Why is everyone talking about Self-Funding?

An introduction to the concepts of self-funding medical plans

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Discussion Guide

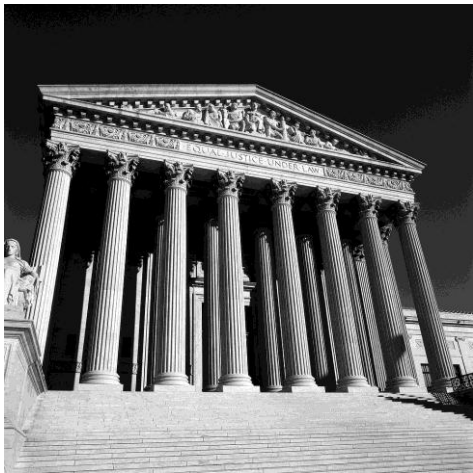
- How Self-funding Works
- History of Self-funding
- Self-funding and PPACA
- Who is a Candidate

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?

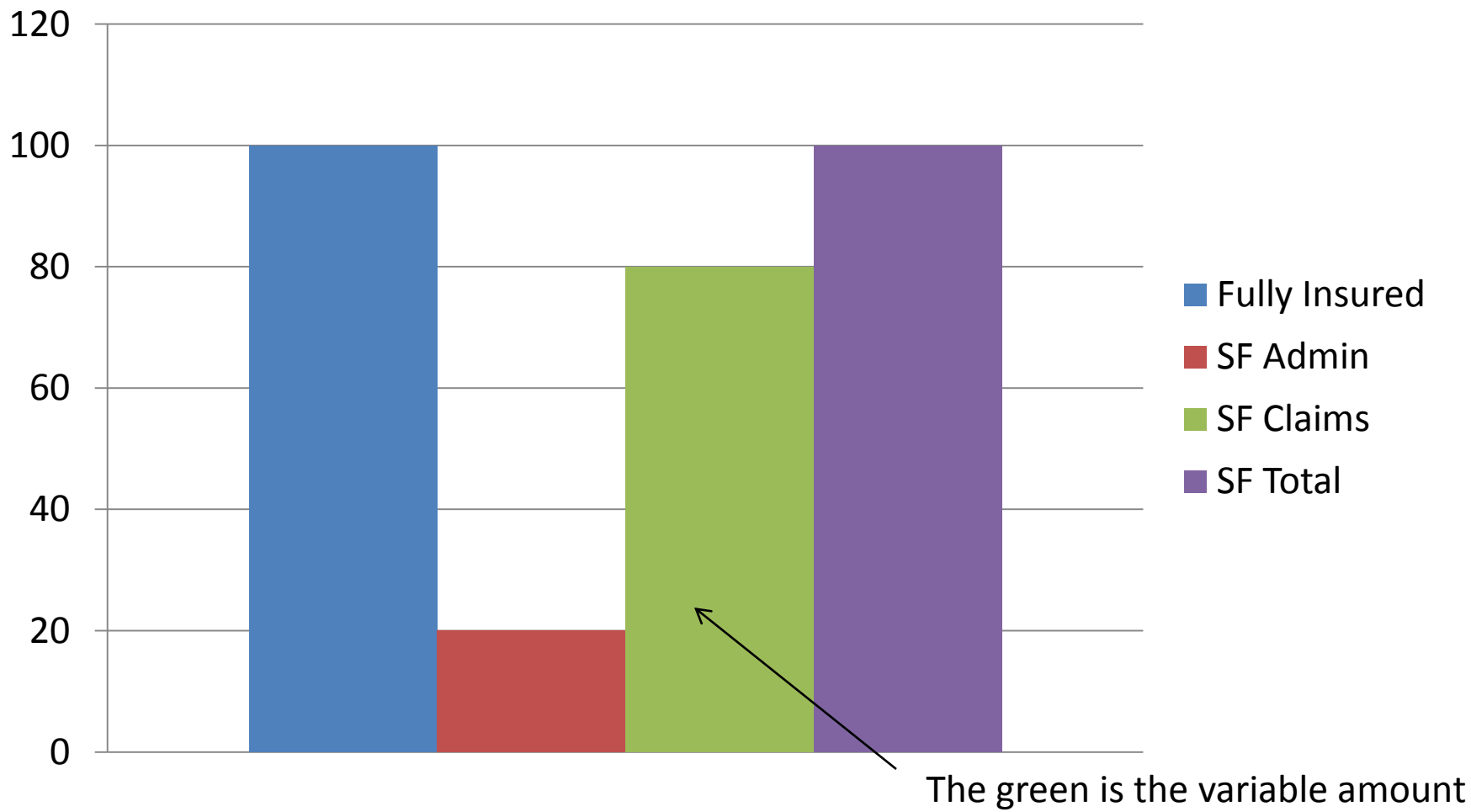
- Yes, but there are lots of moving parts to a self-funded plan that require some attention that you may not always see in a fully insured plan
- Some legal documents are required, such as a Summary Plan Description, but that is also true of fully insured plans



