claims exceeding a specified amount, the integrated aggregate which protects against any excess monthly claims (so the employer may budget and allocate only the conventional equivalent premium each month, then not have to worry about an adverse month when more than usual claims are presented), and an annual aggregate reinsurance to protect against claims greater than the conventional equivalent.

**WHAT ARE THE ADVANTAGES OF SELF FUNDING A HEALTHCARE PLAN?**

The advantages of self funding are many. There is tremendous flexibility in the benefit plan design. You can decide what you want to cover and what you don't, whether it's certain vaccinations, chiropractors, injectibles, obesity, or infertility.

Another major advantage, is portability from one carrier to another. "There's no disruption in plan when you shift between reinsurance carriers. You don't have to start all over again with new I.D. cards, booklets and doctors, the way you do with the fully insured healthcare plans."

Also, for employers with more than one office, it is possible to offer the same plan to everyone in every location. This makes it so much more administratively simple. By Self Funding healthcare an employer can utilize one national network or multiple local PPO networks with the same benefit plans.
But the bottom line, is cost savings. If you have a good expected claims year, that is the best scenario. But even if you don't, there's maximum liability in place.

Another advantage of Self Funding a healthcare plan is the ability to class out the executives and provide them with a 100% benefit where, executives and their families pay no copays, deductibles or coinsurance.

**Immediate Benefits and Advantages of Self Funding**

**Fully Insured Carriers Profit Margin?**

A fully insured carrier’s profit margin can be as high as 52% with your current fully insured health plan. This means if your premium is $1 million, the insurance carriers “Profit” can be as high as $520,000.

Note: Even with a highly profitable employer case a fully insured carrier will have no problem hitting the employer with a “double digit” rate increase. Insurance carriers continually base rate increases upon a concept called “pooling.” Pooling says that if other employers the carrier insures had bad claims experience, which hurt profitability, the fully insured carrier will penalize and raise rates for all employer's. Other reasons fully insured carriers will give for rate increases is “trend.” Trend means increases in the healthcare industry. The fully insured carrier will argue a double digit increase was justified by "trend" on an employer who is running at 50% of claims (highly profitable). This means even though that particular employer has excellent claims experience and is not running at "trend" where other companies have bad experience, the carrier will still raise their rates.

Elimination of Premium Tax: In most states there is no premium tax for self funded plans. This results in an immediate savings since between 2%-4% of your current fully insured health plans costs a premium taxes.

**Improved Cash Flow**

Moving from a fully insured healthcare plan to a self funded healthcare plan usually results in about 3 months of relatively little new claims. During this time, the previous fully insured carrier is still paying claims incurred prior to the new self funded healthcare plan year. This claims lag allows your new Self Funded healthcare plan the opportunity to build and establish a reserve to pay future claims.

Also, reserves for claims are held by the employer and only released if claims materialize, resulting in an improved cash flow for the employer.

**Control & Flexibility of Plan Design – Benefits**

The employer can duplicate it’s current fully insured benefit plan or it can “redesign” and tailor the benefits to meet the specific needs of the employer. This means the employer can eliminate benefits which result in plan abuses or high utilization. The employer can also create special executive benefits.
Eliminate State Mandated Benefits: Since Self funded healthcare plans are governed by ERISA, they follow Federal law, and are not required to cover “State-Mandated” benefits, which can be expensive and unnecessary. By eliminating unnecessary and expensive state mandated benefits employer’s can realize an immediate savings. Employer’s can also set the limits on certain benefits, where with a fully insured plan there may be state required limits. Since fully insured plans include state mandated benefits the cost of offering these benefits raises the costs of the health plan to the employer.

Control of Reserves – Return of Investment on Reserves

A good portion of your fully insured premium is held by the fully insured carrier as a state required reserve for claims and inflation. Under Self Funding healthcare plans the employer maintains and controls reserves and can invest these or put them in an interest bearing account. The employer retains the reserves when claims do not materialize, and there are no restrictions on reserves with a self funded healthcare plan.

Claims Experience – Immediate Realization of Hard Dollar Savings

Under a fully insured healthcare program, if an employer’s experience is “better than expected,” the insurance company gains financially and makes an unexpected profit. The insurance carrier does not refund the excess profit to the employer.

Even if an employer had good experience, the insurance company will still pass on a renewal based upon the insurance companies pool of thousands of groups. You are not truly rated based upon your claims experience and can be treated unfairly.

When Self Funding healthcare plans your renewals are based on “YOUR” companies claims and medical experiences, and it is not based on thousands of other companies that have no relation to your company or industry. You, the Employer, not the insurance company enjoy the advantage of favorable claims experience. You, the Employer, keep the savings.

OTHER IMPORTANT ADVANTAGES OF SELF FUNDING HEALTHCARE

Improved Employee Satisfaction- Personalized Employee Service:
Third Party Administrators specialize in one thing, Customer Service. Their sole purpose is to provide the best quality service possible, and to personalize that service to members. This includes dedicated account representatives who know not only the employer’s account but the individual employees of each company. Employee’s and HR get on a first name basis with claims examiners, and are not transferred to a random person that does not know anything of the employee or the employer.
Lower Costs of Operation:

Third Party Administrators have lower overhead and expenses than a fully insured plan, which result in an immediate direct savings for the employer, when switching to Self Funding their healthcare plan.

