Overview

With healthcare costs trending at higher rates and changes through Health Care Reform, many organizations are dedicating more time to evaluating how their group benefit programs are funded. Understanding the mechanics of self-funding, can be challenging if you are unfamiliar with the basics.

The majority of group benefit plans are “fully insured,” where an organization pays a monthly premium to the insurance company who “fully” owns the risk. Regardless of whether the premium covers the insurance company’s expenses, they are responsible for paying.

This option is popular, because it’s perceived as less risky due to the fixed monthly cost. There is a misnomer that being insured keeps you at arm’s length from plan decisions and potential human resource nightmares. Some also argue that the administrative responsibilities also decrease when fully insured—perhaps. Yet, that would mean you have a complete understanding of the mechanics of self-funding, the other platform available.

Many employers simply shy away from self-funding because it appears complex. Our goal is to take the mystery out of self-funding.
The Pros & Cons of Self-Funding

Self-funding is an alternative funding platform, where an organization assumes the financial risk associated with group benefit programs. The organization typically partners with a plan administrator, often referred to as a third-party administrator (TPA), which in some cases might be an insurance company. The key difference is the organization uses its own money, including the monies collected from employees through payroll deduction to cover the healthcare expenses incurred and administrative costs. There are clear pros and cons to choosing a self-funded plan arrangement over the fully insured platform.

Pros

1. With a self-funded health plan, you are in control of the plan design and are often able to avoid state-mandated plan provisions that are otherwise without input.
2. When claims expenses are low, the organization reaps the reward of the cash savings versus fully insured, where the insurance company wins.
3. You control the overall risk management with what is known as “stop loss” insurance. This safeguards your organization in the event a claims expenditure exceeds a predetermined threshold, ensuring your cash flow is protected and avoiding unforeseen expenses from depleting the company assets.
4. Financial advantages of self-funding include the elimination of a 2% premium tax and having full transparency in the administrative costs paid to the plan administrator for claims and customer service responsibilities.

Cons

1. The insurance company reaps the benefits under a fully insured contract, which typically comes in two forms. One being the lower claims expenses for a period of time, and second, by way of contracted discounts with providers. In some cases, being self-funded means the network savings you have access to through the TPA is less than the discounts achieved by insurance carriers.
2. For self-funded plans, there can be unpredictability in cash flow. Since your organization is paying claims expenses rather than a fixed monthly premium, the expenses can fluctuate from month to month and even year to year, especially if your group is unhealthy.
3. There is also what is known as a “lag” between when the expense is incurred by a plan participant and when the expense hits your books. If the expense is high dollar and eligible for reimbursement from your stop loss insurance, there may be a delay to you in recouping the money from the carrier. Continue reading to learn more about stop loss insurance.
Stop Loss 101

Stop loss insurance protects organizations against catastrophic risk associated with medical expenses. The plan will reimburse the organization at a certain threshold of expenses, which is predetermined each year or thereabouts.

There are two types of stop loss programs. **Specific stop loss** protects the organization from a catastrophic claim incurred by a single plan participant, while **aggregate stop loss** protects the organization against claims exceeding a total dollar amount for a given time period, regardless of whether the expenses are catastrophic in nature or not.

**Example Specific Stop Loss Coverage**

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total claims for John Doe during one-time period</td>
<td>$75,000</td>
<td>$350,000</td>
</tr>
<tr>
<td>Deductible on stop loss policy*</td>
<td>$25,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>Reimbursement to organization by stop loss plan</td>
<td>$50,000</td>
<td>$250,000</td>
</tr>
</tbody>
</table>

* The risk is owned by the organization and is not transferred to the stop loss carrier. This is an important consideration in terms of the deductible amount your organization is comfortable with.

**Example Aggregate Stop Loss Coverage**

<table>
<thead>
<tr>
<th></th>
<th>Example 1</th>
<th>Example 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total claims for entire group for one set time period</td>
<td>$500,000</td>
<td>$900,000</td>
</tr>
<tr>
<td>Trend (inflation/utilization)</td>
<td>x 1.12</td>
<td>x 1.12</td>
</tr>
<tr>
<td>Margin</td>
<td>x 1.25</td>
<td>x 1.25</td>
</tr>
<tr>
<td>Aggregate attachment*</td>
<td>$700,000</td>
<td>$1,260,000</td>
</tr>
</tbody>
</table>

* Any and all claim expenses that exceed this aggregate attachment point are now reimbursed by the stop loss company and are no longer a risk to the organization.
Contract Considerations

With the stop loss contract, there will be additional decisions to make, such as the deductible, shown in the Specific Stop Loss example on the previous page. You will also have to consider the conditions of the agreement in terms of what makes an expense eligible. Two primary factors are the incurred date of the claim and the paid date of the claim.

Most stop loss insurance carriers offer four types of contracts:

1. **Incurred in 12, paid in 12.** This contract provides coverage for claims that are incurred and paid during the same 12-month policy year.
2. **Incurred in 12, paid in 15.** This type of contract, also referred to as a run-out policy, provides coverage for claims that were incurred in the 12-month contract period and paid within the following three months of the contract.
3. **Incurred in 15, paid in 12.** Also known as a run-in policy, this protects against claims incurred in the 12-month contract period, as well as the three months prior to the contract period.
4. **24/12 or "paid" policy.** This is typically only offered as a renewal option when staying with the same stop loss carrier from one year to the next. Essentially, the policy offers seamless protection from one year to the next regardless of when the expense was incurred or paid.

It’s also important to consider the laser provision, which sets a specific stop loss attachment point at a higher level for some individuals than others. For example, if John Doe has historically incurred $250,000 in claims, the stop loss carrier may insist that a higher specific or aggregate attachment point be placed on him.

