SHOULD AN EMPLOYER BE SELF-FUNDED?

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THAT IS QUITE A QUESTION. IN THE PAST WE CAUTIONED THAT CLAIMS SAVINGS WAS NOT GUARANTEED BY SELF-FUNDING. AND WITH A SMALL DIFFERENCE IN FIXED FEES VS. FULLY INSURED RETENTION, THERE WAS NOT MUCH INCENTIVE FOR SMALLER EMPLOYERS TO TAKE THE RISK, GIVEN THAT THEY WERE MORE SUSCEPTIBLE TO WIDE FLUCTUATIONS IN CLAIMS COST.

BUT NOW THINGS ARE CHANGING. AND AN EXPLOSION IN SELF-FUNDING IS EXPECTED. SO THERE IS MUCH TO LEARN!

U.S. business faces competitive challenges in a global market, as a larger and larger piece of operating capital is pulled away to cover employee health care costs. A growing number of employers find that the cost of their health care is the third most significant cost in their operating budget behind salary and materials. It is becoming increasingly difficult for U.S. companies to remain competitive against foreign business as the cost of health care continues to grow.

Employers now have thousands of pages of regulations from the ACA that they have to contend with. This wave of regulations adds a significant compliance liability along with new taxes and fees, contributing to a growing administrative and cost burden for employers. A very significant component of the ACA will reach employers of under 100 employees over the next couple of years, barring some politically unforeseen action. When implemented on January 1, 2016, there will no longer be a relationship between the risk elements of an employer and the rates charged. Instead, the age of the member will be what determines cost. And the age range is being compressed in such a way that young and healthy groups will be hit the hardest.

In this new environment, employers are asking some important questions about the future of their health care plan and even question whether or not they should continue to offer health insurance coverage to their employees. Our Pay or Play exhibit continues to be a popular request. Despite this interest, recent surveys indicate that a majority of employers will continue to offer health insurance in order to attract and retain employees. Some employers are reducing employees' hours in an effort to stay below the 30 hour definition of full-time employees. Employers opting to eliminate, reduce or refrain from offering health insurance will be subject to penalties associated with not covering employees, offering plans that are unaffordable, or failing to meet the minimum value test or the minimum essential coverage test.

THE BOTTOM LINE IS THAT EMPLOYERS ARE LOOKING EVERYWHERE TO CONTROL COSTS. FOR AN EMPLOYER OFFERING A FULLY-INSURED PLAN, A PRIME OPPORTUNITY TO DECREASE COSTS MAY BE FOUND BY CONSIDERING SELF-FUNDING. ESPECIALLY THOSE THAT ARE GOING TO BE HIT THE HARDEST BY THE MODIFIED COMMUNITY RATING RULES. BY SELF-FUNDING, EMPLOYERS CAN ACHIEVE SAVINGS OF 8% TO 10% BY AVOIDING CERTAIN TAXES AND CARRIER FEES. ADD TO THAT LOWER CLAIMS COST BASED ON PRE-ACA UNDERWRITING (WHICH IS MORE ACCURATE), AND THE MARKET IS RIPE FOR A BIG WAVE OF SELF-FUNDING.

KEY TERMS

KEY TERMS	DEFINITION
Fully Insured Plan	An employer contracts with an insurance company to assume the risk and financial responsibility for employees' health care claims. The insurer's responsibilities include processing and paying medical claims according to the plan of benefits, maintaining a provider network, and other administrative tasks. The insurer's profit is built into the premium costs.
Self-Insured Plan (Self-funded)	An employer retains the financial risk of covering employees' health care costs. Contracting with a third-party payer, administrative services organization, or an insurance company, an employer will pay a third party to administer the benefits, pay claims, and perform certain limited fiduciary functions.
Administrative Fee	A per employee per month fee that a self-funded employer pays the benefits administrator to process and pay claims, maintain the provider network, and perform other contracted functions that could include disease management, wellness, utilization review, and case management.
Risk and Reserve	A fee included in the monthly premium that is charged by a fully insured health plan to clients to cover the cost of marketing, retaining business, and includes profit (the reserve piece).
Stop Loss	Stop loss insurance covers large claim costs that exceed a certain threshold set by the self-funded employer, and overall claims cost. Large threshold claims are called specific and the overall claims limit is called the aggregate.
Specific (Individual) Stop Loss Coverage	Reimburses if an individual claim exceeds some threshold amount, typically anywhere from $50,000 to $250,000. Most contracts are on a per member basis. Anthem has contracts that are sometimes on a per subscriber basis.
Aggregate Stop Loss Coverage	Pays out if the aggregate employer costs exceed some percentage of expected claims (typically 125%, but this could be more or less depending on the policy).
Lasering	A practice in which the stop loss insurer will exclude from stop loss coverage a high cost claimant or a participant with a specific medical condition in order to continue to insure the rest of the business. At times the laser may be represented by a higher threshold on an individual.
Specific Stop Loss Limit	The excess amount that an individual claimant must reach before the employer liability stops (typical limits range from $50,000 to $250,000 depending on the size of group and their aversion to risk).