Claim Utilization and Cost Controls

Third Party Administrators review utilization of the plan and benefits and see where the employers claims and costs are. This allows the employer along with the TPA to make informed decisions as to plan benefits, costs, and any adjustments that need to be made. TPA’s also implement unique programs such as hospital bill auditing, case management, pre-certification review, lab programs, etc to keep costs down.

NATIONAL OR REGIONAL COMPANIES & PROVIDER NETWORKS

The fully insured, insurance company’s inflexibility to deal with national or regional employers means a multi-location employer cannot offer the same benefits or insurance carrier options to all of its’ employees. Some mutli-location employer’s have to use multiple fully insured carriers with varying benefit plan designs. This results in far higher plan management costs, and extra administrative work for human resources.

With a self funded healthcare plan, a multi-location employer can choose from one network to dozens of networks, offering a single standard benefit plan design across several states with significant savings on plan management expenses.

This saves your human resource department from dealing with multiple confusing health plan designs and multiple insurance carriers.

PRESCRIPTION DRUGS

With rising prescription drug costs it can be unnerving that an average employer’s prescription drug plan can be the cause of almost 25% of the cost of the company’s group health plan. Fully Insured carriers pass along minimal prescription drug discounts to employers and keep any pharmaceutical rebates. The result is larger Rx costs and claims experience, which then result in higher rate increases.

With a Self Funded Healthcare Plan, Employers’ will actually receive substantial rebates ($ money back each quarter from pharmaceutical managers). Company’s will also receive the strongest prescription drug discounts (depends on the TPA) in the country, reducing the employers’ prescription drug costs, and hence resulting in lower costs for the group health plan.
PERCEIVED DISADVANTAGES OF SELF FUNDING HEALTHCARE

Your own poor current claims experience means that the plan will be costly?

But less costly than an insured plan, as you are not paying for taxes and profit in addition to insurance coverage

Budgeting the Plan will be difficult?

Prior experience guides your financial commitment and stop loss insurance guarantees performance

Termination of the Plan may be difficult?

Stop loss coverage is structured to pick up claims incurred in, but reported after plan year.

There is added fiduciary and legal responsibility?

The professional administrator provides advice and guidance, when help is needed.

How To Choose a TPA

When you decide to self-fund your group health plan or dental plan, you need to choose a Third Party Administrator, which is really like a healthcare partner. Third Party Administrators run your health care "show," and if they're good, they do it seamlessly, so that the employee never knows anything is different from a fully insured plan. If the Third Party Administrator is not a quality administrator they can devastate an employer’s plan.

But that's the key - if they're good.

You want a company with a solid infrastructure, that's been in the business for a while, with experienced personnel. We advise doing a site visit to look at their operation. Also, make sure their claims processing software is up-to-date (windows based). Access to reinsurance markets, an ability to keep up with changes in healthcare legislation, such as privacy law, and adequate Errors & Omissions coverage and bonding are also important.

Self Funded healthcare employers hire a third party administrator to pay and manage medical claims, procure reinsurance coverage, and to establish a provider network, utilization review, precertification, and large case management. Since Employee benefit plan administration is complex it is pertinent to hire a TPA to provide these services. Since there also can be extreme business pressures in the area of claim payment with employees and HIPAA privacy reasons, it is wise to retain a neutral third party administrator to administer your self funded healthcare plans. Also, TPA’s tend to be more aggressive in claims adjudication procedures and standards. It is not advisable to administer the plan in-house with your own employees as this subjects the employer to liability under HIPAA for privacy reasons.
What Services Should Employers Require of their Third Party Administrator?

a. General Counsel: It is very important that your Third Party Administrator has an in-house attorney due to HIPAA privacy laws. An employer will need guidance and answers regarding privacy issues and it can be extremely cost prohibitive to pay to find an attorney who specializes in HIPAA privacy law and ERISA. A quality third party administrator will provide this service at no charge. Also, legal issues will arise where an employee may use an attorney to attempt to get benefits paid when those benefits are not covered by the employer’s plan. TPA’s with in-house counsel are used to dealing and disposing of these matters, where as a TPA who does not have an attorney is not going to pay the expense of outsourcing the matter and may just pay the claim to sweep it under the rug.

Because of HIPAA privacy laws you need a TPA that is fully HIPAA compliant and also EDI compliant. Your TPA should have legal counsel on staff to answer and respond to any of your HIPAA privacy needs or questions.

Claims Payment: You should choose a third Party Administrator that pays claims within two weeks or less. Most quality TPA’s can pay claims within 5 business days or less. Slow claims payment results in poor plan performance and dissatisfied employees. When claims are not paid promptly, doctors send employees balance bills. The employees become very agitated and take time out of their work to discuss these issues with managers and other employees, hence disrupting the work force.

