Self-Funding 101

WMI TPA
www.wmitpa.com

Group Health Plans – General Info

- Group health plans can be set up as: (1) Fully Insured; or (2) Self-Funded (including partially self-funded)
- Group health plans provide coverage to a number of people under one contract
  - Benefits are provided to a group of individuals who have a specific relationship to the policyholder (*e.g.*, Employer/Employee)
  - Employees receive certificates of insurance or plan documents that set forth the benefits
- The group of individuals is underwritten together
- Group plans minimize adverse selection when the group is formed for a legitimate reason other than to obtain insurance, eligibility guidelines are established, and premium is appropriately shared between the employer and employees (contribution levels)

Fully Insured (aka conventional insurance) vs. Self-Funding (aka self-insurance)

- The main difference lies in who ultimately assumes the risk …
  - Fully Insured: Insurance Company or Health Maintenance Organization ("HMO") assumes the risk in exchange for an agreed upon premium amount. The employer is responsible to pay premium, but is not liable for claims.
  - Self-Funded: Employer (*i.e.*, Plan Sponsor) assumes the claim risk, and purchases reinsurance to protect the plan from large or unexpected claims.

Funding Descriptions – Conventional Insurance

- **Conventional Funding (Fully Insured)**
  - An employer purchases a health insurance policy from a licensed health insurance company or HMO for the benefit of employees. Benefits are set forth in a policy that has been filed with, and approved by, state insurance regulators, and the premium rate is set at an agreed upon amount prior to the effective date of the policy. The rate setting process (*i.e.*, underwriting) collects information and establishes a premium rate that is expected to cover claims, expenses, taxes, commissions, reserves, and the insurance company's profit margin. Premium is generally established at the start of the policy period and remitted monthly without regard to claims costs. Rates are one-year renewable and guaranteed for the policy year. The insurance company assumes total responsibility for payment of plan benefits as long as premium is timely paid.

Funding Descriptions – Self-Funded Plans

- **Self-Funded Plan**
  - An arrangement where the employer assumes the responsibility and risk for the payment of participants' claims (up to a predetermined level), contracts with a third-party administrator ("TPA") to provide administrative services, and purchases stop loss coverage from a licensed reinsurer to cap the risk. The TPA pays claims in accordance with the plan document and provides customer service and actuarial support. The TPA may also shop reinsurance and place stop loss coverage. Even though the administrator may assist in placing the coverage, the stop loss contract is between the employer and the carrier.
  - Three Components:
    1. Administrative services provided by a TPA (*e.g.*, enrollment, claims processing, customer service, actuarial support, reporting, ID cards, EOBs, etc.);
    2. Contractual reinsurance agreement between employer and the reinsurance carrier; and
    3. Claim fund established, maintained, and funded by the employer plan.

Reasons to Self-Fund

- Favorable risks are financially rewarded
- Plan design flexibility
- Control over reserves and cash flow
- Control over PPO, PBM and Managed Care Services
- Reduced operating expenses
- Carrier profit margin and risk charge reduced
- State mandated benefits and premium tax are avoided
- Risk management effectiveness through stop loss insurance
- Eliminate many burdensome healthcare reform regulations and requirements

How to Self-Fund …

- Most employers hire a Third Party Administrator (“TPA”) to pay their claims and to coordinate enrollment and billing functions
  - Employers don’t have the technical expertise or administrative and operational systems in place
  - Employer must set up a separate bank account to hold the “Plan’s” assets (the account that is used to pay employee claims)
  - TPA will assist Employer in developing a Summary Plan Description (“SPD”) and Plan Document (“PD”)
  - SPD takes the place of a certificate of coverage.
  - The Plan Document governs the management and administration of the Plan.
  - The legal document binding the TPA’s services is the Administrative Services Only (“ASO”) Agreement