POTENTIAL SAVINGS

There are many benefits to self-funding including plan design flexibility, cost transparency, tax savings and retention savings. Self-funded employers have much more flexibility in their plan design than insured employers as they are not subject to state coverage mandates. They also have insight into the actual cost of care, administrative costs, and any loaded fees or additional expenses to the plan. Other benefits of moving to self-insurance include the following:

THE HEALTH INSURANCE INDUSTRY TAX (HIT)

A new tax imposed by the ACA, the HIT is designed to return to the federal government some of the health insurance industry gains (increased enrollment and federal subsidies) achieved from health care reform. The total annual fee was estimated to be $8 billion in 2014, increasing to $14.3 billion in 2018, and indexed to the growth of health care premiums thereafter. Beginning in 2014, this fee was added to the insured plan premiums. The tax was 2.47% in 2014, and may increase to 3% to 4% in future years. Health plans are liable for the payment of this fee. It is not tax deductible, which increases the cost impact, and most importantly is not applicable to self-insured plans.

AVOID STATE PREMIUM TAXES

Many states include a premium tax on health insurers that is passed along to fully insured employers in the form of higher premiums. For example, in Ohio the state premium tax is about 1.7% of premium. The tax varies state to state, but on average ranges from 1.5% to 3% of premiums. Self-funded employers are not subject to these taxes under ERISA preemption.

AVOID RISK AND RESERVE FEES

All health insurers include expenses loaded in their fully insured premiums for new business sales, marketing expenses, retention of current customers and for profits. These costs generally run around 3.5% of premium depending on the carrier and do not exist in a self-funded environment other than an amount of cost built into stop loss insurance.

CLARIFY AND CONTROL ADMINISTRATIVE COSTS

The cost to administer benefits, pay claims, maintain a network and provide for the overall operation of the health plan can equal 15% of insured premiums depending on the number of employees covered. While self-funded employers will incur administrative expenses through payment to a carrier, third-party administrator (TPA) or administrative services organization (ASO), they can control these expenses through multi-year guarantees, transparent and unbundled agreements, marketing the plan administration contract, and identifying the most cost effective administrative carriers in the marketplace.

RETAIN CLAIMS RESERVES (INCURRED BUT NOT REPORTED)

Since the money for claims comes from the operating income of the employer, a self-insured employer can capture investment income that is accrued on all funds allocated to the funding of insurance claims. This interest can be used to offset benefit costs or administration.

For employers moving from fully insured to self-insurance, there will be an amount that represents about 1.5 months of claims that can be held by the employer for future liability. The fully insured claims run out will be covered by the previous carrier. During this initial period, an employer should bank the excess cash to use for future claim liabilities.

Incurred but not reported (IBNR) reserves need to be calculated on an annual basis, sometimes requiring an actuarial certification. Our method for calculating reserves is based on generally accepted actuarial standards and has withstood auditing. The spreadsheet does a large number of calculations. In short though, we find the patterns of claims development in the data and average that by one of four available averaging methods. This pattern is then applied to the more recent incomplete months to arrive at an expected liability. Our "sniff" test is that medical is generally about 1.5 months of claims while the drug is about 2 weeks since there is a much quicker turnaround on drug claims.

AVOID STATE AND FEDERAL MANDATED BENEFITS

Over the past several years, states have begun mandating very specific employer health care benefits. Each state has its own unique list of mandated coverages that add significant costs to employers and their employees. Self-insured employers can avoid the state mandate costs under the ERISA preemption, which allows greater flexibility in plan design. Also, under the ACA, employers are required to offer essential health benefits. Grandfathered and self-insured employers are exempt from these ACA requirements.

CAPITALIZE ON SAVINGS FROM POSITIVE EXPERIENCE

For the years in which health care claim costs are below expectations, employers can add those savings directly to the bottom line of their profit and loss statement. With the passage of the ACA and proliferation of state health care mandates, employers are focused more than ever on ways to curb utilization costs. Methods include implementing strategies such as consumer directed health care, increased cost sharing, claim price transparency tools, specialty networks, value-based plan designs, and wellness programs. Self-funding can enhance these strategies by providing an employer with more leeway on how they design and fund such programs. Additional spending on appropriate strategies can generate an identifiable return on investment that goes to the employer and not the insurer.

BROKER/CONSULTANT FEES

Many insured employers do not understand the full cost of an advisor as the commissions are loaded in the fully insured rates and often invisible to the employer. By self-insuring, employers see the breakdown of costs their advisors charge and can manage those costs by implementing a fee-based or commission-based structure to fit the employer's needs.