Another important reason to choose a TPA that pays claims promptly is that if claims are not paid within 30 days then all PPO discounts are automatically lost and the employer must pay the full price for the medical services performed. PPO discounts provide significant discounts especially on larger claims. This should be a concern for any TPA that is not processing claims in fewer than two weeks. Also, if the TPA is late submitting promptly a specific or aggregate claim to the Reinsurance – Stop Loss carrier, then the reinsurer will not pay the claim, and the employer may be stuck with the claim.

c. Subrogation: Subrogation is the right of recovery of one party against another party. This refers to the rights of the employer to recover additional money from a second insurance policy. (Third party) Many claims in a health plan can be the cause of “third party liability”, where another party is liable and there potentially is an insurance policy protecting that third party. Every good, quality TPA has a team of Subrogation attorneys who pursue cases against third party’s. They recover money already paid out by the employer. The employer does not pay for this service. The Subrogation firm pays all up front and legal costs and then retains a part of the recovery. It is imperative your TPA utilizes a Subrogation firm with attorneys on staff. Otherwise Subrogation recoveries will be severely limited to nonexistent, hence costing the employer more money for medical services that are not the employer’s responsibility.

Example A: Employee of Acme company is given a bad heart valve during a operation and eventually dies. The defective heart valve helped incur $100,000 in charges. Acme company has already paid the $100,000. The Subrogation firm now brings suit to recover that $100,000 for the employer. Surprisingly, most TPA’s do not provide subrogation services, and do not have an outside subrogation firm. The TPA relies on their “internal subro system”, which is simply an ineffective letter that is mailed out. From the above example,
, the difference can be substantial to your health plan’s success. The difference can be saving thousands to hundreds of thousands of dollars over the course of a year.

**Steerage:** Steerage refers to managed care procedures that direct members inside a contracted network of providers. Sometimes referred to as "repatriation", Steerage also refers to the effectiveness of utilization review functions to get out-of-area members back into the local contracted network. This is especially important to the management of transplant, burn, rehabilitation and neonatal patients. Most TPA’s do not provide steerage, which can save up to $150,000 for every 1,000 employees. It is important to find a TPA that provides steerage.

**Hospital Bill Audits** - The Standard for any quality TPA is to have a group of provider specialists that independently audits all hospital bills over $10,000 and provide quarterly reports showing the savings. "In-house TPA hospital bill auditors" are nothing more than glorified claims examiners who have no medical background or experience to audit hospital bills. Hospital bills are the most expensive cost of a health plan, and a good percentage (%) of savings can range from 10% - 23% on hospital bills that are audited. A quality third party administrator should be able to show a sample of a hospital bill audit (at least 3 inches thick). Note: Most TPA’s do not audit hospital bills due to the intense administrative work required. Do not utilize a TPA that does not audit hospital bills, be wary of a TPA that has internal audits for hospital bills with their “in-house” nurse or claims examiner or the well referred to "eye-ball test." Where a claims examiners looks at a bill and if it "looks good" it is paid.

**Example 1:** Ablation
Patient enters hospital. Bill is $90,000.
Audit Savings : $35,000 of inappropriate charges.
Audit Findings: The hospital broke out one surgical procedure into two surgical procedures and charged the same amount for both procedures. The hospital also charged for medications, services, and supplies not delivered. The hospital also billed for Doctors charges, when the doctors had already billed the TPA and been paid. (It is against policy for hospitals to bill for the doctors charges).

The above "real life" example shows how important hospital bill auditing is and how it can make or break a plan.

**Rx Discounts**
What prescription drug discounts and rebates is the TPA going to pass on to the employer?

Prescription Drugs can cost as high as 25% of the cost of an employer’s health plan. One of the most important decisions in choosing a TPA is one that provides:

1. Strongest discounts for Brand and Retail drugs, lowest cost dispensing and admin fees
2. One that has a Rx utilization and management program.

Most TPA’s do not pass on the strong discounts for prescription drugs or do not have access to it. A quality TPA should be offering a retail brand drug discount of 15% and a mail order
brand drug discount of 19%, with Generic drug discounts on average varying from 40% - 65% off. Prescription Drug discounts are readily available and there is no reason for a TPA to not disclose it. No dispensing fees should be charged on mail order, and minimal dispensing fees at the pharmacy.

There is a very simple statistical formula that can be provided that will show the hard dollar savings between two different TPA’s based on their prescription drug discounts. An employer can actually determine prior to making a choice what they will pay in total annually for their prescription drug plan, based upon the TPA's Rx discounts, dispensing fees, rebates, and administrative fees. An employer should receive some form of rebate for every prescription drug filled.

**Example 1:**
Cost of Company "A”s Prescription Drugs with TPA “1” : $75,000 annually
Cost of Company "A”s Prescription Drugs with TPA “2” $55,000 annually
A recent statistical analysis showed that with an organization of 1,100 employees, a $173,000 immediate hard dollar savings annually by choosing one TPA over another. Discounts matter!