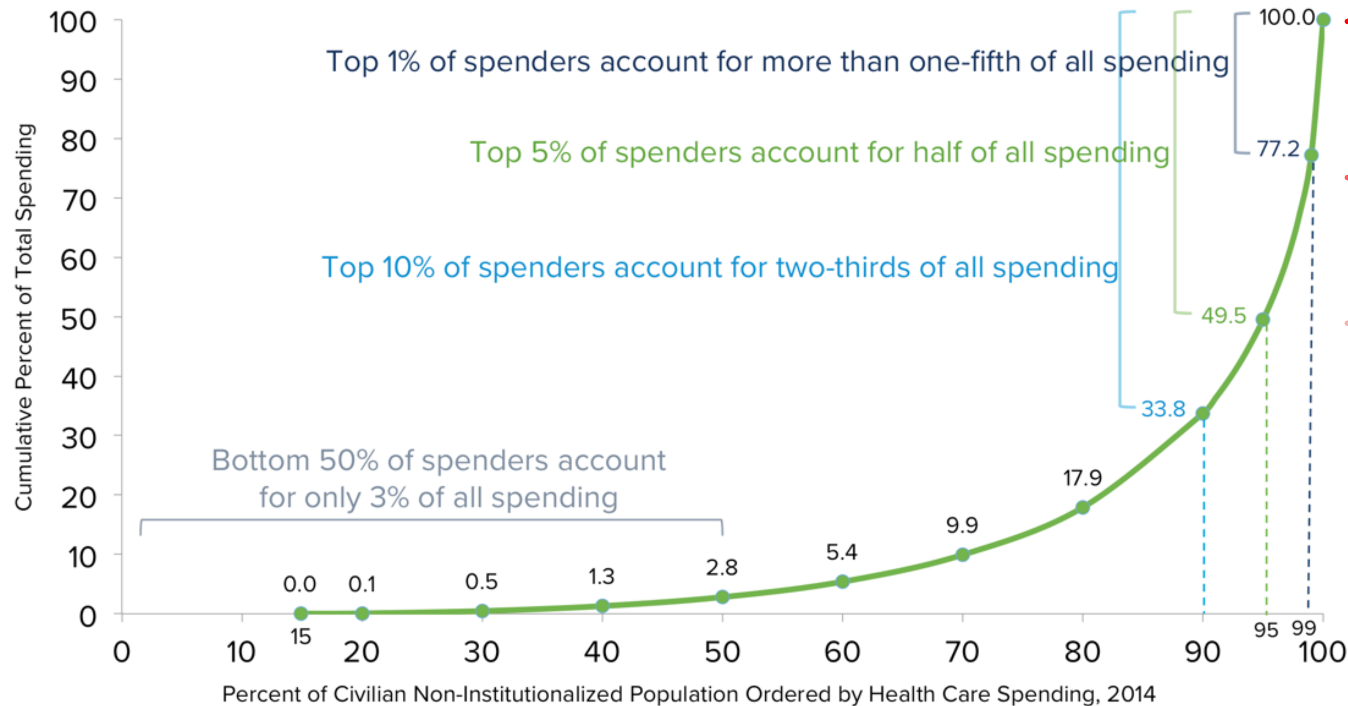
How to Self-Fund (cont.)

- Virtually all self-funded employers purchase stop loss reinsurance coverage to protect the plan from significant claims or extreme loss. (Note: Self-funding is not synonymous with stop loss.)
  - Self-funding is the funding mechanism for providing health benefits for employees
  - Stop Loss is the vehicle used to "minimize the risk" of a self-funded plan and to protect the plan against large or aberrant claims
  - There are two types of stop loss coverage:
    1. Specific Stop Loss – Protects the plan against high claims on any one individual
    2. Aggregate Stop Loss – Protects the plan against the accumulation of claims from the entire group that exceed a pre-determined and agreed upon amount.

Two Kinds of Insurance Protection: (1) Specific Excess Loss Coverage; and (2) Aggregate Excess Loss Coverage

- **Specific Excess Loss Coverage … Individual Protection**
  - Specific Stop Loss: The form of excess risk coverage that provides protection for the plan against a high claim on any individual plan participant. This is protection against abnormal severity of a single claimant rather than abnormal frequency of claims for the entire group.
  - Specific Deductible: The dollar amount to be paid by the plan on each covered individual before the stop loss policy kicks in to reimburse expenses incurred during the contract period.
  - Lasering: The practice of setting a higher specific deductible for a particular individual with a known risk or expected ongoing claim that could be significant or expensive. It is generally accepted within the industry to perform this procedure when taking over a new group as it can keep premiums affordable. However, depending on carrier, this may or may not be the norm when renewing a group.
  - Aggregating Specific Deductible: An additional level of financial responsibility for a plan that is shared between two or more individuals (but not the whole group). In this case, the plan pays all claims up to each participant's individual specific deductible, and an additional amount up to the aggregating specific deductible (for two or more participants) before the reinsurance carrier pays anything. Once the aggregating specific deductible is satisfied, reinsurance kicks in and the stop loss carrier pays all eligible claims. An aggregating specific deductible can be satisfied entirely by one claimant or a combination of claimants. This can be a valuable tool to reduce premiums and funding requirements which can make self-funding more affordable.