UNDERSTAND POPULATION HEALTH RISK AND COST DRIVERS

Access to claim information under a self-insured model allows employers to begin to analyze the health conditions and high-cost chronic disease states within their population. Based on these findings, targeted programs can be implemented to impact costs. Obtaining detailed claim information in a fully insured environment is sometimes challenging, especially for smaller accounts.

Along with the benefits of self-insuring there are several issues that need to be clarified. As employers contemplate a self-funding option, several questions are raised:

What are the additional risks of self-funding?

How can employers control the additional risks of self-funding?

What is the worst case scenario?

How does self-insured accounting work?

What is stop loss insurance and how does it work?

What additional responsibilities do self-insured employers have?

WHAT IS THE RISK?

Of course, no one can predict the future with absolute certainty. In fact I have often said that the only number we know for sure that the claims will not equal is the number that we project. But we attempt to predict future risk and liabilities by observing historical performance. We use multiple years of claims cost then make certain assumptions, such as expected trend cost increases, claim fluctuation, plan design adjustments and administrative fees, and can then project costs forward.

And the client must understand that in any given year, the cost may well exceed the expected amount. This is a key element of the risk of self-funding that employers must realize before changing their funding. Some think that they will automatically save money by going self-funding. This is only true in the cost associated with the fixed cost. But it is not guaranteed when it comes to claims cost.

MANAGEMENT OF RISK – STOP LOSS INSURANCE

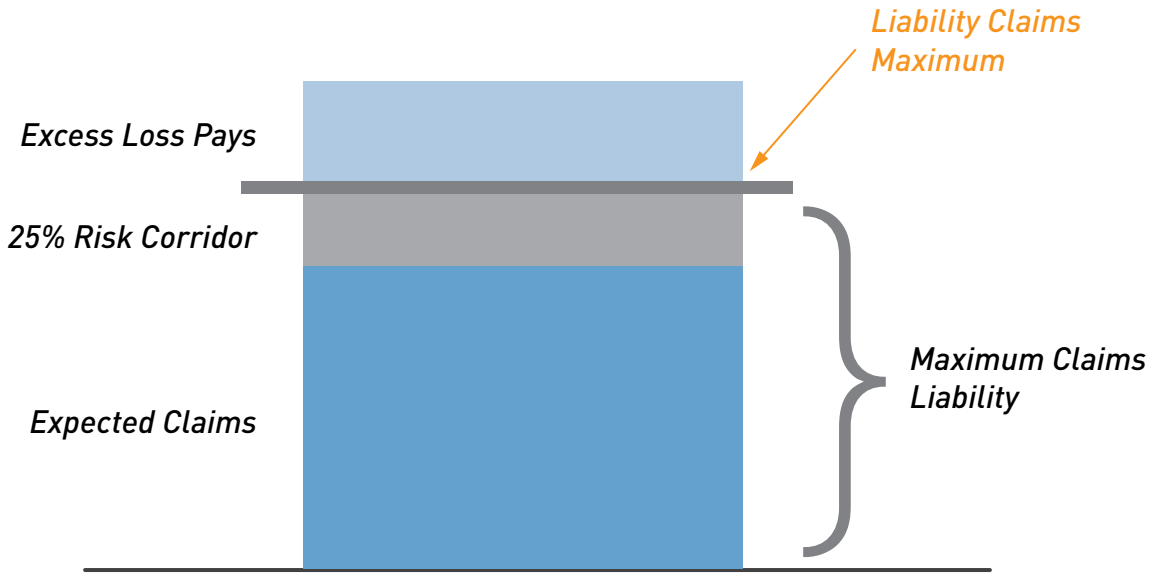
For an employer that has outsourced the risk of health care claim costs to an insurance carrier in a fully insured model, the move to self-funding can be an overwhelming proposition. The biggest concern is that of risk assumption and exposure to large loss claims. One very sick individual or a set of premature twins can incur millions of dollars in claims which could be devastating to the self-insured plan and the employer's business. Stop loss can minimize this risk.

Typically, the employer contracts with a health plan or third party administrator to administer the plan. Generally the employer will purchase stop loss coverage. The risk assumed by the stop loss program is regulated at the state level. However, minimum retentions can start as low as $5,000. Certain states have minimum stop loss levels such as $20,000 - $30,000.

No individual claimant's cost during the contract term will exceed the limit of the plan. All other claims submitted on that member (sometimes employee) during the remainder of the contract year would not count.

