



# TO INSURE OR SELF INSURE THAT IS THE QUESTION

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## CONSIDERATIONS

- FINANCIAL CONSIDERATIONS
- ADMINISTRATIVE CONSIDERATIONS
- COMPLIANCE CONSIDERATIONS
  - FOCUS ON FULLY INSURED OPTION

## INSURE

### **PROS - Financial**

- KNOWN MONTHLY FINANCIAL EXPENDITURE
  - ALLOWS FOR EASIER BUDGETING AND FINANCIAL PLANNING
  - INSULATES EMPLOYER FROM MONTHLY FLUCTUATION OF CLAIMS
  - TAKE ADVANTAGE OF INSURANCE COMPANY'S NEGOTIATED PROVIDER DISCOUNTS

## INSURE

### **PROS – Financial (Continued)**

- DEMANDS LESS KNOWLEDGE OF RISK/FINANCES FROM BUYER
  - VARIATIONS ON PURE RISK CONTRACTS CAN REQUIRE A MORE EDUCATED BUYER
  - VARIATIONS ON PURE RISK CONTRACTS CAN COME CLOSE TO MIMICKING FINANCIAL ADVANTAGES OF SELF FUNDING WHILE MINIMIZING DISADVANTAGES
  - ACCEPT WHERE PROHIBITED, THERE IS SOME CORRELATION BETWEEN UNDERLYING RISK OF SPECIFIC GROUP AND PREMIUM

# INSURE

## **PROS – Administrative**

- GENERALLY MORE STREAMLINED ADMINISTRATIVE PROCEDURES
  - INSURANCE COMPANY EXPENDS SIGNIFICANT RESOURCES IN ACHIEVING ADMINISTRATIVE EFFICIENCIES
  - EMPLOYER INSULATED FROM COSTS OF IMPLEMENTING ADMINISTRATIVE PROCEDURES DUE TO COMPLIANCE, SUCH AS HIPAA
- INSURANCE COMPANY ASSUMES RESPONSIBILITIES FOR PROVIDER RELATIONS, NEGOTIATIONS AND NETWORK MAINTENANCE

# INSURE

## **PROS – Administrative (Continued)**

- LEVERAGE INSURANCE COMPANY'S EXPERTISE IN
  - CLAIM ADJUDICATION
  - COST CONTAINMENT OPPORTUNITIES
    - DISEASE MANAGEMENT
    - PRODUCT DEVELOPMENT
- INSURANCE COMPANY PROVIDES DIRECT ACCESS TO BENEFIT QUESTIONS

# INSURE

## **PROS – Compliance**

- INSURANCE COMPANY MUST BE LICENSED IN STATE
  - FINANCIAL FILING REQUIREMENTS
  - FORMS FILING REQUIREMENTS
- AGENTS MUST BE LICENSED
- LEVERAGE INSURANCE COMPANY'S LEGAL RESOURCES TO ENSURE COMPLIANCE WITH ONGOING CHANGES AT FEDERAL AND STATE LEVEL

# INSURE

## **PROS – Compliance (Continued)**

- STATE REGULATORY AGENCIES
  - ENSURE SOLVENCY OF INSURANCE COMPANIES/HMOS
    - REVIEW OF PERIODIC FINANCIAL REPORTS
      - QUARTERLY
      - ANNUAL
      - TRIENNIAL
  - PROVIDE CONSUMER PROTECTION
    - MANDATED BENEFITS
    - APPEALS PROCESS
    - PROVIDER NETWORK MINIMUM REQUIREMENTS
    - MARKET CONDUCT REVIEWS

# INSURE

## **CONS – Financial**

- INSURANCE COMPANY SETS PREMIUMS
- THEORETICALLY, PREMIUMS WILL BE HIGHER THAN ANALOGOUS CLAIMS PLUS ADMINISTRATION
  - PREMIUM TAX (WHERE APPLICABLE)
  - ASSESSMENTS (GUARANTY FUNDS, HIGH RISK FUNDS, ETC.)
  - MARGIN IN CLAIMS AND TRENDS
  - INSURANCE COMPANY PROFIT

# INSURE

## **CONS – Financial (Continued)**

- MUST COMPLY WITH MANDATED BENEFITS WHICH MAY RAISE COST OF BENEFITS
- CAN ONLY OFFER BENEFITS BEING MARKETED BY INSURANCE COMPANY
  - LARGE EMPLOYERS HAVE MORE INFLUENCE OVER OFFERING OPTIONS THAN SMALL EMPLOYERS
- MUST COMPLY WITH RATING LIMITATIONS, WHERE APPLICABLE

# INSURE

## **CONS – Administrative**

- GENERALLY MUST ADAPT TO ADMINISTRATIVE PROCEDURES OF INSURANCE COMPANY
  - MAY OR MAY NOT BE CONSISTENT WITH INTERNAL PROCEDURES
  - WILL HAVE LITTLE INFLUENCE ON PROVIDER NETWORK
    - IF PROVIDERS DELETED FROM NETWORK, EMPLOYER MAY HAVE TO CHANGE INSURANCE COMPANIES TO RETAIN
    - EMPLOYEE COMPLAINTS ABOUT PROVIDER NETWORK AND/OR LOWER BENEFITS

# INSURE

## **CONS – Administrative (Continued)**

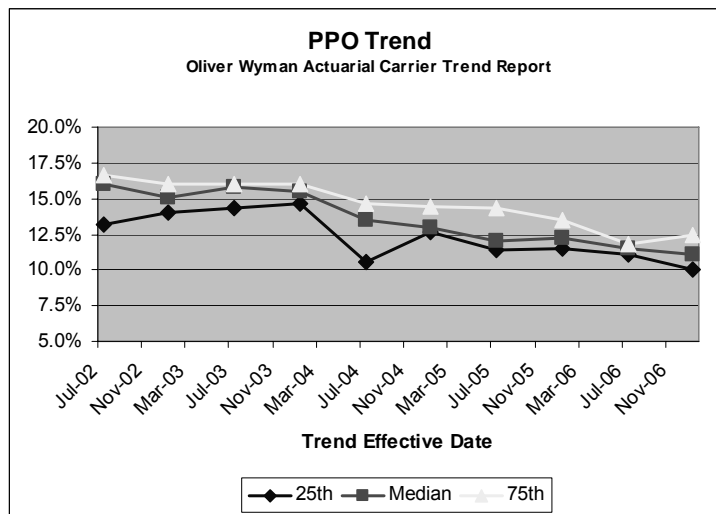
- DIFFICULT TO CUSTOMIZE BENEFIT PLAN
  - MANDATED BENEFITS MAY PRECLUDE SOME OPTIONS
- LIMITATIONS ON THE NUMBER OF BENEFIT PLANS AVAILABLE TO EMPLOYEES
  - MORE COMMON IN SMALL EMPLOYER PLANS WHERE OFTEN THE ENTIRE GROUP MUST PURCHASE THE SAME BENEFIT PLAN