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



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

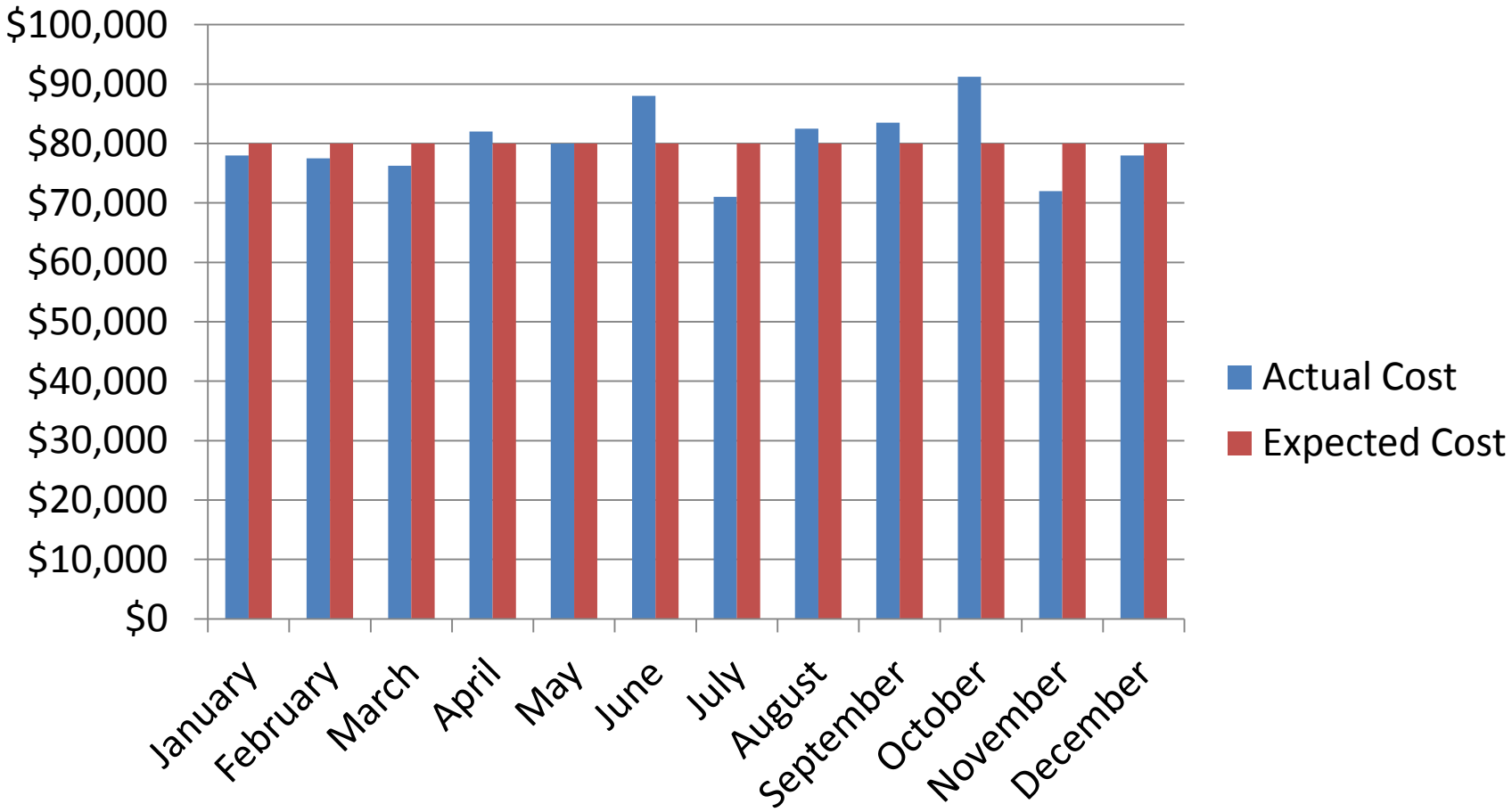
More About Administrative Costs

- 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



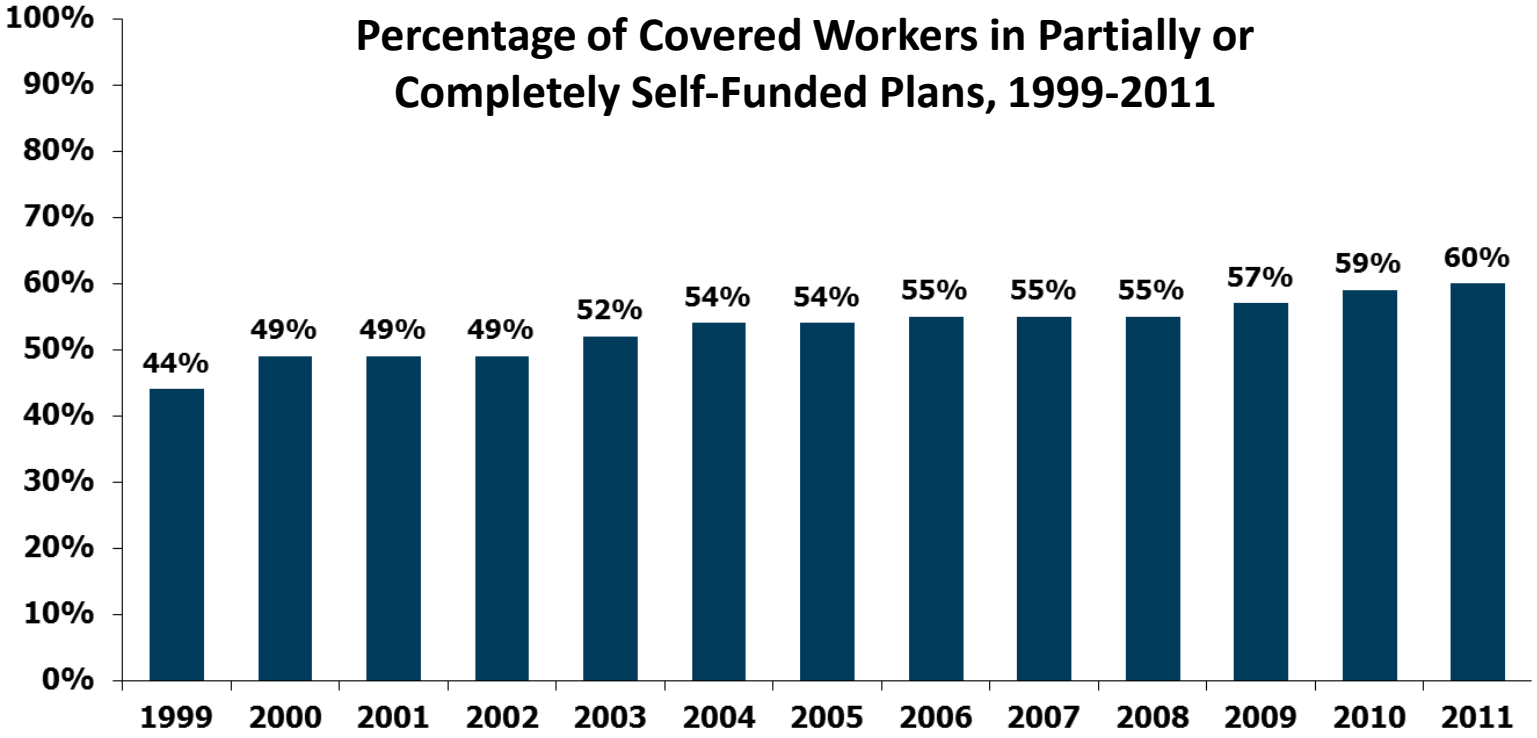
Claims Fluctuations

Month	Admin Costs	Claims Costs	Total Costs	Expected Costs
January	$20,000	$78,000	$98,000	$100,000
February	$20,000	$77,500	$97,500	$100,000
March	$20,000	$76,250	$96,250	$100,000
April	$20,000	$82,000	$102,000	$100,000
May	$20,000	$80,000	$100,000	$100,000
June	$20,000	$88,000	$108,000	$100,000
July	$20,000	$71,000	$91,000	$100,000
August	$20,000	$82,500	$102,500	$100,000