AGGREGATE STOP LOSS

To protect themselves from dramatic swings in claim costs, a self-funded employer contracts with a stop loss insurer to cap the exposure of having overall excessive claims cost during a plan year. A stop loss carrier provides protection for these catastrophic claims by providing insurance to cover the exposure over a certain dollar amount. The coverage is purchased by employers and funds the risk of the program rather than insure employers directly. These stop loss carriers issue policies that will pay when either an individual or aggregate claim exceeds a pre-determined dollar level or attachment point to cover frequency and severity risks. The attachment point is the level above which an excess amount of claims will be covered.

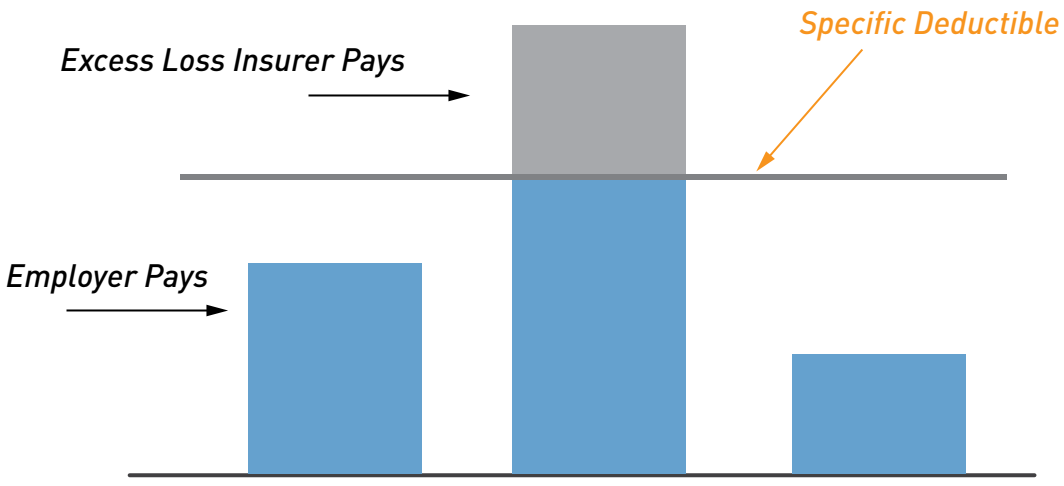


For example, an employer may purchase an aggregate insurance policy that would cover claims over 125% of expected cost. To further illustrate, let's assume that one year a large number of employees are hospitalized with the flu virus. On top of these claims several employees were traveling together and experienced an accident that required hospitalization, surgery and rehabilitation.

With these catastrophic events on top of the normal claims, the employer experiences 140% of expected claim costs. The stop loss carrier would cover the claims from 125% to 140% up to a certain threshold (typically $5 million).

SPECIFIC STOP LOSS

Specific insurance works in a similar manner, but for individual claims. Going back to our previously mentioned example of premature twins, let's assume that these twins incur costs of $1 million and $1.5 million each. If the specific attachment point were set at $250,000, the employer would be reimbursed by the stop loss carrier $750,000 for the first infant and $1.25 million for the second infant. In the example below each bar represents a single individual. The blue bar is the employer liability and the grey bar is the insurer's responsibility.



There is another aspect of Stop Loss Insurance that is important to understand. This is the "terms." If a contract is for 12/12 then the contract will reimburse for claims paid AND incurred in the current contract period. A claim that may have been incurred prior to the start of the contract period will not be considered for reimbursement. This is a particularly important provision that you want to make sure the client understands. If you have a 12/12 and services were rendered prior to the current contract period they will not be covered. To close this gap you can go with a 15/12 or an 18/12. The 15/12 means that if the claims were incurred in the last 15 months they will be eligible for reimbursement if paid during the current contract period. The 18/12 means if they were incurred in the last 18 months they would be covered.

The opposite side is sometimes seen as well. That would be a 12/15 or a 12/18. This means that claims incurred in the current period and paid by the paid limitation (15 or 18 months) then they are considered for reimbursement. Not as popular since you have the incurred hole if you drop or move coverage. Once you have a mature relationship with a carrier you want to get the contract converted to "Paid." That means the claim is covered regardless of incurral date. If the client is concerned about the possible gap in coverage from terminating you will want to negotiate a terminal stop loss limit.

We have developed a Stop Loss Model to assist in price evaluation. The model uses a very large database of claims information that is sorted on a per-member basis. Often Specific Stop Loss premium is market priced. The incumbent carrier offers a price and the competition bases their fee on the existing rates rather than the actual risk which causes an overstatement in premium.

The stop loss model gives you what the rate should actually be. The report is broken into two pieces. The lower half looks at the probability of a claim as well as the likelihood of multiple claims. Together this is used to build estimated claims cost and eventually a rate that should be charged. This enables us to look at the premium and tell for certain if the rate is in line with the risk. Many times it is but there are occasions where it is not.