# INSURE

## CONS – Compliance

- COMPLIANCE REQUIREMENTS FOR FULLY INSURED PLANS RAISE COSTS
- MUST ACCEPT INSURANCE COMPANY'S LEGAL INTERPRETATION OF STATUTES
- INSURANCE COMPANY MAY ADOPT A MORE CONSERVATIVE INTERPRETATION OF THE LAW BECAUSE OF SYSTEM RESTRAINTS AND/OR NUMBER OF GROUPS INSURED
- FOR EMPLOYERS OPERATING IN MULTIPLE STATES, THERE MAY BE MATERIAL DIFFERENCES IN BENEFIT REQUIREMENTS, PARTICIPATION REQUIREMENTS, NETWORK REQUIREMENTS THAT RESULT IN PERCEIVED INEQUITIES AMONG EMPLOYEES

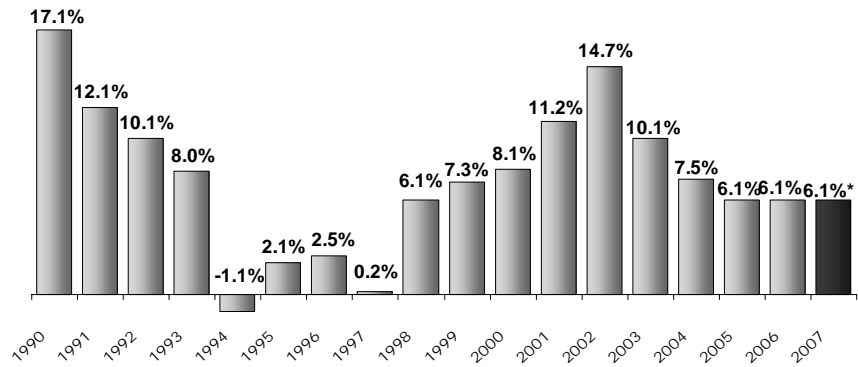
## Trends



# Trends

Annual change in total health benefit cost from 1990-2007

Cost growth levels off at 6.1%

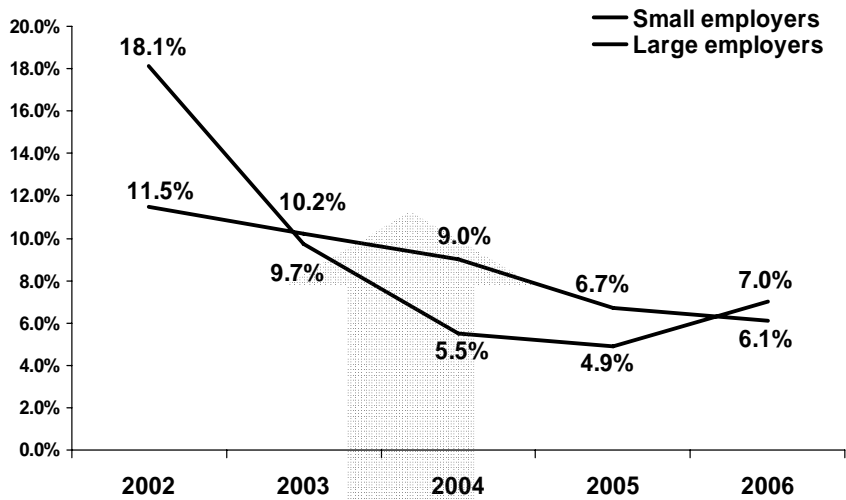


**Note:** Results for 1990-1998 are based on cost for active and retired employees combined. The change in cost from 1998-2007 is based on cost for active employees only.

\* Average increase projected for 2007 after changes to plan design

# Trends

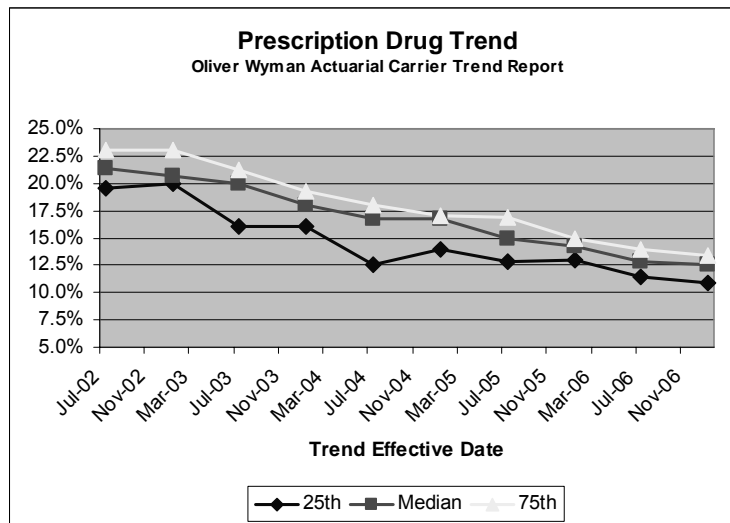
Cost jumps for small employers



## Trends

- DIFFERENCES BETWEEN THE CARRIER TRENDS AND EMPLOYER TRENDS
- CARRIER TRENDS ARE PRICING TRENDS AND DO NOT REPRESENT ACTUAL INCREASES NOR DO THEY REPRESENT IMPACT OF BENEFIT BUY DOWNS
- PREMIUM INCREASES COULD BE GREATER OR LESS THAN PRICING TRENDS DEPENDING UPON EMERGING EXPERIENCE
- EMPLOYER TRENDS REFLECT CHANGES AFTER IMPACT OF BENEFIT BUY DOWNS

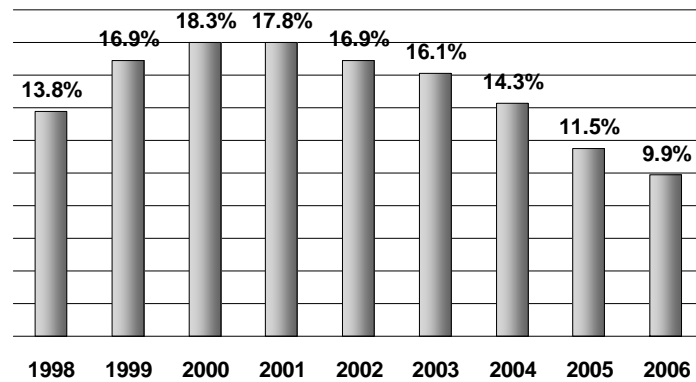
## Drug Trends



## Trends

### Prescription Drug Trend

Cost increase in primary medical plan for large employers



## Trends

- DRUG TRENDS MUCH CLOSER BETWEEN CARRIER TREND SURVEY AND EMPLOYER SURVEY
- BUY DOWNS APPEAR TO HAVE SMALLER IMPACT

## What Constitutes “Fully Insured” vs. “Self Funded”

### NAIC MODEL BILL

- MINIMUM SPECIFIC STOP LOSS \$20,000
- MINIMUM AGGREGATE STOP LOSS
  - GROUPS  $\leq$  50 (DOES NOT INDICATE WHETHER EMPLOYEES OR MEMBERS)
    - “LOWER THAN THE GREATER OF”
      - \$4,000 TIMES NUMBER OF MEMBERS
      - 120% OF EXPECTED CLAIMS
      - \$20,000
  - GROUPS  $>$  50
    - 110% OF EXPECTED CLAIMS