**g. Prescription Drug Management:**

It is very important to find a TPA that performs monthly utilization review and management. Every employer wants a TPA who "Manages" the prescription drug program. They do not just want a TPA to fill prescriptions. Prescription Drug Management and Utilization review is a review of current drug use to see if there is any unusual activity, abuse, or drugs that should not be paid through other insurance. A good TPA's pharmaceutical benefit management (PBM) arm will automatically generate letters to prescribing doctors, who have prescribed expensive drugs, to let them know of alternatives that cost both the employer and employee less.

**Lab Programs**

Any Quality TPA has a laboratory program in effect. Lab programs are free and can save an employer up to 80% on all lab costs. Since lab costs are on average 6% of the cost of health insurance, this can result in significant savings. The lab program costs employers nothing. There is no reason why a lab program should not be implemented. Why would an employer want to pay $36 for a blood test, when they can pay less than $6.00. The price differential is significant. The significance lies in the employer paying full price or a substantially negotiated deep discount.

**Negotiated Out of Network Claims and Transplants:**

Any Quality TPA automatically locks in negotiated discounted rates in the form of a set price for transplants or other large out of network claims. This can happen in the form of access to national networks for specific catastrophic diseases.

Out of network claims and large claims are repriced at no cost to the employer:

* this require no employer or employee cost in accessing the networks
* this requires no contract or plan document addenda
* this offers voluntary use of the networks – network use is not mandated
* this provides patients with access to nationally recognized specialists,
* this has improved medical outcomes, and
* this can produce bottom line hard dollar savings to the employer

**Does the TPA offer a Disease Management program?**

Disease Management & Health Outcomes is a special management program promotes the continuing development of disease management and health outcomes assessment. It educates the members on health issues and disease management, and attempts to guide employees to a healthier lifestyle and provides medical advice and alternatives. Disease management is important in keeping a healthy workforce

**Does the TPA have an Rx Formulary?**

One of the most important savings or costs comes form the Prescription Drug Formulary. Many TPA’s will have an open formulary meaning any drug can be purchased. This causes increased claims and costs to the employer for drugs that in reality should not be covered. For example many drugs are recommended to be excluded: such as “cosmetic” drugs that are for appearance only and the prescribing of them have no behavioral change on the member, ie, Hair loss treatment, such as Rogaine, or “diet-obesity” drugs. Many plans exclude “injectibles, which can cost $1,000 - $6,000 or more each time utilized, (ie 12 months cost of $12,000 to $72,000 by just one employee). But, it is always the choice of the employer as to what drugs they would like to include and what drugs they would like to exclude. Many employers do include these cosmetic drugs in their prescription drug plans.

**Do they have Pre-Certification of Surgery?**

A new concept to reduce the cost of a self funded health plan is to require pre-certification of not only hospital admissions, but also outpatient surgery. Currently, almost 90% of Surgeries are performed on an outpatient basis, and surgeries can easily cost $10,000 to $20,000 or more. Requiring pre-certification will result in only medically necessary surgeries being performed. Without Pre-certification of surgery, there is no gatekeeper for surgeries that are cosmetic or unnecessary, and those cost the employer.

**Guidance in Plan Document Creation & Excluded Benefits?**

One question many employers should ask themselves when going self funded is what benefits do I really need. Allowing benefits that have no proven behavioral change, does nothing but pay for a benefit, which will continue to result in more claims as benefits are used again in the future.

An example of this is obesity procedures “more commonly referred to as lypo-suction”, which have become extremely popular today. Almost every employer has an employee or multiple employees who would like to get have this surgical procedure done of the fact that they are not making any behavioral changes, such as eating habits, going to a gym, etc. These procedures can cost $20,000 - $60,000 and if a complication occurs during the
surgery, the cost could result in an additional $100,000 or more.
An Employer should be given the option and guidance what benefits they can include or exclude.

**What Important Questions should I ask of Any potential Third Party Administrator?**

**How long will my employees be on hold waiting to speak to a customer service rep?**

The least wait time results in a happier workforce and more productivity. As an employer you do not want your employees spending an hour of their workday on hold, and then waiting to resolve a problem or issue. No matter how rich of benefits and excellent of a health plan you offer to your employees, bad customer service or long hold times can result in poor perception of the plan and benefits. A quality TPA should have hold time of no longer than two minutes, and the best TPA’s have no wait time; employees get a live voice almost immediately.

Once an employee enrolls how long will it take for them to get their ID cards and fulfillment kits.

Some TPA’s provide enrollment and ID cards within 48-72 hours of enrollment receipt. Other TPA’s will provide it up to 2-3 weeks later.

**What contingency plans does the TPA have in effect for data backup?**

If a catastrophe happens does the TPA have a secure online backup being conducted to another parts of the country. Otherwise all of the employer’s data could be lost, devastating the employer, resulting in the effect that there is no health plan. Without any proof of claims experience, now the employer will not even be able to go back to a fully insured carrier as they will require claims experience be shown. Quality TPA’s have a “disaster/contingency plan” and the employer need not worry about this. This involves encrypted online back up to HIPAA certified internet site in another part of the country. It also involves having a dual server system in-house, so if one server goes down, the other immediately takes over.