Sample Company
Specific Stop Loss
4/1/2015 - 3/31/2016

ıployees: 162
mbers: 394

pecific Stop Loss	Incidence of Claims	Expected Claims per Year	Average Excess Per Claimant	Total Annual Cost	Pure Claim Cost			Claims Cost	Medical and Rx Premium PEPM	Annual Cost	Medical Only Premium PEPM	Annual Cost	Expected claims	Expected Cost
					PMPY	PMPM	PEPY	PEPM						
$200,000	0.13%	0.5	$ 224,353	$ 113,293	$287.79	$23.98	$699.34	$58.28	$77.70	$151,057	$74.00	$143,864	0.50	$113,293
$225,000	0.11%	0.4	$ 241,182	$ 101,658	$258.24	$21.52	$627.52	$52.29	$69.72	$135,543	$66.40	$129,089	0.42	$101,658
$250,000	0.09%	0.4	$ 256,689	$ 91,926	$233.52	$19.46	$567.45	$47.29	$63.05	$122,569	$60.05	$116,732	0.36	$91,926
$275,000	0.08%	0.3	$ 271,674	$ 83,682	$212.58	$17.71	$516.56	$43.05	$57.40	$111,577	$54.66	$106,263	0.31	$83,682
$300,000	0.07%	0.3	$ 287,753	$ 76,508	$194.35	$16.20	$472.27	$39.36	$52.47	$102,011	$49.98	$97,153	0.27	$76,508
$325,000	0.06%	0.2	$ 305,806	$ 70,295	$178.57	$14.88	$433.92	$36.16	$48.21	$93,727	$45.92	$89,264	0.23	$70,295
$350,000	0.05%	0.2	$ 319,811	$ 64,938	$164.96	$13.75	$400.85	$33.40	$44.54	$86,583	$42.42	$82,460	0.20	$64,938
$375,000	0.05%	0.2	$ 334,191	$ 60,253	$153.06	$12.75	$371.93	$30.99	$41.33	$80,338	$39.36	$76,512	0.18	$60,253
$400,000	0.04%	0.2	$ 349,497	$ 56,163	$142.67	$11.89	$346.68	$28.89	$38.52	$74,883	$36.69	$71,318	0.16	$56,163
$425,000	0.04%	0.1	$ 365,504	$ 52,350	$132.98	$11.08	$323.15	$26.93	$35.91	$69,799	$34.20	$66,476	0.14	$52,350

in Model

pecific Stop Loss	Likelihood of Claims									
	1	2	3	4	5	6	7	8	9	10
$200,000	39.6%	9.2%	1.5%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$225,000	34.4%	6.7%	0.9%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$250,000	30.1%	5.1%	0.6%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$275,000	26.5%	3.9%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$300,000	23.3%	3.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$325,000	20.5%	2.3%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$350,000	18.4%	1.8%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$375,000	16.5%	1.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$400,000	14.8%	1.2%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
$425,000	13.3%	0.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

To run the model we need expected claims for the period in question on a PEPM basis. We also would like to have the number of members. The spreadsheet handles the rest. Please note that this model provides the cost with and without drug included in the stop loss.

Anthem will provide a contract that is on an "employee" basis. All other carriers will provide a contract on a member basis. The Anthem contract is a better offering, but multiple large claims incurring in the same family unit are rare. The benefit of this is generally low, with more incidental type of claims being pulled into consideration. The best approach here is to get Anthem to quote it both ways so the client can fully understand their options.

AGGREGATING SPECIFIC STOP LOSS

Another form of stop loss product is called aggregating specific coverage. This type of coverage is for employers who can assume more risk and by doing so pay a lower premium. If the specific deductible is $50,000, there would be a second deductible, for example $100,000, an employer would need to meet before the insurer would pay. Once the second deductible of $100,000 was met for the year for the group, the insurer would reimburse all individual claims over $50,000.

When pricing an Aggregating Specific Stop Loss the carrier will generally reduce the stop loss premium by $1 for every $1 that the employer adds to the Aggregating Specific Stop Loss. The net pricing change then does not usually represent a good value since the carrier effectively receives a trumped up administrative and risk cost that remains in the rate. There are occasions, though, where it makes sense to the client so it should be something you understand. It is best to play this idea when the client is comfortable with the Specific Stop Loss limit but not quite there on the premium.

LASERING

Some stop loss carriers engage in a practice called "lasering." This is a method of decreasing risk for the stop loss carrier by excluding from coverage specific high-cost individuals from the population upon renewal. To further our example of the twins, let's assume that as the twins grow they have some congenital physical defects that require significant medical care over time. As the claims continue, year-after-year, the stop loss carrier is required to increase the stop loss premium in order to cover costs. To bring the overall stop loss premium down, the stop loss carrier will exclude the twins from coverage. The employer is now responsible for the full claim costs incurred by these twins, but coverage remains for the rest of the group.