## What Constitutes “Fully Insured” vs. “Self Funded”

### MARYLAND LAWSUIT

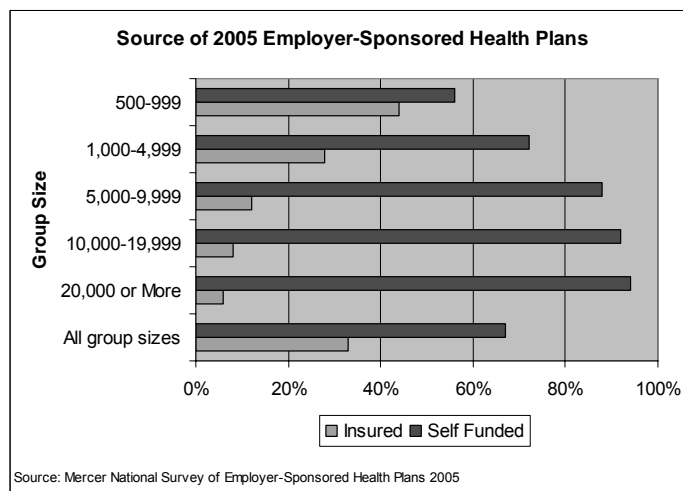
- AMERICAN MEDICAL SECURITIES WON
- ABANDONED PURSUIT OF SELF FUNDED OPTION FOR SMALL EMPLOYERS
  - EFFICIENT ADMINISTRATIVE SYSTEM
  - DIFFICULT FOR AGENTS TO EXPLAIN
  - DIFFICULT FOR GROUPS TO FULLY UNDERSTAND
  - RESULTING LIABILITY ISSUES

DOESN'T APPEAR TO BE SIGNIFICANT MOVEMENT  
TOWARD SELF FUNDING FOR EMPLOYER GROUPS  
 $\leq$  50 EMPLOYEES

## Who Should Consider Fully Insured Plans

- EMPLOYER GROUPS THAT CANNOT SUSTAIN SIGNIFICANT FLUCTUATION IN CLAIMS
  - GROUPS WITHOUT ACCESS TO SIGNIFICANT CAPITAL
  - MUNICIPALITIES, SCHOOL BOARDS, COUNTIES, STATE GROUPS
  - UNION GROUPS THAT HAVE NEGOTIATED CONTRIBUTION RATES AND DO NOT HAVE SIGNIFICANT SURPLUS
  - ANY GROUP, SUCH AS ASSOCIATIONS, THAT HAVE DIFFICULTIES ASSESSING MEMBERS FOR ANY ADVERSE CLAIM FLUCTUATIONS
- EMPLOYER GROUPS WITH HIGHER-THAN-AVERAGE MORBIDITY
  - ESPECIALLY TRUE IF RATE LIMITATIONS ARE PRESENT
  - SOMETIMES “PRESTIGIOUS” GROUPS RECEIVE EXTREMELY FAVORABLE RISK RATES
- EMPLOYER GROUPS THAT DO NOT HAVE THE FINANCIAL EXPERTISE, ADMINISTRATIVE OR LEGAL RESOURCES TO SUPPORT SELF FUNDED OPTIONS

## Who Should Consider Fully Insured Plans



- Current State of Market
- Insured
- Self Funded

Truth is Stranger than Fiction

# Third Party Administration

Lynn Brunner, ASA, MAAA  
VP, Pricing & Actuarial Services  
Fiserv Health, Inc.

# Third Party Administration

- What needs to be done
- How to select a Third Party Administrator (TPA)

## What needs to be done

- Select a broker that understands self-funding
- Request for proposal (RFP) process
- Determine services that you wish to receive quotes on
  - Medical, dental, flexible spending, COBRA
- Define your plan

## Define your plan

## Define your plan

- Prepare your plan document
  - Networks
    - Access to facilities/providers
    - Discounts
    - Primary, secondary, travel, specialty networks
  - Plan benefits
    - Deductible, coinsurance, LTM, OOP are easy
    - Other covered benefits
      - Pharmacy, Vision, wellness, transplant, usual & customary levels, etc.....

## Define your plan continued

- Plan benefits
  - Excluded benefits/internal limits
    - Experimental, investigational, fertility
    - Nervous, Mental, Substance Abuse
    - Transplants
    - State mandates (pre-empted by ERISA)

## Define your plan continued

- Eligibility
  - Who is covered/plan definitions?
    - Full Time Status (32, 35, 40 hours?)
    - Part Time (are they covered?)
    - Retiree?
    - Student status

## Define your plan continued

- Other plan benefits
  - Appeals/Fiduciary (first & second level)
  - Pre-cert (IP, OP, MRI's, etc..)
  - Consumer driven/wellness initiatives
    - Care Targeted Benefits for managing chronic conditions
    - Wellness Incentives to keep the healthy that way

You're still not done

## What else needs to be done

- Banking
  - TPA will process claims direct from account
  - Reconciliation
- Stop-loss
  - How much risk are you willing to take
  - Which markets do you want to go to
- Administrative Service Agreement (ASA)

## What Else cont...

- Reporting
  - 5500/DOL
  - 1099 reporting
  - Financial reporting
    - Budgeting/forecasting
    - Reserving/liabilities
- Implementation

## GIVE ME YOUR CHECKBOOK



## How to select a quality TPA

- What products do they offer
- Tools available
  - Plan management
  - Members
- Important things to look for in your TPA

## Products

- Medical
- Pharmacy
- Consumer driven
- FSA
- COBRA
- Care Management
  - UM/CM
  - Disease Mgmt
  - Maternity Mgmt
  - Lifestyle Mgmt  
(Health & Wellness)

## Understand the services

- What services are included in the fees ???
  - Run-in/run-out claim processing
  - ID Cards
  - Plan document preparation/amendments
  - Reporting
  - Communication materials
  - Outside vendor interfaces
  - Minimum enrollment
  - Pharmacy (look for hidden costs)

## Plan management tools

- Plan reporting
- Eligibility updates
- Online check register
- Legislative updates
- Educational material

## Employee tools

- Easy access to online tools
  - External sources (Web MD, ....)
  - PPO Directories and plan documents
  - Pharmacy (mail) refills
- Health Risk Assessment
- Claim inquiry
- Plan comparison tools

## Quality measures for TPA's

The URAC accreditation process demonstrates a commitment to quality services and serves as a framework to improve business processes through benchmarking organizations against nationally recognized standards. For more on URAC, visit [www.URAC.org](http://www.URAC.org)



SAS70 audit or service auditor's examination is widely recognized, because it represents that a service organization has been through an in-depth audit of their control activities, which generally include controls over information technology and related processes.