**Self funded Healthcare Plan Example/ Self Funding Healthcare Plan Example**

**Self Funded Plan Example: Acme Incorporated**

**Acme Inc. has 139 emlpoyees.**

Acme Inc. is currently fully insured with "fully insured" carrier. Current Premium is $570,000 annually. Claims experience shows that only 50% of Acme Inc’s annual health insurance premium is due to claims experience.

If Acme Inc, sets up it’s own Self Funded Healthcare plan, with a PPO, and better administration, why can’t Acme Inc then retain that 50% savings instead of paying it to the fully insured carrier?
Partially Self Funded Healthcare Quote with Reinsurance for Acme Inc

Specific Deductible: $25,000.00
Specific Contract Period: 12/15
Aggregate Contract Period: 12/12

Fixed Costs:

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<tr>
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<td>Monthly fixed costs</td>
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Maximum Claim factors/Costs: (Aggregate Factors)

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<tr>
<td>Monthly claims (aggregate attachment point)</td>
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Conventional Equivalents: (total maximum monthly costs)

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<tr>
<td>Maximum Annual Plan Year Cost</td>
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<td></td>
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<td>(worst case scenario)</td>
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<td>(Aggregate Attachment Point)</td>
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The Fixed costs must be paid monthly. Claim Liability costs are only paid if claims materialize.

Acme Incorporated’s Worst Case Scenario is $610,602.00. Their fixed costs, which is the amount they must pay monthly is $20,018.50. Then Acme Inc. must reserve $30,865.00
monthly in a worst case scenario for claims.

**Analysis:** Currently Acme Inc is paying $570,000 for insurance with "fully insured carrier." By going to a self funded healthcare plan Acme Inc takes on a potential $40,602.00 more risk. But this is only in a “worst case scenario”, which is rare. A worst case scenario is where everything going wrong with the self funded plans and there are catastrophic medical conditions and illnesses. By taking on the extra risk, Acme Inc will most likely save at least over $100,000 in savings versus staying fully insured.

**Note:** When coming from a fully insured plan to a fully insured plan, it is very difficult to get claims experience from the fully insured carrier, and almost impossible to get large claims/shock claims reports. Because of this the Reinsurance carrier does not know the actual risk it is getting into, and assumes a worst case scenario. This means the reinsurer assumes that the group has some medical conditions.

The reinsurer then inflates the claims factors to protect against this. So the employer's rates will seem higher the first year than the current fully insured premium because the reinsurance carrier doesn’t know what they are getting into. After your first year, Acme Inc knows what it’s claims are running and will get a much more accurate and competitive quote the following year. Once again what you are comparing is not the actual cost of the self funded plan, but it's worst case scenario. The employer must understands they will most likely see significant savings off of this amount.

**How do you choose a Reinsurer?**

**As an employer do I have a choice on who we use for Reinsurance for our Self Funded healthcare plan?**

Of course you do. When you decide to Self Fund your healthcare plan or partially self fund your healthcare plan, you need to choose a Reinsurer, which is really a financial partner in your group health plan. Reinsurers fund claims that are over the specific deductible or aggregate deductible. Reinsurers are there to protect against catastrophic claims. If the Reinsurer is not a quality carrier they can hurt an employer’s plan by failing to pay claims.

But there are many Quality "A” and “B” rated Reinsurance carriers that are great financial partners. You want a Reinsurance company with a sound financial structure that's been in the business for a while, with experienced personnel.

**WHAT QUESTIONS SHOULD YOU ASK OF YOUR PROPOSED REINSURER?**

**What is the Carrier’s AM Best Rating?:**

A.M. Best is the oldest and most commonly used rating agency. These ratings represent an independent opinion of the carrier's financial strength and ability to pay claims. The top ratings are A++ and A+. Both ratings are given the distinction of being superior. It is recommended that you only use a carrier that is A or “B” rated or higher.
How quickly will the Reinsurer Reimburse you for claims?

Since stop loss contracts protect against catastrophic claims, quick claim turnaround by the carrier is critical to the employer to protect against financial strain. A Specific claim should take 7-14 days for reimbursement. An aggregate claim can take up to 45 days from the end of the plan year. A monthly accommodation aggregate claim can take 7-14 days for reimbursement. Steer clear of any organization who suggests these types of claims can take longer than this. Many TPA’s will attempt to place the reinsurance with the “cheapest rates carrier”, who can take up to 60 days or longer to reimburse both specific and aggregate claims, and who may even fight paying claims. Quality reinsurers reimburse claims promptly and reliably. It is very important to partner with an established quality reinsurer who has the reputation and history of paying promptly. With an established quality reinsurer the employer does not have to worry about reimbursements for specific claims and the employer will be paid promptly.

Does the Reinsurance Carrier provide advance funding for Specific Stop Loss Claims?