Why is Specific Excess Loss Protection Necessary?



- Mean Spend of Top 1%: $107,130
- Mean Spend of Top 5%: $47,455
- Mean Spend of Top 10%: $31,180

NIHCM Foundation analysis of data from the 2014 Medical Expenditure Panel Survey.

Two Kinds of Insurance Protection: (1) Specific Excess Loss Coverage; and (2) Aggregate Excess Loss Coverage (cont.)

- **Aggregate Excess Loss Coverage … Groupwide Protection**
  - Aggregate Stop Loss: The form of excess risk coverage that provides protection for the plan as a whole against the accumulation of many claims exceeding an agreed upon level. This is protection against abnormal frequency of all claims combined rather than the abnormal severity of a single (*i.e.*, specific) claim.
  - Aggregate Attachment Point: This number establishes the maximum claim liability for the entire group. It is the plan's expected claims plus a margin factor (usually 25%). Once this cap is reached, the stop loss policy indemnifies the group for all eligible claims (usually up to $1 million).
  - Aggregate Factors: The dollar figures that are used to calculate a plan's maximum monthly and/or annual financial risk (*i.e*., the aggregate attachment point). The reinsurance carrier determines these amounts during the quoting process, and they relate to the type of coverage selected by the employees (*e.g.*, single, two-party, family). The plan's maximum risk is calculated by multiplying the various enrollment totals and the applicable financial factors (which include margin), and is adjusted monthly to reflect enrollment fluctuations.
  - Margin: The difference between expected paid claims and the aggregate attachment point. Assuming expected claims will be paid in a normal plan year, the margin is the corridor of additional risk the plan accepts in the self-funded program. It is expressed as a percentage of expected claims.

Two Kinds of Insurance Protection

- Specific and Aggregate Excess Loss Coverage Working Together
  - Only amounts up to the specific deductible accumulate toward the aggregate attachment point. This is because the claims above that amount are reimbursed to the plan as a specific claim.
  - The specific and aggregate stop loss contract periods do not have to be the same (*e.g.*, 12/15 “spec” and 12/12 “agg”). Also, the plan can purchase specific coverage without aggregate protection.
  - Specific claims are a more common occurrence than aggregate claims. The estimated “agg hit ratio” is 5%, which means 95% of the time, the plan will realize savings over maximum costs.

ABC Company

PARTIALLY SELF-FUNDED EMPLOYEE BENEFIT PLAN
2021 Contract - 12/15 Specific ($40,000) and 12/15 Aggregate
Continuation of Current Benefits (Plan: 500 (80/20))
Lasers: John Smith - $60,000 Specific Deductible
Insured by: XYZ Reinsurance Company
Underwritten by: MGU, Inc.
Presented by: WMI TPA, Inc.

2021 Renewal

	2021				2020 Contract Year		Notes
Monthly Fixed Costs (Reinsurance) Per Employee Per Month	$40,000 Specific De 12/15 Specific 12/15 Aggregate				Current Rates - $40,000 12/15 Specific 12/15 Aggregate		$40,000 Specific Deductible = Plan is responsible for $40,000 per member during plan year. Specific deductible claims incurred during plan year and paid within three month run-out are reimbursable. Aggregate deductible claims incurred during plan year and paid within three month run-out are reimbursable.
Cost Per:	Single	Family			Single	Family	
Specific Excess Loss Protection (unlimited)*:	$156.92	$356.21			$145.97	$331.16	Premium for specific deductible coverage
Aggregate Loss Protection ($1,000,000)**:	$8.59	$8.59			$7.99	$7.99	Premium for aggregate deductible coverage
Monthly Aggregate Protection: (optional)	available	available			available	available	Allows for an aggregate reinsurance advance during months that exceed averaged aggregate liability.
Monthly Terminal Liability: (optional)	available	available			available	available	Extends aggregate deductible run-out if the employer returns to a fully-insured plan.
Commission (Specific and Aggregate)	$24.83	$54.72			$23.09	$50.87	Agent commission (generally 10-15% of spec and agg premium)
Total (PEPM):	$190.34	$419.52			$177.05	$390.02	