WHAT IS IN AN EQUIVALENT RATE?

Funding rates, or funding factors, are the individual components of the self-funded plan cost. These components include the administrative fees, stop loss and an expected claims amount. For budgeting purposes, these funding factors are often converted to a more traditional "premium rate" that is called an equivalent rate. These look like fully insured premiums but should also generate a budget that is in line with the cost that you would get when using the funding factors. Equivalent rates are not premiums because premium connotes the transfer of risk and in a self-funded model there is no transfer of risk unless the stop loss carrier is engaged to cover the risk of the high cost claims. Equivalent rates are developed annually to provide a calculated estimate of the claims projection, administrative fees and other plan expenses anticipated during the plan year.

The equivalent rates contain the following elements:

Medical and prescription claims

Medical trend assumptions

Administrative fees

Stop Loss premium

Plan design risk adjustments

Age/sex or risk adjustments

Claim fluctuation margin

Other plan expenses (taxes, fees, etc.)

Medical and prescription claims are costs that are incurred as covered participants in the plan access care. These costs increase annually with typical medical and prescription drug costs increasing 7-10%. Medical claims comprise the largest portion of medical costs - typically about 80%. Prescription costs typically comprise about 20% of total medical costs.

ADMINISTRATIVE FEES

Administrative fees are paid to the third-party administrator, administrative service organization, or insurance company that manages the network, adjudicates and pays claims. A typical administrative fee can cost an employer $25 to $75 dollars per employee per month. Such costs are dependent on plan design complexity, size of the group, and whether or not other services are loaded in, such as wellness, disease management, vision, or other additional benefits. Traditional insurance carriers usually charge higher fees than independent third party administrators. Typically these administrative fees increase 2-5% per year and can be negotiated over multiple years. Larger groups have the most leverage in securing multi-year arrangements because of the large number of employees and participants in their population.

STOP LOSS PREMIUM

The stop loss premium is also included in the equivalent rates and can typically range anywhere from $40 for an individual to $180 for a family. Higher stop loss attachment levels have lower rates. These stop loss premium costs increase at a much higher rate than underlying medical trends because of the leveraging effect of the high attachment levels. Increases may be in the range of 15-20% depending on the size and experience of the group. The increases are often moderated by increasing stop loss attachment levels. Sometimes stop loss carriers will have a cap on increases as they spread the risk out over a large pool of insured participants. Carriers with these types of rate caps in place protect their customers from large rate swings and foster customer loyalty through good years when claims are running low, and bad years when claims are running high.

PLAN DESIGN FLEXIBILITY

Employers can modify their plan designs each year and adjust expected claims based on those modifications. For example, if an employer increases an office visit copay from $10 to $25, the impact to expected rates could be a decrease of anywhere from 1% to 3% depending on the number of office visits and expected office visits in the upcoming plan year. Tables and models to determine plan relativities and the value of plan design changes over time.

Additional adjustments to equivalent rates may be impacted by factors such as age, sex, or risk. Each year as a population ages, the risk to the group increases. The highest risk groups are females in childbearing ages, and older males. As females age out of childbearing years, their risk decreases.

Conversely as men age, their health risk increases significantly. Also, health risks in a given population can be used to adjust rates up or down, assuming data from a population health risk assessment or population risk information is available.

CLAIM MARGIN

Another useful tool that assists in managing year-to-year fluctuating claims is a claim fluctuation margin. A self-funded employer may use anywhere from 3% to 10% margin to include in the rates. This margin can be used to cover claims in years when claims are high, or may be used as a reserve in years claims perform at or below expectations. Depending on the philosophy of the employer, the margin may be excluded altogether from the rate development. Some employers may feel it is unnecessary to include this margin and that the pricing should reflect the true price of the underlying claim costs and trend.

Lastly, equivalent rates may include other taxes, fees, or expenses that are not classified as claims or administration. With the passage of the ACA, employers may choose to add in the transitional reinsurance tax and comparative effectiveness research fee. The two ACA fees/ taxes are described below.

	COMPARATIVE EFFECTIVENESS RESEARCH FEE	TRANSITIONAL REINSURANCE TAX
Purpose	A fee assessed on specific health insurance policies and employers offering applicable self-insured health plans. This fee goes to fund the Patient-Centered Outcomes Research Institute (PCORI) which will engage in research to be used by patients, clinicians, purchasers and policy-makers, to make health decisions and advance the quality and relevance of evidence-based medicine.	A fee assessed on specific health insurance policies and employers offering applicable self-insured health plans. This fee goes to fund the Patient-Centered Outcomes Research Institute (PCORI) which will engage in research
Key Elements	First payable in July 2013 $1 PMPY in year one; $2 in year two Indexed to 2019 Insured: Carriers are responsible (IRS Form 720) ASO: Employers are responsible (IRS Form 720)	Payable 2014 – 2016 Estimated per participant fee: TBD 1st payment Jan 1, 2015 Insured: Built in ASO: Employers are responsible

CAPTIVES

The equivalent rate is a proxy for premiums and provides a self-funded employer the flexibility to manage costs and contributions effectively over time.