Most stop loss carriers require an employer to totally pay a claim and wait until the end of the plan year before reimbursement will be considered. This could be a tremendous financial burden to the employer. Good, Quality carriers will begin paying claims (advance funding) after the employer has satisfied the specific deductible. There is no reason not to have advanced funding with your self funded healthcare plan.

Does the Reinsurance Carrier offer Monthly Accommodation/ Integrated Aggregate?

If the employer is concerned with having budgeting for claims and having a set monthly budget, it is very important to partner with a reinsurance carrier who provides monthly accommodation.

What is the Lifetime Maximum offered by the Reinsurer?

Some Reinsurers will give you a $500,000 lifetime maximum hoping you will not catch the reduced benefit. To increase the lifetime maximum to $1 million or $2 million is relatively penny’s. Employer’s must be careful in how they deal with.

Like any other product or service in any marketplace there are quality companies and companies that do not offer a quality product. If you are not heavily involved in the self funding healthcare Reinsurance marketplace it can almost be impossible for an employer or employee benefits consultant/agent to determine whether a reinsurer is quality.

Some TPA’s utilize specific reinsurers not because they are quality, but because they are the only Reinsurers that will deal with that TPA!!
True Life Example: When your TPA and Agent don’t deal with an established Reinsurance Carrier “AND” don’t know how to read or interpret Reinsurance Contract Language.

Caveat Emptor: Buyer Beware?

Many stop loss carriers have policy language that exclude (or cap) reimbursement for certain claims (usually transplants). This creates a significant liability for the employer. Quality carriers will have a policy that mirrors the employer's plan document. It is very important to read the contingencies of the quote and the reinsurance contract. Many insurance agents do not read or understand the reinsurance contracts, and many insurance agents mistakenly trust the TPA to be the expert in contract review.

Example 1: Reinsurer Games: Real Life Story –

"The Rendered Contract": Company “B” purchases self funding healthcare from their local insurance agent and through a TPA recommended by the agent. The reinsurance is purchased from a well known “A” rated carrier. Company “B”’s insurance agent/consultant does not know the reinsurance marketplace, but thinks he has a good grasp of it. The “A” rated carrier’s core business is fully insured group health insurance, and not reinsurance. The insurance carrier has a great reputation for all of it's group health products, as it has sold for decades group disability, life and health insurance to employers. The reinsurance arm of the carrier is a totally separate entity. Long time experts in the reinsurance industry know of rumors of this particular “A” rated carrier playing games with their reinsurance contracts with employers, and they steer clear of the carrier.

Rendered Contract:

Company B has a large claim that turns into a specific (catastrophic) stop loss claim. It is anticipated that after the plan year is over the claimant will have another $75,000 - $100,000 of claims.

Buried in the reinsurance contract is that the contract is a rendered contract. What is a rendered contract? A rendered contract states that claims that are received towards the end of the contract year will not be paid out in the run out period under a 12/15 contract with this reinsurance contract, when the client is not renewing.

What does this mean? That the employer must now pay the $75,000 - $100,000 the reinsurer is not going to pay. The reinsurer has placed special contract language to the extreme detriment of the employer.

The lesson: The above scenario is an absurdity. The worst part about it, is it is true. And many TPA’s and agents write with this carrier because they are inexperienced and do not understand Reinsurance contract language. They do not know about the "rendered" exception, because they have not had the experience of the situation occurring to them.

If the employer and/or employee benefits consultant dealt with a TPA that was knowledgeable and experienced, they would not have placed the business with the reinsurance carrier or asked that the provision be removed.
If this reinsurance contract had been placed with a quality reinsurer this result would never have happened. Because of the TPA and agents inexperience and inability to decipher Reinsurance contract language or deal with a established reputable reinsurance carrier the employer has experienced more claims than they should have..

**Aggregate Stop Loss – Aggregate Reinsurance**

**Aggregate Stop Loss** provides limits on an employers total liability to a certain dollar amount (creates a ceiling of the maximum amount of dollars an employer would have to pay during a contract period/plan year. (Otherwise known as the attachment point). When claims exceed the attachment point, or the “worst case scenario” than the Reinsurance carrier will pay claims exceeding that attachment point under the aggregate reinsurance. Some reinsurers limit the maximum annual aggregate reimbursement to $1 or $2 million. This is more than adequate to protect most employer plans.

Under an aggregate stop loss policy the reinsurance carrier would reimburse the employer for any “excess claims” after the end of the contract period/plan year. Through Monthly Accommodation also knows as an “integrated aggregate” an employer can also budget on a monthly basis and have the reinsurer reimburse them for amounts over the budget.

**Monthly Accommodation – Integrated Aggregate**

Monthly Accomodation – Integrated Aggregate provides cash flow protection against a monthly fluctuation of claims where claims are higher in one month than prior months. A Monthly Accommodation - Integrated Aggregate breaks your attachment point (worst case scenario) into (12) twelve “(1) one” month periods.