Choosing a Plan Administrator

If you have chosen to use a self-funding arrangement, you must determine the plan administrator—either a TPA or an insurance carrier.

Both are viable options. Simply being self-funded, regardless of who administers the plan, offers great flexibility; however, there are a few advantages to selecting an insurance carrier as the plan administrator, including:

- Greatest savings potential through contracted network discounts
- Proactive case management eliminating potentially excessive expenses
- Stop loss protection factored into the contract for administrative ease and decreased risk in cash flow mishaps

In Summary

There is no one-size-fits-all solution to benefits. As you develop and refine your health and benefits strategy, be sure it is aligned with your organization’s strategic goals and objectives. Talk to a trusted advisor to see what funding option makes sense for you.

About the Author

**Paul Ashley** is a Managing Director at FirstPerson and plays an integral role on the Senior Leadership Team.
Terminology Toolbox

Administrative Services Only
A contract in which a third-party administrator (TPA) or insurance company processes claims for a self-funded health plan.

Aggregate Accommodation
Also known as Aggregate Advancement, an optional stop loss protection against monthly claim fluctuations. The stop loss carrier advances the health plan amounts in excess of the accumulated monthly aggregate attachment point.

Aggregate Attachment Point
Under an aggregate stop loss policy, the amount of total claims that must be paid before the stop loss carrier begins to reimburse the plan.

Aggregate Report
A monthly claims report that exhibits total paid claims and claims that are subject to loss reimbursement.

Aggregate Stop Loss
Stop loss coverage that protects the plan against total annual claims greater than predicted. It is usually written to attach at 125% of expected annual claims.

Creditable Claims
The proportion of the claims experience of a group that is used in the calculation of the renewal premium, based primarily on the size of the group.

Capitated Charge
A service charge based on the number of participants in a group plan.

Deficit Carry-Forward
A provision of minimum premium (and some other) plans that prohibits any savings from favorable claims experience in a partial self-funding arrangement if the plan has experienced a deficit in previous years.

Disease Management
A cost control service within a group plan whereby individuals with specific chronic conditions are identified and provided additional services to help them manage their conditions.

Disruption Report
A report comparing the discounts and providers in a proposed network to the discounts and providers in the current network.

ERISA
Employee Retirement Income Security Act of 1974, a Federal law that (among other things) allows self-funded health plans to be considered exempt from state regulations and provides for non-discrimination in self-funded plans.

Expected Claims
A prediction of paid claims for a plan year based on plan demographics, current claims experience, and insurance company trends. The expected claims calculation is used to determine the aggregate attachment point.

Fixed Costs
Those costs in a self-funded plan that are in addition to the claims and generally include all administration charges plus stop loss premiums.

Fully Pooled
A type of fully insured group insurance contract whereby the claims experience of an individual group is not used in the calculation of rates. The claims experience is “pooled” with other companies insured by the insurance carrier.

Geo-Access Report
A report providing information on the types and numbers of health care providers within a PPO network based on their proximity to the participants in a group health plan.

Incurred But Not Reported (IBNR)
A term applied to claims wherein the service has been provided by the health professional (incurred) but has not yet been processed and paid. This amount is also referred to as the Reserve.

Lag Report
A claims report that shows the amount of time between the time claims are incurred and paid.
**Large Case Management**
A service provided to group medical plans whereby plan participants that have large medical events are assisted by a trained professional (usually an RN) in obtaining effective and cost-efficient care.

**LASER**
A provision in some stop loss contracts, which sets a specific stop loss attachment point at a higher level than the rest of the contract for specific individuals.

**Maximum Liability**
The amount calculated by adding the annual fixed costs to the annual aggregate attachment point in a self-funded contract.

**Minimum Premium**
A type of partial self-funding arrangement wherein the insurance company assumes the risk but charges the plan monthly fixed costs plus paid claims up to predetermined limits. It is usually characterized by a deficit carry-forward provision.

**Per Event Charge**
A service charge based on a specific occurrence in a health plan.

**Pharmacy Benefit Manager (PBM)**
An entity that supplies a network of member pharmacies to a health plan and manages the prescription claims to control costs.

**Pooling Point**
In an insured contract, the limit to the amount of paid claims on an individual that will be charged against the experience of the plan.

**Predictive Modeling**
The science of ranking individuals from those with the greatest probability of disease onset to those with the least probability of disease onset.

**Percent of Claims Charge**
A method of charging for claims administration, whereby the fee is set as a percentage of paid claims instead of an amount per participant.

**Run-In**
Claims that are incurred prior to the start of a plan year but are paid during the plan year.

**Run-Out**
Claims that are incurred during the plan year but are paid after the plan year ends.

**Shock Claims**
Large claims, usually in excess of 50% of the specific deductible. Details of these claims are crucial to the underwriting process of a self-funded plan.

**Specific Deductible**
Also called Individual Stop Loss, stop loss insurance that protects a health plan against catastrophic claims on an individual in excess of a predetermined amount.

**Stop Loss**
A type of insurance that covers a health plan for claims in excess of a predetermined amount. Stop loss insurance is written on a specific and aggregate basis.

**Terminal Liability**
Stop loss insurance that covers Run-Out.

**Third-Party Administrator**
An organization that contracts to process the claims and provide other administrative services for a self-funded health plan.

**Trigger Diagnosis**
A diagnosis that affects the stop loss underwriting. Dollar amount of current claim may be small, but nature of the diagnosis is an alarm to the underwriter.

**Unfunded Liability**
The amount between the maximum liability and the sum of the fixed costs and paid claims that some employers choose not to fund.

**Utilization Review**
A service provided to a health plan whereby the services provided by the health care provider are evaluated for medical necessity and appropriateness of charges.

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