September	$20,000	$83,500	$103,500	$100,000
October	$20,000	$91,250	$111,250	$100,000
November	$20,000	$72,000	$92,000	$100,000
December	$20,000	$78,000	$98,000	$100,000
	$240,000	$960,000	$1,200,000	$1,200,000

Are you comfortable with the variation?

- 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?



Control is the Key

- 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

Control is the Key

- 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

Legislative Points

How do HIPAA, ERISA, PPACA and others impact self-funded plans?

Legislative Points

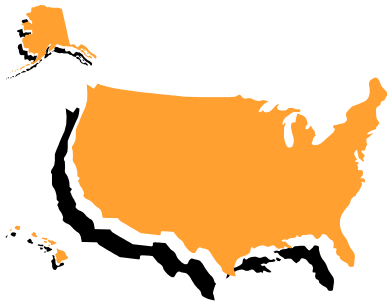
- HIPAA
- ERISA vs. State mandates
- No Medical Loss Ratio (MLR) Requirement
- Open Plan Designs
  - No “Metal” Plans
  - No Deductible Requirements
- Loosened Minimum Essential Benefits Regulation
- No Community Rating Rules
- No Fully Insured Fees – Health Insurance Provider Tax Is $8 Billion In 2014 Going Up To Almost $15 Billion in 2018

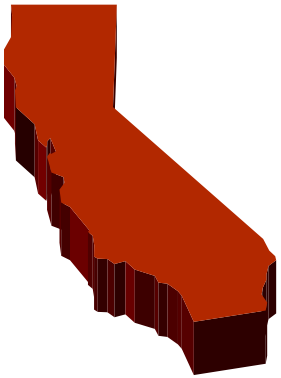
HIPAA

- HIPAA does require safeguarding of data
- The information you receive will be compliant
- The key word is “de-identified”

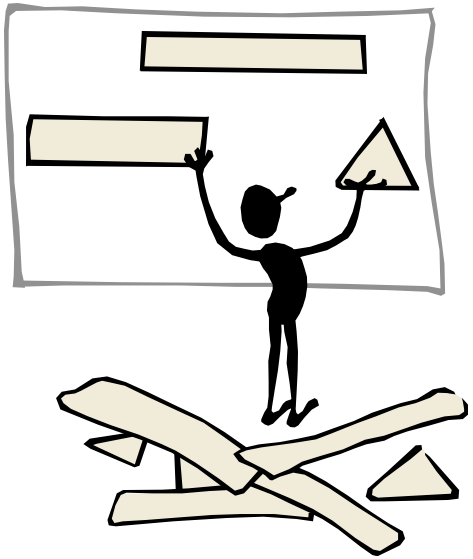
ERISA vs. State Mandates

- 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

Taxes

- 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

Questions?