Example: a $1,000,000 aggregate attachment point would be broken down to $83,333.33 per month. For any month that exceeded that amount, the reinsurance carrier under the monthly accommodation would advance funds over this monthly amount. If at the end of the year claims did not hit annual aggregate attachment point, the employer would refund any advanced amounts to the Reinsurance Carrier. This feature allows the employer to budget monthly and to not enter into a financial bind, when any one month’s claims are larger than expected. Every quality Reinsurance carrier offers monthly accommodation. The only time when monthly accommodation may not be attractive is when an employer receives a self funded healthcare quote where a reinsurance carrier is offering a quote with no monthly accommodation for a significant amount less.

**Example: 1**

Reinsurer “A” worst case scenario is $1,081,000 with monthly accommodation.

Reinsurer “B” worst case scenario is $891,000.

If the Employer has good credit and can obtain a loan, there is no reason to go with the monthly accommodation. Even with a 5% or 7% loan, if the employer has a bad year, the employer will save around $190,000. Of course, if the employer cannot obtain the credit for
a loan, and the employer does not want the risk of a potential bad month of claims, then the employer may choose the option with monthly accommodation. Especially if the “fixed” costs are less with Reinsurer A, and the employer has a good claims year, the employer will do better with Reinsurer A.

**What is the average turnaround time for reimbursement of Aggregate Stop Loss Reinsurance claims from the Reinsurance Carrier?**

An aggregate claim can take up to 45 days from the end of the plan year. A monthly accommodation aggregate claim can take 7-14 days for reimbursement. Stay way from any TPA, consultant, or Reinsurer one who suggests these types of claims can take longer than this. Many TPA’s will attempt to place the reinsurance with the "cheapest rates carrier", who can take up to 60 days or more to reimburse both specific and aggregate claims, and who may even fight paying legitimate ‘bone fide’ claims. Quality reinsurers reimburse claims promptly and reliably.

**Types of Aggregate Stop Loss Policies**

Incurred and paid: Incurred means the time period claims were incurred, or “when employees receive treatment from providers or incur claims. (not when the claims were received, but when they were "incurred."). Paid means the exact date that the incurred claim was paid. Reinsurance carriers will not pay claims that do not fall under the stop loss contract. This means they won’t pay claims that were not incurred under the contract type, or weren’t paid within the policy contract year. Therefore it is important to choose stop loss based upon the needs of each individual specific employer.

**Definitions:**

**Incurred:** Incurred means a claim that is “incurred” or is received by the Third Party Administrator during the reinsurance contract period.

If a claim is not “incurred” within the contract period, it is not eligible for reimbursement from the reinsurance carrier.

**Paid:** Paid means a claim that is “paid” within the contract period.

If a claim is not “paid” during the contract period, it is not eligible for reimbursement from the reinsurance carrier.

**Types of Aggregate Stop Loss Policies**

**12/12 Incurred and Paid Policy**

A 12/12 incurred and paid policy provides coverage for claims that are incurred and paid during the policy year (12 months). This policy is for an employer who is looking for the most inexpensive stop loss policy and believe they have very little likelihood of incurring large claims.
"12/15" Incurred and Paid Policy

A 12/15 incurred and paid policy is also referred to as a run-out policy. It provides coverage for claims that are incurred within the contract period (12 months), and paid within 15 months, (incurred within the plan year, or received and paid as long as three months after the end of the first 12 months of the contract. (the extra three months is referred to as the “run-out” period.) This provides greater protection to the employer for large claims than a 12/12 contract, by protecting against late filed claims by medical providers.

"15/12" Incurred and Paid Policy

A “15/12” Incurred and Paid Policy is also referred to as a “run-in” policy. It provides coverage for claims that are incurred three months prior to the effective date of the reinsurance contract and through the current contract year. This option is a good solution for an employer who is currently self funded, and is switching Third Party Administrators or reinsurance carriers and does not currently have a run-out policy.

"Paid" Policy

Paid policy’s occur upon the renewal of a 12/12 or 15/12 specific stop loss policy. This plan accumulates claims toward in the contract year in which the claim is paid, and it provides continuous, uninterrupted coverage when claims are incurred in one agreement year but paid in the next year.

Other Option Specific Stop Loss Contract Policy Periods

24/12 , 12/24, 15/15, 18/15

Terminal Liability Provision

The Terminal Liability provision provides an additional period of coverage for claims incurred while the agreement is in force but which are paid during the selected period following termination of the agreement. Activated only at termination, claims paid during this period will accumulate toward the final year’s Deductible Amount and/or Aggregate Attachment Point under an Aggregate Stop Loss Policy. Employers can choose from 90 days to 120 days of extended coverage under the aggregate. Most reinsurers require employer’s to pay for terminal liability at the beginning of the plan regardless of whether the employer ever uses it. Special aggregate factors and rates are determined for the terminal liability period.