## Assess claim controls

- EDI and auto-adjudication levels
- Large claim review
- Unbundling of charges & excessive charges
- Subrogation
- Suspect billing practices
- Claim performance (accuracy, turnaround, speed to answer etc..)

## Other qualities to look for

- Depth of expertise
  - Customer service reps and claim processors
  - Account Management
  - Actuarial and underwriting (benefit modeling, reserving, claim projections)
  - Legal/compliance (plan updates)

## Technology platforms

- Claim system rented or owned
  - Flexibility
  - Integration
  - Privacy/security controls
  - New Development (i.e. consumer driven)
- Stoploss reporting
  - Automation
  - Timeliness

You decide who you  
want handling your  
checkbook

# Self-Funding/ASO

Chandler Lincoln, ASA, MAAA  
VP, Stop Loss Business Development  
StarLine Group

## Self-Funding Basics

- Definition: Self-Funding
  - Employer funds/pays its own claims (usually medical)
  - Employer delegates administrative responsibilities to a TPA / Insurer / HMO
  - Employer can manage its exposure to catastrophic or high-cost claims expense by purchasing Stop Loss (excess risk)
- ERISA (1974)
  - Recognized Self-Funded Plans
  - Specifically exempts most self-funded employee benefit plans from state-mandated benefits [ERISA Section 514(b)]

## Employer Considerations – Medical Plan

- Benefit Design
- Funding Considerations
- Risk Considerations
- Administrative Considerations

## Self-Funding – Benefit Design

- Flexible - Employer Determined
- Not Subject to State Mandates
- Same Plan - Many Locations
- Mid Year Plan Amendments
- Extra Contractual Coverage

## Self-Funding – Funding Considerations

- Cash Flow
- Reserve Interest Retained by Plan
- Lower Premium Tax
- Reduced Carrier Profit & Risk Charges
- Cost of Administration

## Self-Funding – Risk Considerations

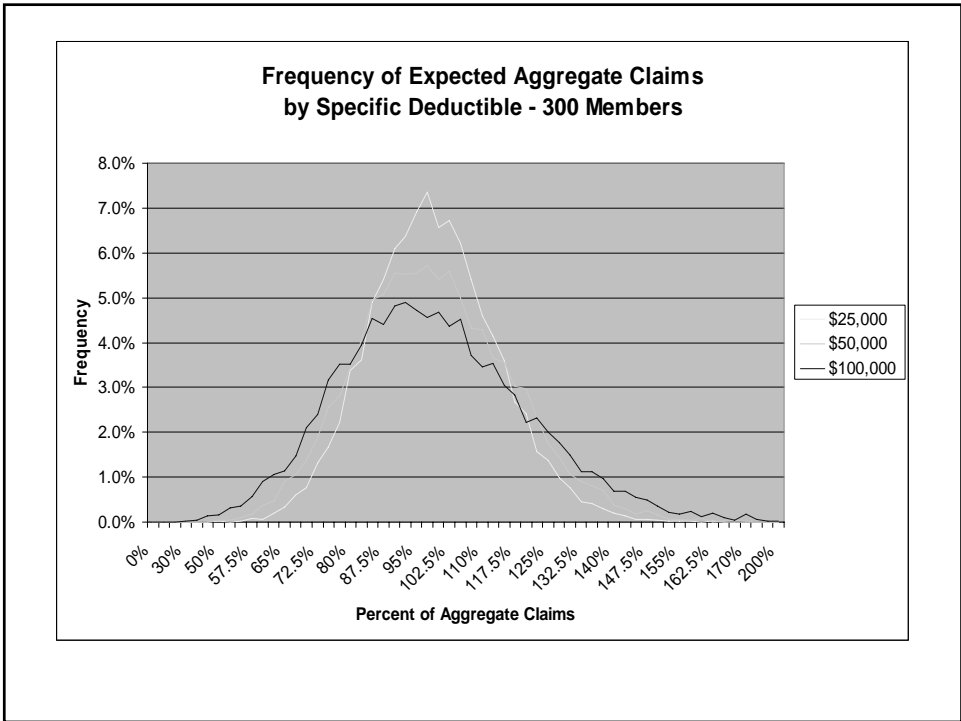
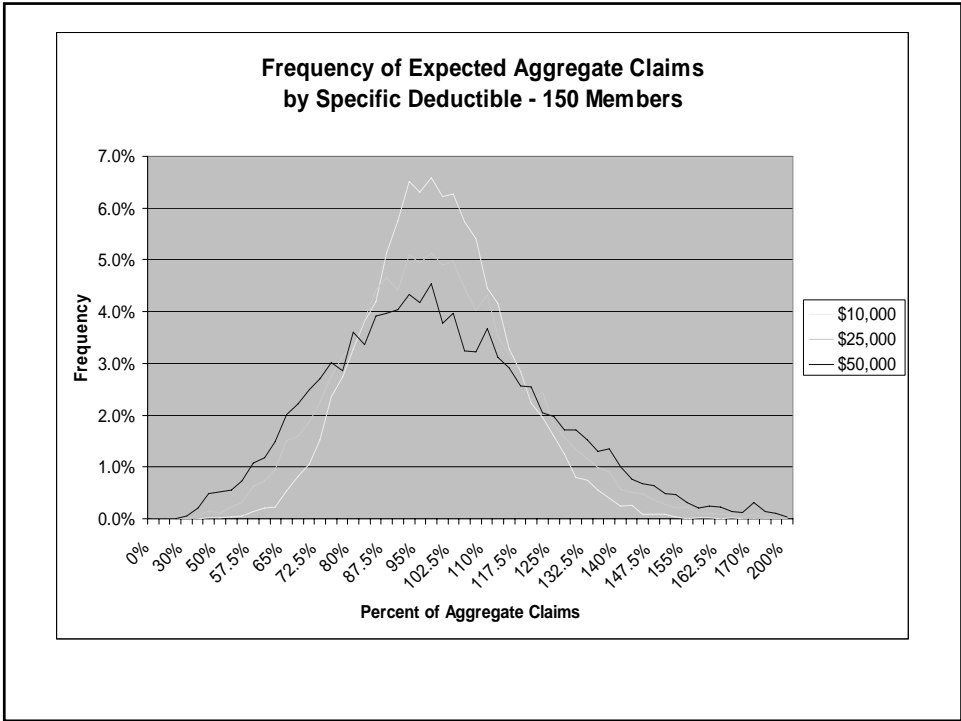
- To ASO or Not
- Stop Loss Insurance
  - Specific & Aggregate Contract Type
  - Specific Deductible – Aggregate Deductible
  - Integration with Current Medical Plan

