Self-Funding Of Medical Plans

The self-funding of a medical plan requires that the reader become familiar with certain insurance terms and concepts.

Therefore, we have prepared a list of definitions as they are used in this report.

Self-Insured Plan ...

Refers to an employee benefit plan where the employer alone is liable for all benefits provided for under the provisions of the plan.

Self-Funded Plan ...

Refers to an employee benefit plan where the employer will retain the liability for a certain portion of the benefits liability and an insurance company will pay the excess balance, if any.

Re-insurance ...

Is a process of where an employer will convert a self-insured plan into a self-funded plan by shifting liability that it does not want to retain, through the purchase of insurance (i.e. re-insurance) from an insurance company. This process is also known as the purchase of "stop loss" insurance.

Stop Loss Re-insurance Policies

Stop loss re-insurance policies / contracts come in a variety of sizes, shapes and flavors. The first thing that you have to analyze is the general type of contract. There are only two, which are as follows:

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Indemnification Re-insurance Contract

Is a type of insurance policy / contract that pays you immediately for losses that you have incurred and which were insured. This type of contract is what most people think of as a typical insurance arrangement.

Reimbursement Re-insurance Contract

Is a type of insurance policy / contract that will reimburse you, usually only after the end of a policy or contract year, for losses that you have incurred, which were insured, for which you have paid out of your own funds. This type of contract requires you to spend your own funds then wait to be reimbursed by the insurance company. This type of policy always has lower premiums than an indemnification contract, However, the important consideration in this type of contract is the value of the loss of use of your funds.

Next, you have to then determine which claims will be covered under either of the above types of contracts. Each reimbursement and indemnification re-insurance contract comes in three (3) varieties, which are as follows:

Incurred Contract ...

Refers to a contract which provides coverage for eligible claims if the date of service of medical bills falls within the "contract" or "policy" year. It does not matter when the bills are submitted for payment as long as the dates of service are rendered within the "contract" or "policy" year. Almost all of these types of contracts will include a time limit as to when claims must be submitted after the end of the contract or policy year.

Paid Contract ...

Refers to a contract which provides coverage for eligible claims only if they are paid within the contract or policy year regardless of the date of service of the medical bills.

Incurred and Paid Contract ...

Refers to a contract which provides coverage for eligible claims only if both the dates of service and payment of medical bills fall within the contract or policy year.

There are two (2) types of liabilities that an employee benefit plan faces and for which it can protect itself. These are:

1. A very large claim by one, two or more individuals; and

2. Lots of claims by lots of individuals.

Therefore, a plan can reinsure its exposures both on a specific individual basis and/or on an aggregate of claims basis.

Specific Re-insurance Coverage

Each individual participant in an employee benefit plan (employee and dependents) has certain specific insurance coverage; i.e., $2,000,000 per lifetime with a $50,000 deductible (NOTE: 1.) Do not confuse with the plan that the participant is covered under which may only have a $200 deductible and unlimited lifetime maximum benefit 2.) Since the ACA, some re-insurance companies have policies available with unlimited lifetime maximums.). The sum of all these individual coverages is referred to as the specific contract. Each participant is not issued a separate policy, but is covered under a single master contract.

$2,000,000	1	2	3	4	5	6	---------- >
$50,000	Deductible for each specific individual						

If the plan covered 300 employees and all were married and we further assumed that each employee had three dependents (spouse and two children), then the employer's maximum liability for the 1,200 participants

would be 1,200 x $50,000 or $60,000,000. To solve this potentially huge liability exposure problem, the following re-insurance contract is available:

Aggregate Re-insurance Coverage

Is a type of insurance contract that limits the liability of a plan sponsor for all eligible claims in a plan year. An example would be a $60,000,000 policy limit with a $1,250,000 deductible. An anticipated annual "loss fund" or projected claims experience is calculated by the insurance company. The loss fund is then usually multiplied by 125% to determine the attachment point or deductible for the aggregate policy. Using the example above, the re-insurance company calculated an anticipated "loss fund" of $1,000,000 and then multiplied it by 1.25 to arrive at the $1,250,000 attachment point or deductible.

