Why is everyone talking about Self-Funding?

An introduction to the concepts of self-funding medical plans

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Discussion Guide

• How Self-funding Works
• History of Self-funding
• Self-funding and PPACA
• Who is a Candidate
What is Self-funding?

• Self-funding is merely a different way of paying the costs for your employees medical needs
  – By transferring a portion of the expense from the insurance company to the Plan Sponsor (Employer) a group becomes “Self-funded”
  – Some groups will accept a large portion of the risk, some will accept a small portion of the risk
Is it really that simple?

- Yes, but there are lots of moving parts to a self-funded plan that require some attention that you may not always see in a fully insured plan.

- Some legal documents are required, such as a Summary Plan Description, but that is also true of fully insured plans.
How Does It Work?

• Most self-funded cases ask Employers to pay a fixed administrative cost each month, and then pay the claims for participants as those claims occur
  – As part of the administrative costs employers purchase “reinsurance” that will limit the employers maximum exposure
  – If claims run well, the employer is rewarded by lower costs and improved cash flow
  – If claims run poorly, the reinsurance will pick up the extra costs above the policy limits
Administration versus Claims

The green is the variable amount.
More About Reinsurance

• A “specific” deductible will limit the exposure *per individual*
• An “aggregate” deductible will limit the exposure *per employer*, and is based upon annual expected claims costs
• With these protections in place you will know what your maximum exposure would be
What Are Administrative Costs?

- Third Party Administrator (TPA) fees
- Network Access Fees
- Reinsurance Costs
- Pharmacy Administration
- Broker Fees
- Wellness Fees
- Other Fees as necessary
More About Administrative Costs

• Generally will be 12-20% of your total medical insurance costs
• Paid as a per employee per month charge
• Due whether or not that employee receives any health care during that month
And the Other 80% is Claims

- Claims costs are paid as they are incurred
- They will vary based upon the actual activity
- Some months will be below expected, some will be above
Claims Fluctuations

- Actual Cost
- Expected Cost

January: $70,000, $80,000
February: $70,000, $80,000
March: $70,000, $80,000
April: $70,000, $80,000
May: $70,000, $80,000
June: $70,000, $80,000
July: $70,000, $80,000
August: $70,000, $80,000
September: $70,000, $80,000
October: $70,000, $80,000
November: $70,000, $80,000
December: $70,000, $80,000
<table>
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<tr>
<th>Month</th>
<th>Admin Costs</th>
<th>Claims Costs</th>
<th>Total Costs</th>
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• Many employers prefer a fixed cost each month
• Total costs can vary by over 20% from month to month
• However, if you are able to accept the risk, in the “good months” the money never leaves your account
• The claims data you receive can help you tailor your plan to reduce future costs
Who is Self Funded?

Percentage of Covered Workers in Partially or Completely Self-Funded Plans, 1999-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
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<tbody>
<tr>
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<td>2000</td>
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<tr>
<td>2010</td>
<td>59%</td>
</tr>
<tr>
<td>2011</td>
<td>60%</td>
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At what point does it make sense?

- Historically we would only consider plans with over 1,000 enrolled employees.
- Now, we can comfortably consider those employers with as few as 300 enrolled.
- For smaller employers, we can look at aggregated risk programs like captives.
- It is possible to self-fund groups as small as 50 employees.
- The driving force has been the stop loss market.
Why would a Plan Sponsor consider Self Insurance?

- Control over plan design
  - National Plans free from State Mandates
- Control over costs
  - Select the benefits that matter to you
- Control over data
  - Use the data to make adjustments to plans
How do HIPAA, ERISA, PPACA and others impact self-funded plans?
• HIPAA
• ERISA vs. State mandates
• No Medical Loss Ratio (MLR) Requirement
• Open Plan Designs
  – No “Metal” Plans
  – No Deductible Requirements
• Loosened Minimum Essential Benefits Regulation
• No Community Rating Rules
• No Fully Insured Fees – Health Insurance Provider Tax Is $8 Billion In 2014 Going Up To Almost $15 Billion in 2018
• HIPAA does require safeguarding of data
• The information you receive will be compliant
• The key word is “de-identified”
ERISA vs. State Mandates

• ERISA plans follow Federal guidelines
• They do not necessarily need to follow state mandates
• California has over 50 mandates in place
• More mandates means more premium
More Freedom in Plan Designs

- Change your plan design on 60 days notice
- Make the changes that will most impact your population
• Lower Premium Taxes  
  – Paid only on Admin fees, not entire premium
• No HIT (Health Insurer Tax) – estimated to be 3-5% of premium, over $8 Billion in 2014
Who Is A Candidate For Self Funded Plans?

- Some Characteristics Include
  - Long Term Thinker
  - Financial Stability
  - Population Stability
  - Location Stability
  - Employers who are “tired of subsidizing the rest of the pool”
Service Differences

• The self-insured client functions like any other fully insured client about 90-95% of the time

• Key difference – instead of calling carrier they will instead call the TPA or Broker

• The financial reporting allows employers to see where the dollars are being spent
  – Focus on key areas of health improvement
  – Maximum flexibility of plan designs
  – Change vendors when needed without disrupting the entire plan
So What Is Different?

• Reporting
  – Financial Reports
  – Professional versus Pharmacy versus Facility
  – Know the different types of reports provided
    • 50% of Spec
    • Aggregate attachment
    • Aggregated Group Reports
  – Mid Point Analysis