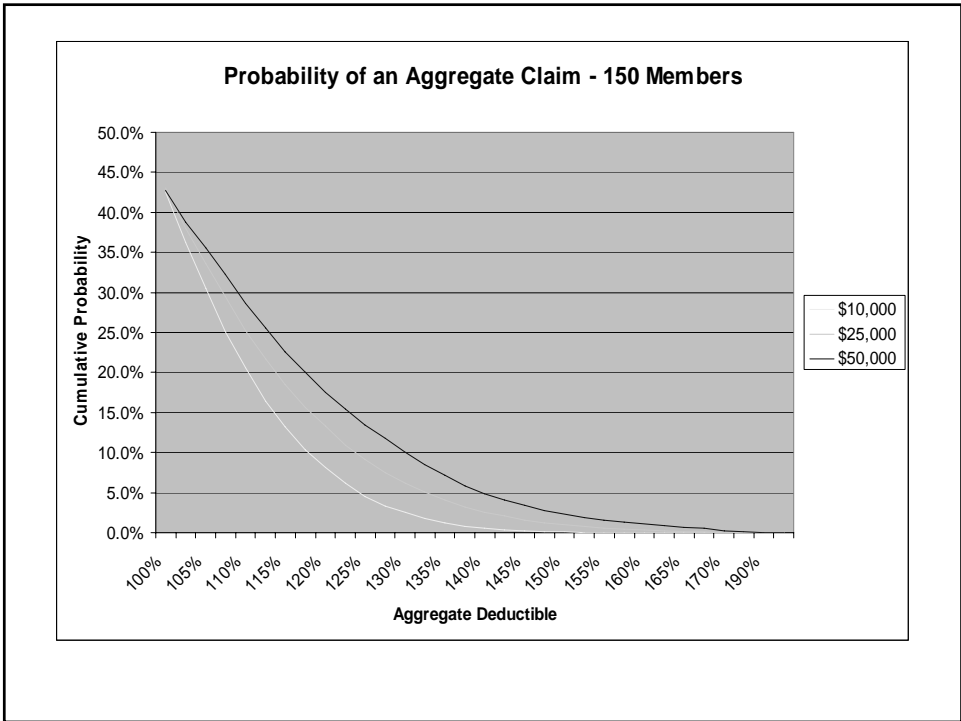
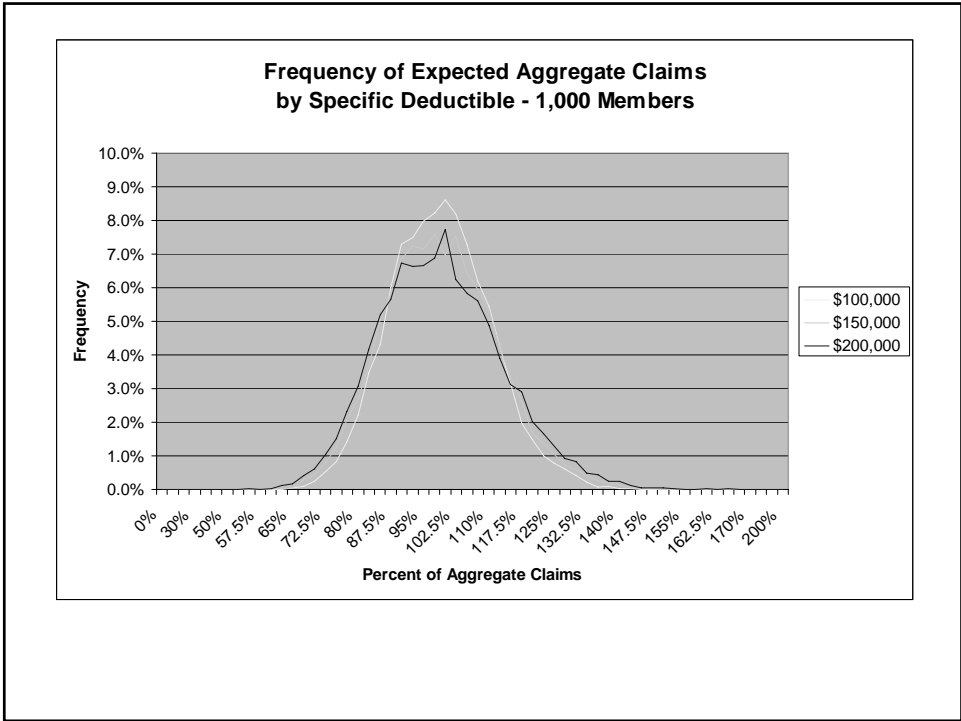
## Self-Funding – Risk Considerations (2)

