SELF FUNDING 101

AHT INSURANCE
A BALDWIN RISK PARTNER

What is Self Funding? Self-funding is an alternate means of financing and structuring a group health insurance program.

Fully Insured Plans – bundle the cost of administering the plan, paying the claims and managing any excess risk. If the plan runs in a surplus, the insurer keeps it. If the plan runs at a loss the insurer bears that risk, as well.

Self Insured Plans – break up this package and pay for administration and excess risk (via Stop Loss), while funding the interim claim expense directly. This allows the plan to keep any gains, while the Stop Loss protects them from much of the excess risk.

Generally, medical, dental, vision, and short-term disability may be self-funded

Medical – holds more risk but has the potential for the most potential savings

Dental, vision, and short-term disability – fixed benefit programs and, therefore, hold less risk. Generally, you will see less gain in self-funding these lines, however there are other benefits that we'll cover further on.

Stop Loss insurance is a key component to limiting the liability in self-funding medical plans

In general, it's prudent to cover medical and prescription costs with Stop Loss insurance. Because dental and vision are already limited in benefits payable, there is no need to have additional protection on that spend.

Employee Benefits Solutions Inspired by Your Business & Workforce Objectives

The necessity for a well-structured benefits plan designed to attract and retain employees has never been greater. Whether you are searching for a new employee health plan or renewing your current plan, BRP's MiddleMarket group designs and implements programs that bring financial security and wellness together in an integrated approach designed to reach your goals. We provide our clients access to industry leaders and top-tier service, giving you peace of mind as you work toward your business objectives, earn employee trust, and make some of life's most important decisions.

KEY DIFFERENCES

	Fully-Insured	Self-Insured
Cash flow	Insurer is responsible for all incurred claims	Employer is responsible for all incurred claims
Reserves	Insurer holds reserves and retains any investment income	Employer holds reserves as a balance sheet item, retains any investment income
Plan design	Insurer controls; bound by state mandates	Employer controls; state mandates become optional
Claim data	Insurer owns data; HIPAA protections limit employer access	Employer owns data and has more access but owns HIPAA responsibility
Compliance	Insurer is HIPAA covered entity; owns responsibility for ACA MEC filings	Employer is HIPAA covered entity; owns responsibility for ACA MEC filings
Fiduciary Responsibility	Insurer is fiduciary	Employer is fiduciary; option to out-source claim fiduciary with some administrators
Payment Structure	Fixed monthly premiums based on plan and coverage tier	Fixed monthly payments for administration and stop loss, claims typically funded weekly

Components of a self-funded medical plan

Administration

- The Administrator is the company that will manage the plan for the employer. Generally, they will perform many of the same duties as an insurer, but the employer will bear the claim liability.
- The Administrator will manage the claim payments and bill the employer, either on a weekly or monthly basis, for the claim payments made on their behalf.
- Administration is typically your smallest expense. As such, it's worth selecting an administrator you trust rather than the least expensive option. This is not where the savings should come from.

Stop Loss Insurance

- Stop Loss is insurance coverage that stops the losses of the plan when claims exceed expectations.
- There are two levels of stop loss protection:
    - **Specific Stop Loss:** Protects the employer against an excessive amount of claims being paid on behalf of any specific claimant during the plan year.
    - **Aggregate Stop Loss:** Protects against the entire plan's expenses far exceeding what is predicted to be the average expense per employee over the course of the plan year.
- Stop Loss is your second smallest plan expense.

Claim Funding

- Claim Funding is the variable part of the expense that the employer takes on when they self-fund their plan.
- It will be the company's responsibility to pay claims each week or month, outside of any stop loss reimbursements.
- The claim spend can be impacted somewhat by plan design and other medical management programs, however the biggest component and variable in the claim spend will be high-cost claimants.
- As a result, the Specific Stop Loss will have the biggest impact on the claim fluctuation an employer sees from month to month.

ADMINISTRATION – IN DETAIL

Administration is the expense you pay to a third party to administer your benefit plan. The third party may be an insurer (Blue's, Aetna, Cigna, UHC) or an independent claims administrator whose sole focus is self-funded claim management.

Administration is priced on a Per Employee Per Month (PEPM) basis, but administrators do take dependent enrollment into account with pricing because higher dependent participation means more members to manage, more claims to pay, etc.