*Specific Excess Loss Protection Includes Medical and Prescription - Lasers: John Smith - $60,000 Specific Dedu — A "laser" is an additional specific deductible exposure for a particular plan participant with a known health risk and higher expected costs.

**Aggregate Loss Protection Includes Medical and Prescription. Rates include a 10% commission load.

Monthly Fixed Costs (Administration) Per Employee Per Month							
Plan Administration :	Single	Family			Single	Family	
Medical, COBRA, HIPAA - $20.95	$20.95	$20.95			$20.95	$20.95	
Dental - $1.90	$1.90	$1.90			$1.90	$1.90	
Vision - $.60	$0.60	$0.60			$0.60	$0.60	
PPO Access Fee - First Choice Health ("FCH	$6.35	$6.35			$6.15	$6.15	
Prescription Drug Service - Caremark*	$2.00	$2.00			$1.90	$1.90	
Utilization Review - MedWatch	$2.50	$2.05			$1.95	$1.95	
Hope Newsletter (Optional)	$0.55	$0.55			$0.55	$0.55	
Total (PEPM):	$34.85	$34.40			$34.00	$34.00	WMI TPA's fees

* Prescription Drug Rebates are retained by WMI TPA, Inc.

Based upon eligibility disclosed	Total Fixed Costs, Per Month						
Employee Lives:	94		Single:	78	Family:	16	
	$40,000 Specific Ded				Current Rates - $40,000		
	Single	Family			Single	Family	
Fixed Costs, Insurance	$190.34	$419.52			$177.05	$390.02	The amount the plan pays for specific and aggregate insurance protection.
Fixed Costs, Administration	$34.85	$34.40			$34.00	$34.00	The amount the plan pays to WMI TPA for administration.
Fixed Costs, Total, per employee	$225.19	$453.92			$211.05	$424.02	
Monthly Total, Fixed Costs	$24,827.27				$23,246.57		The total amount of fixed costs the plan must pay every month (varies with enrollment)

Total Monthly Plan Costs			
Funding Recommended by Reinsurance	$40,000 Specific Ded	Current Rates - $40,000	
Single	$430.39	$395.18	The amount the plan must put in the ERISA fund to pay claims. These amounts are established
Family	$1,020.51	$1,038.87	by the reinsurance company, and they are used to calculate the plans aggregate claims liability.
Total Monthly Attachment Point*	$49,898.58	$47,445.96	A mathematical calculation (# of S x funding for S + # of F x funding for F)
Total Annual Attachment Point*	$598,782.96	$569,351.52	Monthly attachment point x 12. This is the plans responsibility before aggregate protection kicks in.
Total Monthly Fixed Costs*	$24,827.27	$23,246.57	See above
Total Annual Fixed Costs*	$297,927.20	$278,958.86	Monthly fixed costs x 12.
Maximum Monthly Plan Cost*	$74,725.85	$70,692.53	Monthly attachment point + monthly fixed costs.
Maximum Annual Plan Cost*	$896,710.16	$848,310.38	Monthly plan costs x 12.
Expected Monthly Plan Cost*	$64,746.13	$61,203.34	These figures remove the 25% claim corridor "cushion" required by reinsurers for the monthly aggregate
Expected Annual Plan Cost*	$776,953.57	$734,440.08	attachment point. They provide a more accurate calculation of the plan's expected exposure for the plan year.

*These amounts may increase/decrease if enrollment increases during the contract year.

Who Should Self-Fund?