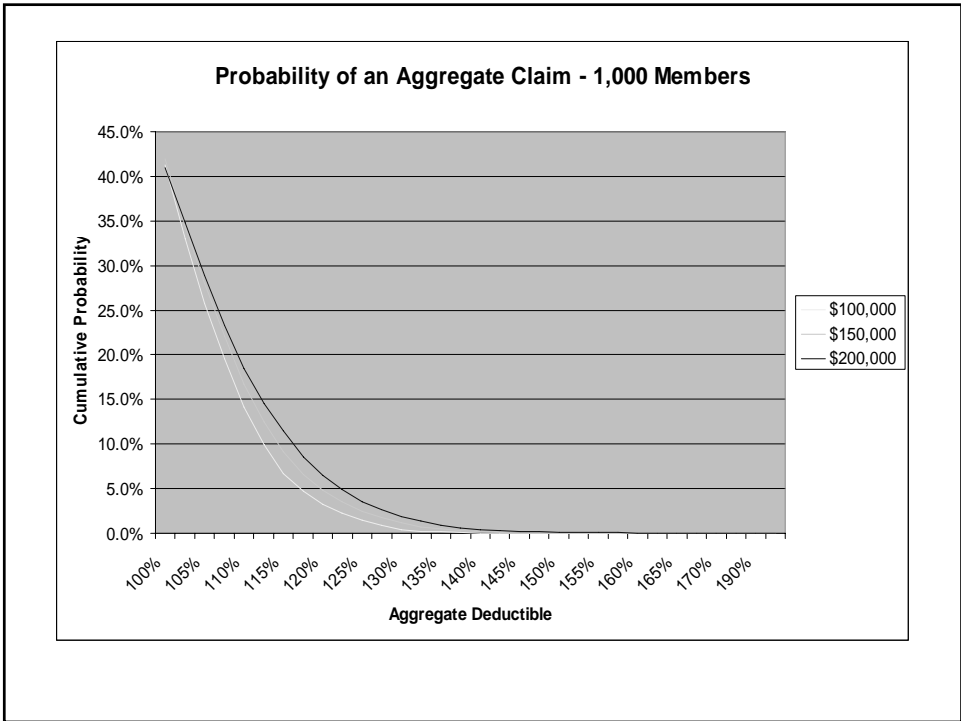
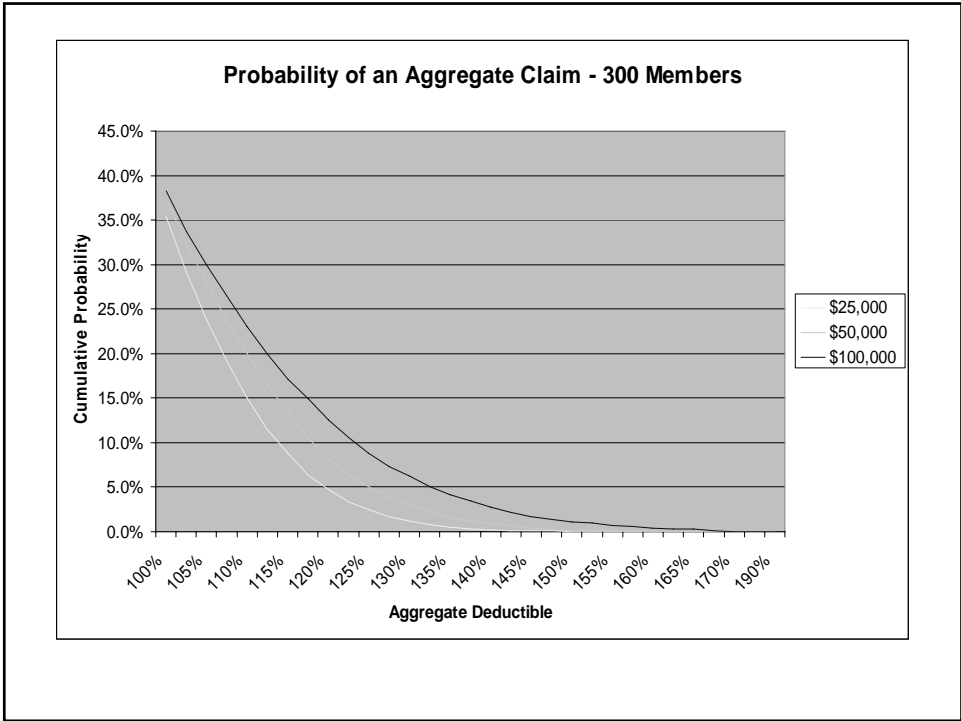
- The Big Nut - Adverse Claim Experience
- The Bigger Nut – What Risk to Reinsure?
  - Specific Deductible
  - Aggregate Deductible
  - Terminal Liability Option

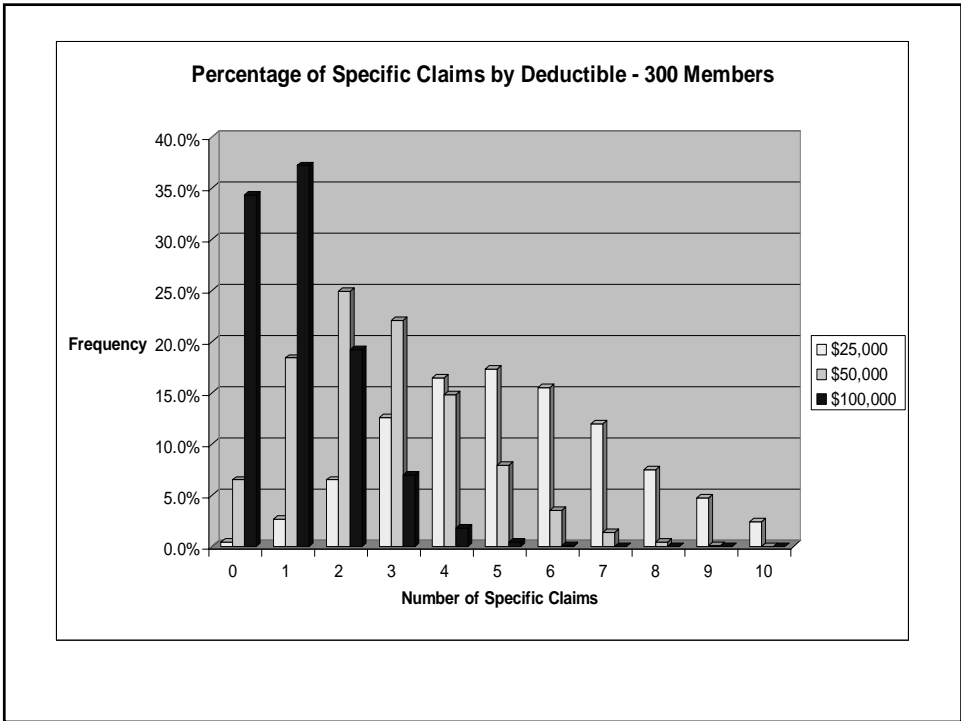
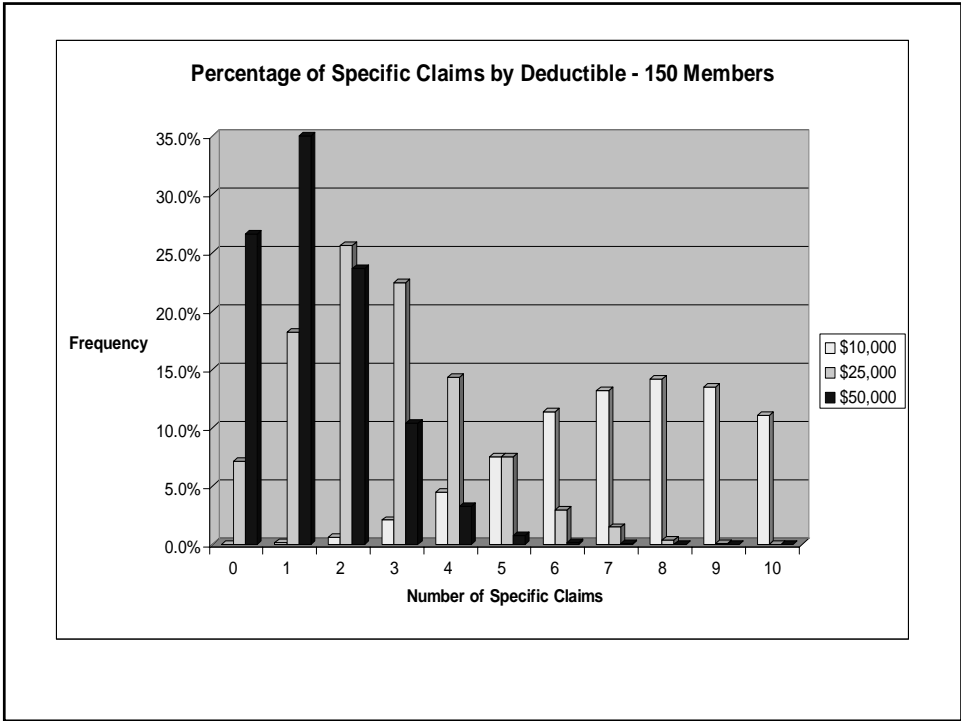
## Self-Funding – Reinsurance Benchmarks