Captives have been around for a number of years. Their origins were as a tax shelter for "odd" risk. For example, the employer may decide the risk of their CEO being hit by lightning while singing in the shower. I am sure that some executive somewhere has been struck by lightning while singing in the shower. The employer would place funds into the Captive trust to cover that risk. In recent years the IRS has become a bit uncomfortable with these arrangements and has begun auditing the cash flow into these documents. While no one is sure who originally thought of the idea, someone did have the idea that you could put your medical cost into a Captive arrangement and in turn shelter that money and retain the insurance cost pieces.

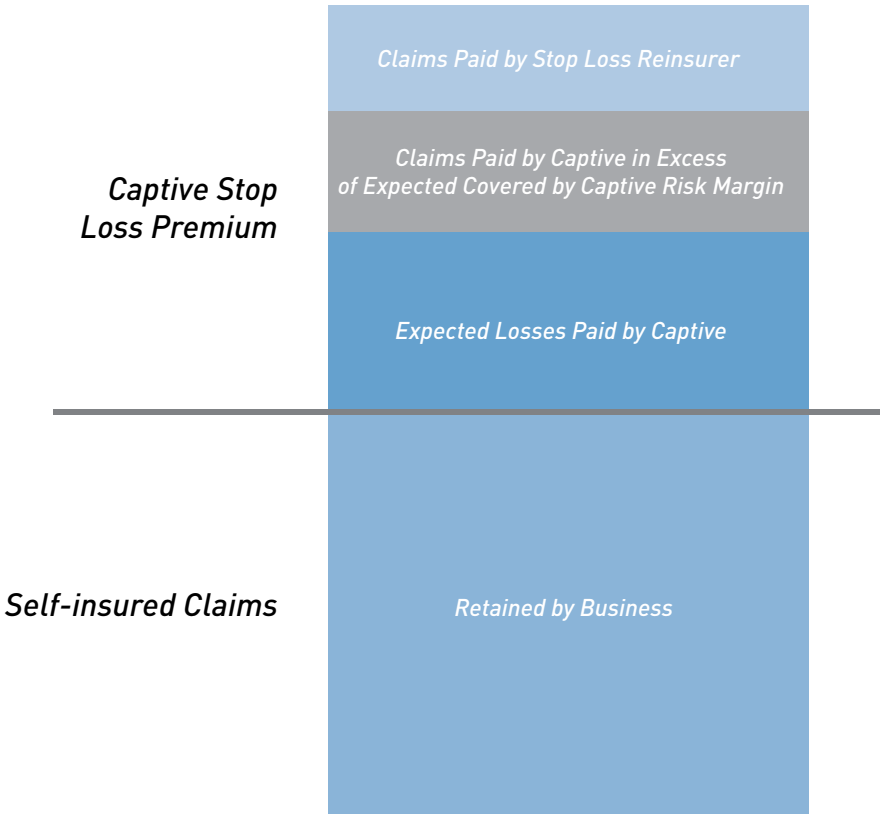
A captive insurance entity can be created to hold stop loss and other types of benefit and business risks. A captive is an insurance or reinsurance company, specifically established to insure or reinsure the risks of its parent or associated third parties. These captives can generate savings of up to 25% of the stop loss premium.

There are several types of captives designed to meet different needs. A few of them follow:

TYPE OF CAPTIVE	OWNERSHIP	PURPOSE
Single Parent (Pure) Captive	Single Employer	Cost savings and investment retention
Group Captive	Group Members	Pool risk and decrease the cost of stop loss with a captive
Risk Retention Groups	Group Members	Designed to hold and manage the risk of several entities for the employer's liability associated with health care and can write business in multiple states.
Association Captives	Association	Created for the use of like employers
Agency Captive	Broker	Established by brokers on behalf of their clients
Rent-a-captive or cell facilities	Owned by a sponsor or sponsors	Allows employers or groups of employers to have captive benefits without a captive

For a captive, the stop loss premiums and risk are held and managed by the captive program and paid out as catastrophic claims are incurred. Premiums are paid into the captive and segregated into loss funds – held to reimburse losses as they occur, operating costs – that reimburse the captive manager, and reinsurance premiums for aggregate protection.