CORE SERVICES

Typically, your base administrative fee includes:

- Housing eligibility
- Programming plan benefits
- Issuing ID cards
- Processing and paying claims
- Determining medical policy
- Issuing explanations of benefits
- Customer service
- Managing first level appeals
- Providing claim reporting
- Generate plan booklets
- Generate Summary of Benefits and Coverage (SBC)
- Coordinate and file claims with your stop loss carrier and sometimes apply stop loss credits directly to your account

OPTIONAL SERVICES

May be included or added to the administration cost on a PEPM basis:

- Providing access to and managing provider networks
- Providing access to a Pharmacy Benefit Manager (PBM), such as Express Scripts, Caremark or Optum
- Managing pharmacy rebates
- Providing access to a Specialty Pharmacy vendor
- Claim fiduciary responsibilities for second level appeals, IRO, etc.
- Consolidated billing (in some cases)

Typically charged on a Per Instance basis:

- Regional fees or surcharges (some BlueCard access fees, NY Surcharges, other taxes)
- Subrogation and recovery (recouping third-party liability claim expenses)
- Run-in or run-out claims processing
- Utilization review and Care Management programs*
- Disease Management programs*

* Sometimes billed on a PEPM basis but generally advantageous to pay per instance

STOP LOSS – IN DETAIL

Stop Loss is insurance that is purchased to protect the plan from excess loss from unexpected high claimants or unexpectedly high claim volume overall. These two levels of protection are called Specific Stop Loss and Aggregate Stop Loss, respectively.

SPECIFIC STOP LOSS

- Protects against excess claim expenses from a specific claimant.
- Dollar threshold typically set around 3-6% of annual expected claims for the entire plan, depending on risk tolerance.
- Claim amounts over the dollar threshold are reimbursed by the insurer through the end of the contract period.
- Accumulation will reset with the new contract period for each covered participant.
- Pays at the point the claimant hits the dollar threshold once the claim is verified by the Stop Loss carrier.
    - Advanced funding is an option that may be included in the contract. This feature requires the Stop Loss carrier to advance the stop loss payment, so the employer doesn't have to front the money for the high claim.

AGGREGATE STOP LOSS

- Protects against unexpectedly high overall claim volume over the course of the plan year.
- Protection threshold set based on expected claims per employee per month plus a corridor of 20-25%. This comprises your Monthly Attachment Factor.
- The Monthly Attachment Factor is then multiplied by enrollment each month of the year. Claims over the aggregated Attachment Point for the year are reimbursed by the Stop Loss insurer.
    - Monthly Accommodation is an option that can be purchased that provides monthly protection against the year-to-date accrued Attachment Point, so there is no risk of going over the maximum accrual and having to wait for reimbursement at year end.
    - This option tends to be very expensive for the value it provides but may be worth it for employers who are risk-adverse but still have a need to self-fund their plan.

UNDERSTANDING CLAIM TIMING

INCURRED AND PAID CLAIMS

The first number in your stop loss contract term refers to the period when claims are incurred. Incurred claims refers to the date the member visited the provider or hospital, or the date they filled a prescription. The second number in your Stop Loss contract term refers to the period during which claims are paid. Paid claims refers to the date the claim was actually processed for payment by the plan administrator.

Claim lag is the period of time between the incurred and the paid date. Most of the time the lag is a month or less. However, high dollar hospital claims go through an audit process at the hospital and again with the claim administrator before payment is made, which can cause a longer lag period. Coordination of benefits claims, particularly with Medicare, also have a longer claim lag. This lag creates additional risk for the plan if the lagged claim doesn't fall within the Stop Loss contract period.

KEY COMPLIANCE CHANGES

HIPAA

The party who funds the claims is considered the "insurer" and the insurer is the covered entity with regard to HIPAA regulations. So, when a company self-funds, they become responsible for HIPAA Privacy and Security rules. This means establishing internal HIPAA policies, training staff who have access to HIPAA information, ensuring all databases which house HIPAA protected information are secure and have appropriate firewalls, and forming a data breach protocols.

ACA Minimum Essential Coverage Reporting

As the insurer, the employer becomes responsible for Minimum Essential Coverage (MEC) reporting to employees and the IRS (as well as some states which have individual mandates). If the employer is already filing 1095c forms to report their offer of coverage according to Employer Shared Responsibility requirements, the MEC portion can be combined on the same form by completing Section III. Having an HRIS or access to good reporting from your Administrator will be key in this reporting element.

Section 105 Non-Discrimination Testing

Self-insured plans are required to perform non-discrimination testing annually to ensure that the benefits offered are not more beneficial to the highly compensated employees (HCEs) than to the other participants. If the plan fails, the benefits received under the plan by the HCEs may become taxable.

Reserve Requirement

Self-insured plans are required to maintain reserves on their balance sheet sufficient to cover any Incurred But Not Reported claims, should the plan terminate for any reason. Keep in mind that in most cases, when a plan terminates, the Stop Loss coverage also ends, so the reserves are based on the cost of all paid claims, even if they would have qualified for Stop Loss reimbursement when the plan was active.