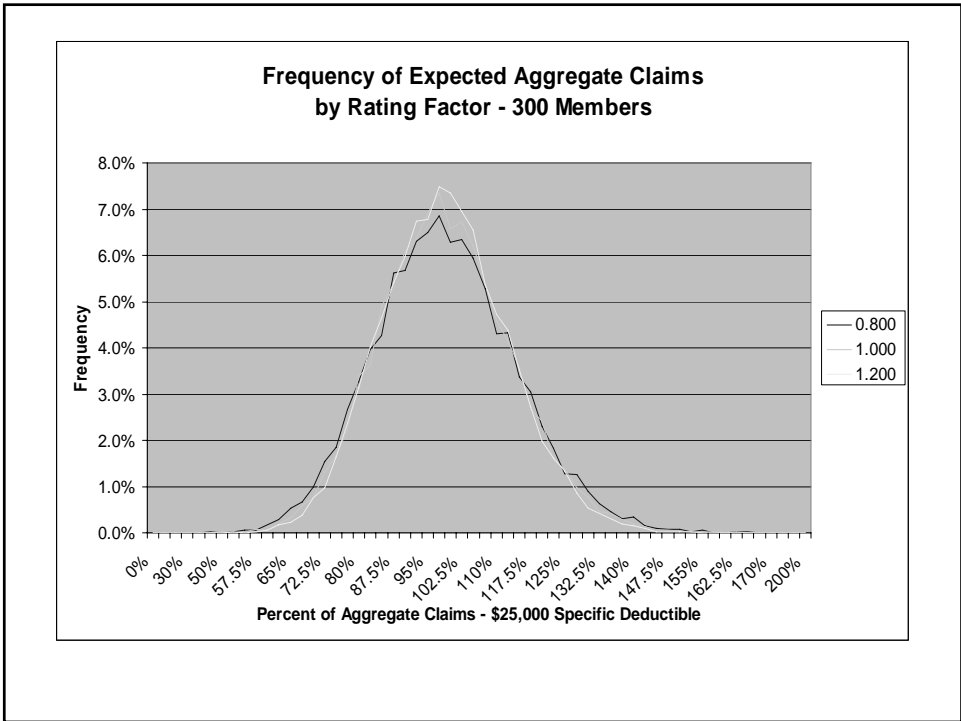
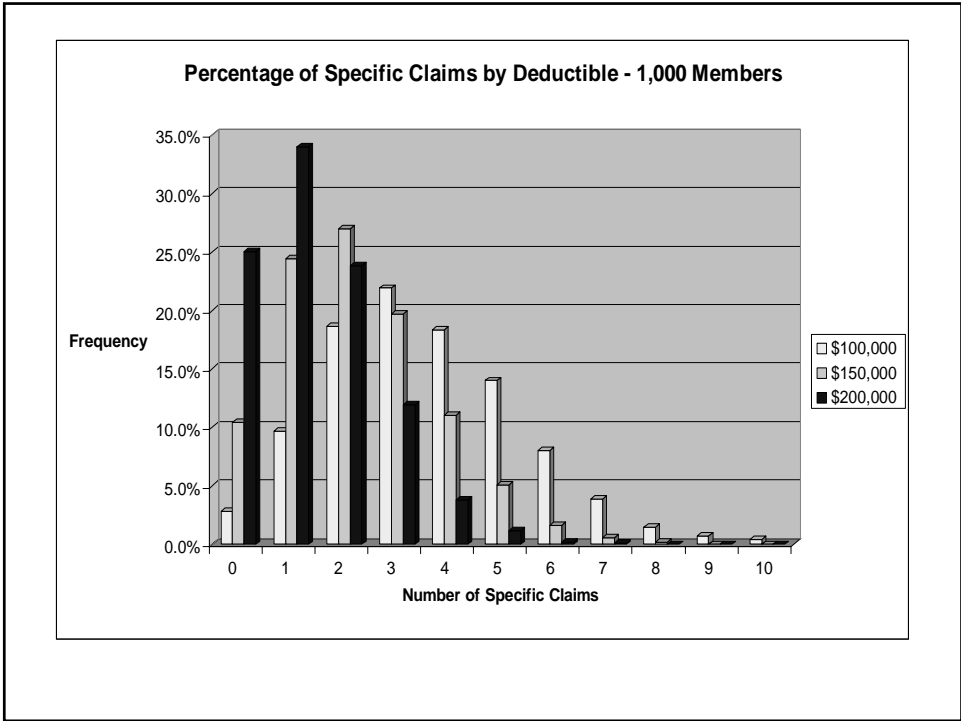
- Specific Deductible
  - 5% - 10% of Expected Claims (Small Groups)
  - 1% - 1.5% of Expected Claims (Large Groups)
- Aggregate Deductible
  - 125% of Expected Claims (Small Groups)
  - 120% of Expected Claims (Large Groups)