As catastrophic claims are incurred, the claim amounts below the deductible are paid out from corporate operating funds. Claim amounts over the deductible are then reimbursed by the captive up to a certain threshold. Once the expected loss threshold has been met the additional portion of the claim is covered by the loss funds retained by the captive. In the event the aggregate claims exceed expectations reinsurance covers the excess.



A captive can assume risk on a fronted or direct basis. A fronted arrangement is where an insurer stands "in front" of the captive to provide administrative simplicity and compliance. Their fee adds some cost and is usually a percentage of the overall premiums.

BENEFITS OF A CAPTIVE

Along with the potential savings, one of the biggest advantages to establishing a captive is that all of the profit and control remain under the employer's oversight. Furthermore, a stop loss captive is not subject to ERISA and avoids the ERISA "Prohibited Transaction" or MEWA classification. The Captive that we market through Scott Insurance is a like a Group Captive or a Risk Retention Group Captive. The loose association of groups pools their funds to provide an intermediate level of stop loss which is capped off by a larger traditional stop loss limit.

A captive can be a valuable tool for employers of virtually any size as it allows total transparency of cost, access to claims data, asset growth and retention, and a decrease in insurance costs that would normally be paid to the insurer. Employers that implement a captive should remember that the cost savings opportunities will not be incurred immediately, but are achieved over time.

CASH FLOW

As claims fluctuate from month-to-month, the employer covers the costs of claims typically on a weekly basis. The administrator will draw down funds out of a bank account funded by the employer. For the high dollar claims that go to stop loss coverage, there can be a delay on reimbursements back to the employer while the claim is processed, eligibility verified, and proof of coverage issues are resolved. This can strain employer cash flows.

COMPLIANCE

A self-funded employer needs to be aware of the compliance issues related to self-funding, including the requirement to file a form 5500 and related schedules, comply with the Mental Health Parity Act and additional laws and requirements of ERISA, and most importantly the new requirements under the ACA that apply equally to fully funded and self-insured plans. All of these new issues and administrative tasks should be identified and addressed before or during the implementation of the self-funded plan so as to prevent any surprises.

FIDUCIARY RESPONSIBILITY

Under a self-insured model, the employer now bears the sole responsibility to ultimately approve or deny claims. This includes claims that have been appealed. This responsibility, however, can and should be outsourced to the TPA, ASO, or insurance company paying the claims. This may prevent the employer from being exposed to lawsuits or falling into the trap of becoming the required medical reviewer on all appealed claims. If the employer starts to make exceptions and approve some claims, but not others, it could open them up to claims that they arbitrarily and capriciously cover certain appealed claims, an explicit violation of a fiduciary's duties. By outsourcing this function to the administrator, these liabilities may be avoided.

HIPAA

Another area of significant liability for self-insured employers has to do with the receipt, storage and transmittal of protected health information (PHI). A self-insured employer has access to claims information that can be identifiable down to the individual employee and dependent level. Access to this information must be controlled, limited and monitored under strict policies and procedures outlined in the HIPAA regulations. Release of such information, both accidental and deliberate, are subject to fines and penalties under the law. Employers are well advised to familiarize themselves with these regulations and make the appropriate adjustments in their policies and procedures to fully comply.

SUMMARY

AS AN EMPLOYER BEGINS TO CONSIDER THE PROS AND CONS OF SELF-FUNDING, THERE ARE MANY ISSUES TO CONSIDER. FOR AN EMPLOYER THAT USES A FULLY INSURED MODEL, A CHANGE TO SELF-FUNDING REQUIRES CHANGES TO ACCOUNTING, BANKING, AND ADMINISTRATIVE PROCESSES. IT ALSO REQUIRES EXPERTISE THAT MAY NOT BE READILY AVAILABLE IN-HOUSE, SUCH AS ACTUARIAL SUPPORT, CONSULTING ADVICE, VENDOR MONITORING, AND DATA ANALYSIS. ALL OF THESE SERVICES WILL REQUIRE ADDITIONAL EXPENSE, BUT THE SAVINGS AND BENEFITS OF SELF-FUNDING, SOME IMMEDIATE AND OTHERS LONG-TERM, FAR OUTWEIGH THE COST OF THESE SERVICES.

ONCE AN EMPLOYER HAS MADE THE CONVERSION TO SELF-FUNDING, THEY CAN ACHIEVE SAVINGS DEPENDING ON ACTUAL CLAIMS AND FEES. SELF-INSURANCE REMAINS A POWERFUL WEAPON IN THE WAR ON GROWING BENEFIT COSTS. EMPLOYERS WHO MAKE THE CHANGE CAN REAP IMMEDIATE BENEFITS AND AVOID, OR AT LEAST SLOW DOWN, SOME OF THE SIGNIFICANT AND INEVITABLE COST INCREASES ON THE HORIZON.

EMPLOYEE BENEFITS CONSULTING

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