- Employers with 50 or more employees should consider self-funding (although some reinsurance carriers will quote employers with as few as 15 employees)
- Stable employee base with better than average claims experience (Some costly conditions: kidney disease and dialysis; hemophilia; transplants; specialty drug treatments; and premature births)
- Employers with a healthy cash flow, strong balance sheet, and an adequate risk tolerance
- Employers with few or no ongoing potential large claims
- Employers willing to take responsibility for their benefit offering (privacy, fiduciary, administrator functions, additional complexity, added responsibilities)

Benefits to Self-Fund

- What benefits can be self-funded?
  - Medical
  - Rx
  - Dental
  - Vision
  - Weekly Income (short-term disability)
  - Life and Accidental Death & Dismemberment ("AD&D")

Stop Loss Contract
- General Information

- There are three basic types of stop loss contracts: (1) paid; (2) incurred; and (3) incurred and paid.

  - Paid Contract: With this coverage, the stop loss carrier applies any benefits <u>paid</u> by the plan during the policy period to the stop loss coverage. The contract ignores dates of service and is only concerned with dates of payment. This contract is usually only available on renewal (with the same carrier), and applies to claims incurred on or after the original effective date of coverage. Paid contracts are the most comprehensive form of renewal coverage, but they don't protect against exposure after termination so plans often include the optional "terminal liability" coverage rider to add protection.

  - Incurred Contract: With this coverage, the stop loss carrier applies any benefits <u>incurred</u> during the policy period to the stop loss coverage. This contract closely resembles a fully insured plan, and is the natural choice for a client that is converting from a fully-insured plan.

  - Incurred and Paid Contract: With this coverage, the stop loss carrier applies any benefits both <u>incurred and paid</u> during the policy period to the stop loss coverage. This contract is typically only used for the initial year.

Stop Loss Coverage – Additional Protections

- There are two ways to modify a stop loss contract to cover claims that are paid or processed outside of the plan year: (1) "run-in" coverage; and (2) "run-out" coverage.
  - Run-In Coverage: A stop loss contract with run-in coverage gives the plan protection from claims that were incurred prior to the effective date of the stop loss policy, but that have not yet been paid. It generally includes coverage for claims that are incurred during the plan year as well as claims that were incurred three to six months before the effective date of the stop loss policy (as long as they are paid during the plan year).
  - Run-Out Coverage: A stop loss contract with run-out coverage protects the plan from claims that are incurred during the plan year, but aren't processed and paid by the end of the plan year. It generally includes coverage for claims that are incurred during the plan year, provided they are processed no later than three to six months after the end of the plan year.

Stop Loss Contracts – Most Common Contract Periods

- Stop loss contracts determine reimbursement eligibility based on the incurred and/or paid date of claims. The first number represents the period in which the claim is incurred, and the second number indicates the period in which the claim must be paid. The most common contract types are:
  - 12/12 Contract: Claims must be both incurred during the 12-month period and paid during the same 12-month period. This straight plan year contract considers the incurred date and the paid date, and it stipulates that only services that are incurred and paid in the specified 12-month period are eligible to be applied to the stop loss coverage. Such an arrangement places pressure on the employer and the TPA to ensure timely submission and payment of claims. In effect, the employer has little protection for claims incurred very late in the policy period, since it is unlikely that they will be received, processed, and paid before the expiration of the contract. For that reason, although it might be an affordable contract in the initial year for an employer coming from a fully insured plan, the employer should renew it as a paid contract in subsequent years to avoid risk and gaps in coverage.
  - 12/15 Contract or a 12/18 Contract: These types of contracts are known as "run-out contracts." Claims must be incurred in a 12-month period, but they can be paid in a 15-month or 18-month period. The type of contract allows for a 3-month or a 6-month "run-out" period, which allows a reasonable time for the claims to be received, processed, funded, and paid.
  - 15/12 or 24/12 Contract: These types of contracts are known as "run-in contracts" or sometimes as "paid contracts." They allow for reimbursement of claims that are incurred prior to the contract year, but paid during the contract year (sometimes to an agreed upon limit). This type of contract is desirable to an existing self-funded employer that does not have a run-out provision and is changing carriers on renewal.