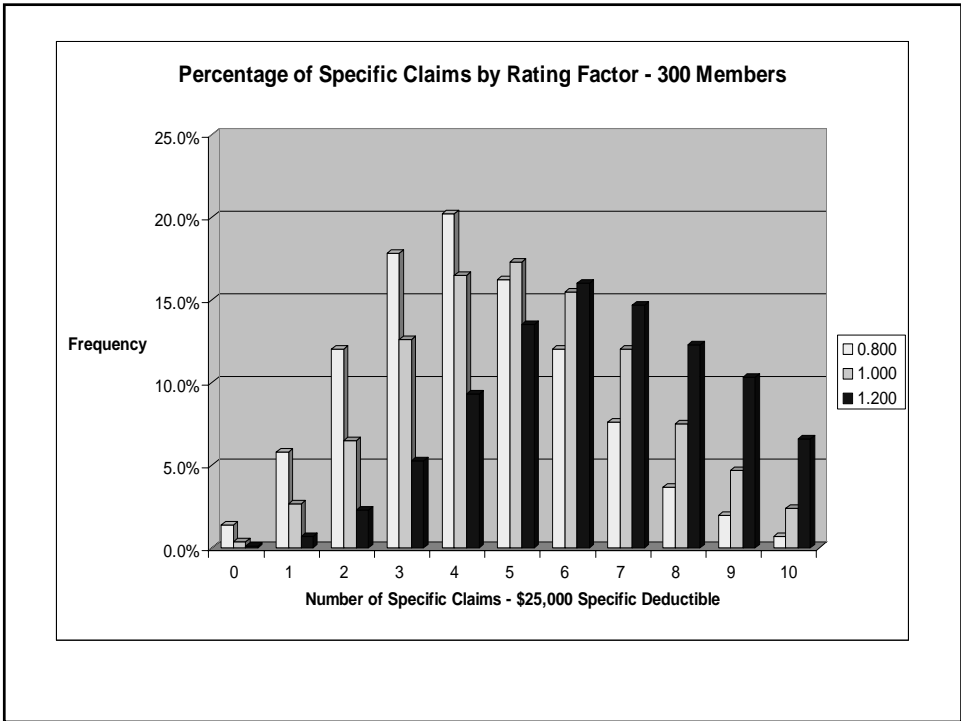
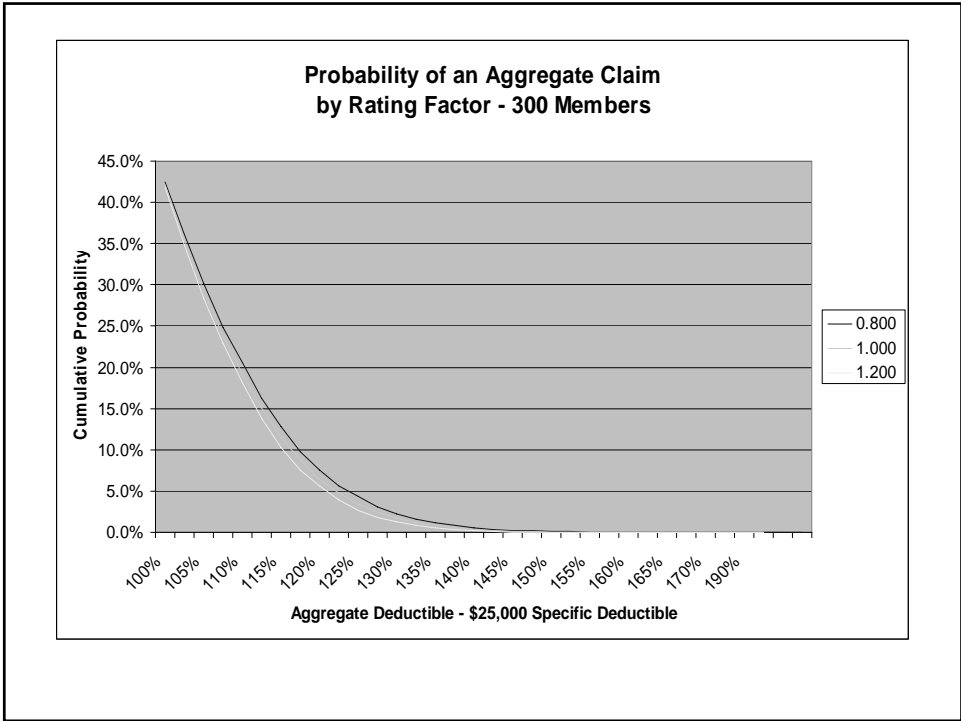












## Self-Funding – Reinsurance Considerations

- Specific Claims
  - Lifetime Maximums
  - Individual Deductibles (Lasers)
  - “Advance” Funding
  - Disclosure Issues
- Aggregate Claims
  - Lifetime Maximums

## Self-Funding – Administration Considerations

- To Self Administer or TPA
  - Manage Eligibility
  - Adjudicate Claims
  - Coordinate with Stop Loss Carrier
  - Provide Value Added Services

## Stop Loss Contract Definitions

### Incurred

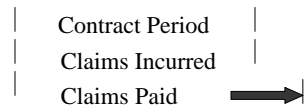
- The date the service or products are actually delivered

### Paid

- Drafts or checks that are issued on a plan account that contains adequate funds in order to be honored when first presented

## Stop Loss Contract Types

### “12/15” Contract



Incurred in 12 and Paid in 15 (12/15) - Eligible claims must be incurred during the contract period and paid within the contract period or the three months immediately following. This is an abbreviated version of the “true incurred” contract. Variations include 12/18 and 12/24 contracts.

Appropriate if group currently fully insured or has runout protection (12/15, 12/18).

## Stop Loss Contract Types

### “12/12” Contract

	Contract Period	
	Claims Incurred	
	Claims Paid	

Incurred and Paid (12/12) - Eligible claims must be incurred *and* paid within the policy year. For renewal years, the contract will convert to a Paid contract and the claims will be eligible under the renewal contract regardless of the date incurred, as long as it was incurred on or after the initial effective date of the contract.

This is the appropriate first-year contract type for a group that is currently fully-insured or a group that is self-funded and the policy has a run-out provision. (12/15, 12/18)

## Stop Loss Contract Types

### “Paid” Contract

	Contract Period	
←	Claims Incurred	
	Claims Paid	

Paid - On renewal, a 12/12 or 15/12 contract becomes a Paid contract. Claims will be eligible under the renewal contract regardless of the date incurred, as long as it was incurred on or after the initial effective date of the employer's self-funded plan.

This is appropriate for renewal contracts that started out as 12/12 or 15/12 contracts.

## Stop Loss Contract Types

	<u>“15/12” Contract</u>	
	Contract Period	
←	Claims Incurred	
	Claims Paid	

Run-In (15/12) - Claims incurred up to 90 days before the effective date and paid during the first contract period will be eligible under the policy. For renewal years, the contract will convert to a Paid contract.

This is the appropriate first-year contract for a group that is currently self-funded with no run-out provision. (12/12, Paid)

## Stop Loss Concepts Terminal Liability

- Generally applies to Aggregate coverage only
- Available on “Paid”-type contracts (12/12, 15/12, Paid) only
- Provides the Policyholder with protection for claims incurred while the plan is in-force but paid following termination
- Purchased on inception of the coverage at minimal cost
- Expenses must be incurred prior to the termination date, paid within 60 or 90 days of the term date (elected at inception of the coverage), and not be eligible under any other plan (i.e. run-in coverage with new carrier.)
- The new aggregate deductible is based on the 14 or 15 month period, and is adjusted based on factors provided at the beginning of the policy year

## Stop Loss Concepts - Lasering

Definition: *Setting a higher Specific Deductible level on an individual due to a known risk*

- *Example:* A stop loss contract has a \$50,000 specific deductible, but one individual with a known risk is “lasered” at \$100,000.
- The amount between the group’s specific level and the lasered amount does not apply toward the aggregate stop loss.

## Comparing the Competition

- Know your competition/market
- When comparing rates and factors, make sure you are comparing “apples to apples”
- Make sure the competition is showing maximum aggregate claims, not expected claims
- Compare the contract type being quoted
- Know the compensation amount built into the rates
- If a run-in is quoted, note any caps that the competition may have on that run-in period
- Know what is included in the competition’s administration fees
- Have a clear understanding of the contingencies placed on the quote

## Comparing the Competition

- Hard Dollars
  - Specific premium, aggregate premium, managed care and administration fees
- Soft Dollars
  - Aggregate Loss Fund Factors