PCORI Fees

The self-insured employer is responsible for PCORI fee payment. Payment is made annually by July 31st following your plan year end. The PCORI fee is indexed every year and was $2.54 per member enrolled for benefits (includes employees, dependents, COBRA continuants, retirees).

Plan Document

ERISA Section 401(b) requires that any self-funded plan not only have a funding policy, but that such policy be stated in your plan document. It is especially important to ensure all plan documentation is in order and up to date on a self-insured plan because if an employee elects to sue the plan, unclear or dated plan information can be used to strengthen the employee's case.

ADMINISTRATION CHANGES

PROCESS CHANGES FOR SELF-INSURED PLANS MAY INCLUDE:

- **Two to three payments with varying frequencies where there was formerly one monthly premium payment**
    - Administration is billed monthly
    - Stop Loss is billed monthly, most commonly on a separate invoice
    - Claims can be billed weekly (most common), monthly or sometimes daily

- **Rate finalization**
    - Where on an insured plan the issued renewal rates do not change except where negotiated, Stop Loss contracts have a final look at claims through the 9th or 10th month of the plan year. If there are surprise diagnoses, which indicate a significant claim in the following year, they may make last minute adjustments to their rates. This can lead to higher rates or Lasering the claimant (see Self-Funding Terms).

- **Claim appeals**
    - As the insurer, the employer is responsible for responding to appeals. Depending whether you outsource Claim Fiduciary responsibilities to the Administrator, this responsibility may be minimal, or it may take some planning and bandwidth. Outside of claims, there may also be eligibility appeals with which to contend.
    - The keys here are:
        - Remember the non-discrimination rules and ensure consistent practices for all members.
        - Keep in mind that the Stop Loss policy will only cover benefits outlined in your plan, so approval of benefits outside the terms of the plan will generally not be covered under the Stop Loss.

SELF-FUNDED TERMS TO KNOW

- **Aggregate Stop Loss** – The dollar amount in total claims for all members within the contract period. Any claims greater than the aggregate Stop Loss are reimbursed by the Stop Loss insurer, per the contract terms, except in a case where the Minimum Annual Attachment is not met.
- **Aggregating Specific Stop Loss** – If applicable to the Stop Loss contract; the first claim(s) that exceed the individual specific Stop Loss up to the aggregating specific Stop Loss amount are funded by the client. Used to reduce Stop Loss premium by transferring some additional risk to the employer.
- **Corridor** – Difference between Expected Claims Liability to client's Maximum Claims Liability, typically 20% or 25%, such that the Maximum Claims will be 120% or 125% over the Expected Claims.
- **Expected Claims Liability** – Stop Loss carrier's calculated prediction of where claims are expected to fall for the renewal period, using claim history, trend, and other market factors.

- **Fixed Costs** – Total of TPA administration, Stop Loss premium, broker fee and any other costs associated with expenses that are NOT claims.
- **Fully-Insured Equivalents (FIEs) (also known as Premium Equivalents)** – The plan's "premium", which is used to establish COBRA premium and employee contributions.
- **Incurred Claims** – Claims based on when services took place (office visit, surgery, prescription fill, etc.) during a specific period. Does not mean that the given claim has been paid.
- **Laser** – A secondary Specific Stop Loss level that has been set on an individual basis for a particularly high-risk claimant. Claims for the lasered individual will continue to be the plan's responsibility, over and above the Specific Stop Loss level for the plan, until the Laser amount is met.
- **Maximum Claims Liability** – Contractual maximum of client's financial responsibility for claims typically on a PEPM basis but can also be on an enrollment tier basis derived from Expected Claims Liability plus an added risk Corridor.
- **Minimum Annual Attachment** – The minimum claims amount for which the client is responsible over the stop loss contract term. It is typically based on a percentage of Maximum Claims Liability and enrollment. This is established at the beginning of the plan year and does not change with enrollment throughout the year.
- **Paid Claims** – Claims that have been actually paid regardless of Incurred date.
- **Specific Stop Loss** – The dollar amount in total claims for any specific member that the employer is financially responsible. Any claims for a specific member greater than the specific Stop Loss is paid for by the Stop Loss insurer, except in the case of a Laser.
- **Reserve** – The amount of money set aside (accounting notation, not actually in a separate account), which the plan is liable for even if the plan was terminated for any reason (acquisition, bankruptcy, etc.). The Reserves are a calculation of your IBNR, which means Incurred But Not Reported claims.