Specific Stop loss Reinsurance

Specific Stop Loss - Reinsurance (also known as Individual Stop Loss or Specific Deductible) protects a self funded healthcare employer from large claims from any one individual or dependent. If any one individual’s claims hits the Specific deductible / Individual Stop Loss level (A specific dollar amount) the employer’s liability ceases and the reinsurance carrier takes on the liability and the claims. The Stop loss carrier will then reimburse the employer for all claims in excess of the specific deductible for the rest of the plan year. The Specific
Stop Loss Deductible is determined by the demographics of the employer, number of employees, age, sex, claims experience, etc. Aggregate Reinsurance protects against the possible of receiving multiple Specific Stop Loss claims.

**Specific Stop Loss Reinsurance Maximum Benefit:**

The maximum benefit the Reinsurance Carrier will pay under a Specific Stop Loss policy can vary. The standard is either a $1 million or $2 million lifetime maximum per person. The benefit can be increased to as high as $5 million or more depending on the group. Higher amounts are available based upon the demographics of the case and employer's needs. Normally $1 million is sufficient.

**Specific Stop Loss Definitions:**

**Incurred:** Incurred means a claim that is “incurred” or is received by the Third Party Administrator during the reinsurance contract period.

If a claim is not “incurred” within the contract period, it is not eligible for reimbursement from the reinsurance carrier.

**Paid:** Paid means a claim that is “paid” within the contract period.

If a claim is not “paid” during the contract period, it is not eligible for reimbursement from the reinsurance carrier.

**Standard Types of Specific Stop Loss Policies**

**"12/12" Incurred and Paid Policy**

A 12/12 incurred and paid policy provides coverage for claims that are incurred and paid during the policy year (12 months). This policy is for an employer who is looking for the most inexpensive stop loss policy and believe they have very little likelihood of incurring large claims.

**"12/15" Incurred and Paid Policy**

A 12/15 incurred and paid policy is also referred to as a run-out policy. It provides coverage for claims that are incurred within the contract period (12 months), and paid within 15 months, (incurred within the plan year, or received and paid as long as three months after the end of the first 12 months of the contract. (the extra three months is referred to as the “run-out” period. This provides greater protection to the employer for large claims than a 12/12 contract because it protects against late filed claims by medical providers.

**"15/12" Incurred and Paid Policy**

A “15/12” Incurred and Paid Policy is also referred to as a “run-in” policy. It provides coverage for claims that are incurred three months prior to the effective date of the reinsurance contract (three months into the previous plan year) and through the current contract year. This option is a good solution for a employer who is currently self funded, and
is switching Third Party Administrators or reinsurance carriers and does not currently have a run-out policy.

**Other Optional Specific Stop Loss Contract Policy Periods**

24/12, 12/24, 15/15, 18/15

**Additional Specific Stop Loss Options:**

**Specific Advance Reimbursement**

The reinsurance carrier does not reimburse the employer for specific deductible claims until the end of the plan year. With Specific Advance reimbursement the reinsurance carrier advances the funds for specific deductible claims as they are incurred instead of waiting for the end of the contract period. Usually, the reinsurance carrier puts a minimum dollar threshold on specific advancements such as $1000 or $2,000. For those amounts under that threshold they are reimbursed at the end of the year. This is to protect the reinsurer from constantly dealing with smaller claims during the plan year, which adds an accounting and administrative problem for the reinsurer.

"Paid" Policy

Paid policy’s occur upon the renewal of a 12/12 or 15/12 specific stop loss policy. This plan accumulates claims towards the contract year in which the claim is paid, and it provides continuous, uninterrupted coverage when claims are incurred in one agreement year but paid in the next year.

**Aggregating Specific Deductible**

An Aggregating Specific Deductible is an option that can provide savings for an employer. This option is for an employer who can afford to take on a little more financial risk for reduced Stop Loss premium in the hopes the employer will not have any stop loss claims.

The employer must satisfy two levels of the specific deductible before the Specific Stop Loss policy kicks in and the carrier reimburses the employer.

- Specific Deductible
- Aggregate Deductible

Once the employer hits the specific deductible under an aggregating deductible approach the employer must then meet the aggregate deductible for the group before the reinsurer will pay for eligible expenses for that individual. The aggregate deductible is the equivalent dollar amount of the specific deductible. This means there is a second level of liability and risk for the employer above the actual specific deductible. (Only for one individual, after the aggregate is met the first time, then the plan reverts back to a normal specific stop loss policy). In return the employer receives reduced reinsurance premium. Monthly Accommodation -
**Integrated Aggregate**

The integrated aggregate also known as Monthly Accommodation protects the employer so that the maximum for any month will not exceed the conventional equivalent. Monthly Accommodation is included to protect monthly cash flow from the impact of larger specific claims. It allows employers to break the year into 12 month segments so the employer can budget on a month by month basis of funds to reserve for in a worst case scenario. The monthly accommodation is a cumulative factor. Employers may have to pay back advances at the end of the plan year if it turns out that claims in a later month wouldn’t be reimbursable because over the course of the year claims were below the yearly aggregate.

**Source:** Provided by the Self Funding Employer Healthcare Conference in partnership with the Self Funding Employers Healthcare Association