Stop Loss Contracts

- How do "run-in" and "run out" protections interact?
  - If an employer group is currently fully insured or has a self-funded reinsurance contract that provides "run-out" protection (*e.g.*, 12/15, 12/18, incurred or terminal liability), then you would not offer a "run-in" protection plan.
  - If the employer group is currently self-funded and does not have "run-out" protection, then you would offer "run-in" protection.
- What are the cost differences in stop loss contracts:
  - The longer the incurred period, the higher the cost
  - The longer the payment period, the higher the cost
  - On a scale with '1.00' being a straight paid stop loss contract, other stop loss contract loads would fall in these general ranges:
    - 12/12 = .83 to .90 factor
    - 15/12 = .96 to 1.00 factor
    - Paid = 1.00 (no factor)
    - 12/15 = 1.00 to 1.03 factor
    - 12/18 = 1.00 to 1.05 factor

Leveraged Trend

- Similar to basic medical inflation (*i.e.*, “medical trend”), “leveraged trend” is an annual increase in medical costs, the effect of which is compounded unless the self-insured plan concomitantly increases its stop loss retention. Self-insured plans can minimize the effect of leveraged trend by periodically adjusting their specific stop loss retention level to cover the same percentage of the total large medical claim.

  Example: ABC Company is a self-funded plan with an individual specific deductible of $25,000. In Year #1, plan participant John Brown incurs a large claim of $100,000. If we assume basic medical inflation is 6%, that same claim will cost $106,000 in Year #2. If the plan does not increase its specific stop loss deductible, the effect of the 6% medical trend on the reinsurance claim will be 8%. If, however, the plan increases its specific retention to $30,000, the effect of basic medical trend on the reinsurance claim will be closer to 1%.

	YEAR #1 ($25,000 SPEC)	**YEAR #2 ($25,000 SPEC)**	**YEAR #2 ($30,000 SPEC)**
Medical Claim	$100,000	$106,000	$106,000
Plan Retention	$25,000	$25,000	$30,000
Stop Loss Carrier’s Responsibility	$75,000	$81,000	$76,000
Reinsurance Carrier’s Increase Over Year #1	N/A	$6,000 (8.0%)	$1,000 (1.34%)

Information Needed to Quote

- Employer Data
  - Name of employer and all subsidiaries to be covered
  - Location (zip code) of the employer and subsidiaries
  - Current census (*e.g.*, EE ID, age/DOB, gender, active/retired/COBRA, dependent status)
  - SIC code or industry type
- Employer Coverage History (3 years if available)
  - Carrier
  - Current contract type (if self-funded)
  - Schedule of benefits
  - Rate history
  - Enrollment
  - Monthly paid claims (if available)

Information Needed to Provide a Quote

- Large Claims Information (Shock Loss)
  - Claims that have reached $15,000 or exceed 50% of the proposed specific deductible
  - Claims that are expected to exceed 50% of the proposed specific deductible
  - Some carriers may request a 60-day precertification report
  - Information should include
    - Diagnosis and prognosis
    - Dates of treatment
    - Payment dates
    - Past, present, and future treatment
    - Claimant status (active, retired, COBRA, Employee/Dependent)
- Request Coverage
  - Contract Type
  - Specific Deductible
  - PPO Network to be used
  - Effective Date
  - Commission

Distinguishing "Minimum Premium" (aka "level funded") Plans from Self-Funded Plans

- Minimum Premium / Level Funded Plans
  - An arrangement that allows an employer's premium to be divided into a predetermined monthly dollar amount that is set aside to cover claims and premium. A bank account is established and funded by the policyholder. Claims up to a maximum liability are funded by the policyholder via this bank account. The rest of the premium is remitted to the insurance company to cover non-claim liabilities (*e.g.*, overhead, taxes and risk charges).
  - Some advantages of this type of arrangement are that the policyholder only deposits funds as needed to cover claims, premium taxes are reduced, and the policyholder in effect has received an advanced dividend when claims liabilities are less than predicted. Employer assumes risk to an agreed upon level. Claims above that level are the responsibility of the insurance company. Policyholder can manage the cash flow associated with the bank account. Employer is not at additional risk for any claims above the maximum agreed upon funding amount and fixed monthly premium charge (*i.e.*, "upside" risk only).
  - Some disadvantages: Premium is only slightly lower than fully insured; oftentimes, strings are attached to refund (*e.g.*, future premium credit only); employer is still responsible to pay reserves, terminal fees or a "terminal fund adjustment" upon termination.