Using our example for the specific contract, the plan can now be protected or can reinsure itself as follows:

<table>
<tr><td>$2,000,000</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>---------- ></td></tr>
<tr><td>$50,000</td><td colspan="5">$1,250,000
Loss Fund</td><td colspan="3">60,000,000
---------->
Aggregate Re-insurance</td></tr>
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Therefore, the plan will now only incur the following liabilities: for any one specific individual, the maximum liability will be $50,000; and, for the plan as a whole it will be $1,250,000. The rest in re-insured.

Loss Fund Factor ...

This is normally expressed as a monthly, per employee only, anticipated claims expense that is calculated by the actuaries at the insurance company that is offering the re-insurance coverage. Normally, you could expect it to be conservative (high) so that they can limit their liability and shift the risk to the employer.

It should be noted that "specific re-insurance contracts" are offered on an indemnification and reimbursement basis. "Aggregate re-insurance contracts" are normally only offered on a reimbursement basis. The reason for this is that since the loss fund is an accumulation of monthly units, the final deductible or attachment point is not determined until the end of the plan or contract year and, therefore, the insurance company's liability is not determined until the end of the year. It is only then that the plan sponsor can be reimbursed for the losses that are covered by the aggregate contract. An important consideration to keep in mind when purchasing stop/loss insurance coverage, is the possibility that the insurance company may attempt to impose a minimum deductible on the aggregate contract even though it is supposed to be an accumulation of the monthly units.

There are many advantages and disadvantages to self-funding medical/hospital plans. We have identified and enumerated some of each as follows:

Advantages ...

1. Opportunity to reduce cash outflows. Money is only paid as claims are incurred.

2. Opportunity to substantially reduce cost of employee benefit plan with a guarantee of maximum plan cost.

3. Ability to greater manage and control claim utilization taking into consideration coordination of benefits for working spouse, workers' compensation, subrogation, etc.

4. Ability to be the captain of your own ship.

5. Ability to manuscript benefits tailored to your specific needs under the federal Employee Retirement Income Security Act of 1974 (ERISA) rather than buying an "off the shelf" insurance company "package" with that ACA mandates and being subject to state mandated coverages.

6. Savings that are achieved over a fully insured arrangement are yours to keep each year. They do **NOT** have to be reserved in anticipation of future claims like an experience rated insurance contract.

Disadvantages ...

1. In very rare instances, aggregate re-insurance contracts may not be available with high enough indemnity limits or have such high deductibles that they do not satisfy your needs.

2. Due to the nature of re-insurance contracts, there is generally a time limit after the end of the plan year in which claims can be submitted and paid for the prior plan year to be included in the loss fund and, therefore, subject to the re-insurance. This time limit is generally three (3) to five (5) months and is often referred to as the "tail." That is not usually a problem since the Doctors, Hospitals and Pharmacies are looking for reimbursement well prior to that date.

3. Generally, a conversion privilege to an individual policy is not available in a self-funded plan. However, this is often handled through a continuation privilege through the plan for a set period of time (COBRA). This is generally far preferable to the conversion option offered by an insurance company under a fully insured arrangement. Rather than offering your former employees, and their dependents, if any, an inferior plan of limited benefits at a premium that includes a significant conversion charge "load" from the insurance company for each former participant who elects the guaranteed conversion option, those participants can stay under your plan for the short period of time that they generally need the coverage.

4. The aggregate re-insurance is generally a reimbursement contract with the deductible or loss fund being the accumulation of monthly units. It is possible that the employer would have to finance any losses in excess of the loss fund prior to the end of the plan, but those losses would be reimbursed after the end of the plan year. However, we have often been successful in negotiating with re-insurance carriers to at least advance funds when aggregate claims paid exceed 150% of the anticipated attachment point.

5. Since self-funding is not your typical fully-insured prospective rated contract, this type of arrangement requires that the employer fully understand the arrangement so that its benefits can be fully appreciated and utilized.

6. Upon termination of the re-insurance and/or Third Party Administrator contracts, a great deal of care must be taken to handle the "run-out" and/or "run-in" of claims; pending claims; incurred but not yet reported claims, etc. during the transition of providers. If not done correctly, potentially significant liabilities could be incurred by the employer for claims that "fell through the cracks". Be sure and seek experienced counsel and advice during these types of transitions.