THE MECHANICS OF SELF-FUNDING

Understanding why and how to self-fund your organization's health plan

FIRST PERSON

CONTENTS

The Case for Self-Funding Your Health Plan

Between 1996 and 2015, U.S. healthcare spend rose nearly a trillion dollars.[1] Add to that the ever-changing regulatory landscape, and you have a lot to factor into your benefits strategy. Rising healthcare costs[2] and changes through healthcare reform have forced many organizations to dedicate more time to evaluating how their group health plans are funded – self-funding or fully insured.

Many group health plans are fully insured. In this arrangement, your 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 and more stable due to the fixed monthly cost. There's a misnomer that being insured keeps you at arm's length from plan decisions and potential human resources nightmares. Some also argue that the administrative responsibilities also decrease when fully insured—perhaps. Yet, that would mean you have a complete understanding of self-funding, the other strategy available.

In 2020, 67% of workers in the United States were enrolled in a self-funded health plan, compared to just 44% in 1999.[3] It's clear that self-funding is a growing trend. You, like many employers, may shy away from self-funding because it appears complex or even too risky. Our goal is to take the mystery out of self-funding, so you can make an educated decision about what's best for your team.

Between 1996 and 2015, U.S. healthcare spend rose nearly a trillion dollars.

In this guide you'll:

- Gain a basic understanding of self-funding
- Learn what to consider as you make the transition to self-funding
- Understand what to expect your first year with a self-funded health plan

UNDERSTANDING THE BASICS

Self-funding is an alternative funding platform, where your organization assumes the financial risk associated with your group benefits. You'll typically partner 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 your organization uses its own money, including the funds collected from employees through payroll deduction to cover the healthcare expenses and administrative costs you incur. There are clear pros and cons to self-funding over the fully insured platform.

Benefits of Self-Funding

- With a self-funded health plan, you're in control of the plan design and are often able to avoid state-mandated plan provisions that are otherwise without input.
- When claims expenses are low, your organization reaps the reward of the cash savings versus fully insured, where the insurance company wins.
- 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.
- 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.

Potential Downsides to Self-Funding

- 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, 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.

- For self-funded plans, cash flow can be unpredictable. 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.

- There can also be 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.

Risk vs. Volatility

Like we've mentioned before, a self-funded plan has less predictability month-to-month in cash flow, which makes it more volatile than a fully insured plan. That doesn't necessarily mean it is riskier. In fact, in many ways you can reduce your overall risk by taking on hills and valleys of the health plan.

There are strategies you can employ to hedge against risk. For example, all self-funded plans will have stop loss insurance to protect against excess loss for both individual claimants and the plan as a whole. You can also work with other partners, like stop loss captives and pharmacy benefits managers, to safeguard your plan.

RISK

[risk]

exposure to the chance of loss; the degree of probability of such loss

VOLATILE

[vol-uh-tl]

tending to fluctuate sharply and regularly

Control Over Your Health Plan

Business leaders and plan sponsors do best when they have confidence and are in control of their strategy. Choosing a self-funded approach to a health plan provides the pathway needed to take control in a way that is simply not possible when fully insured. With the ability to tailor the plans, partners and cost containment strategies[4], leaders can take the mystery out of the "black box" of insurance. The investments in cost containment and approaches begin to show a more direct ROI (return on investment).

An example is the ability to choose a pharmacy benefits manager (PBM)[5] that aligns with your financial and clinical best interests. When fully insured, partnerships like a PBM, are determined exclusively by the insurance company and may not fully align with your culture and goals. When self-funded you take on the challenge and opportunity to build the right fit to meet the organization's financial, administrative and cultural goals.

Analyze the Numbers

Part of your decision in choosing to go self-funding is analyzing the numbers. They break down into three basic buckets. Let's take a look – and we promise we won't make you do any math!

ADMINISTRATIVE FIXED COSTS

These are costs derived from fees paid to the TPA and network to administer and adjudicate claims of the plan - potentially fixed costs paid to a PBM. While these can vary, they will make up the smallest piece of the overall cost pie of a self-funded plan.

REINSURANCE AND STOP LOSS PREMIUMS

An important financial protection for the plan sponsor. This allows risk to be transferred to a reinsurer for claims that go above a specific amount per individual covered under the plan and an overall aggregate limit of claims per year. The stop loss market is dynamic, and while it is not the largest portion of the costs, managing this closely by ensuring quality partners with favorable contract terms is key to protecting the financial status of the plan.

CLAIMS

Claims can make up 80-90% of your plan costs. The decisions you make determine how well your plan performs. As you gain more access to your plan's claims as a self-funded plan, you will be able to use data from both carrier reporting and data analytics tools to develop strategies around controlling claims. First Person partners with Springbuk, a health analytics platform, to draw insights on gaps in care, clinical forecasting and claims benchmarking.

Use Data to Inform Your Decision

It's important to partner with a benefits advisor when considering self-funding to analyze the possibilities. Here are a few critical steps when determining if your organization should self-fund or not.

1. If possible, review historical claims data and perform a lookback analysis to determine if self-funding would have created positive outcomes. This will not project future claims but will give you an idea as to the performance of the plan over the past few years.

2. Gather historical claims, high-cost claimant and other data available to project future claims liability. It's important to consider the health of your population and what outcomes are likely when self-funding. Compare these projected costs (and the maximum self-funded liability) to your fully insured premium to evaluate the potential cost savings opportunities. Last but not least, be sure to consider all costs including TPA fees, stop loss premiums and any other additional costs that would be associated with the preferred strategy (captives, PBMs, etc.).

3. Evaluate future strategies that may create savings such as point solutions to help members manage conditions or a partnership with a third-party administrator (TPA) or PBM. These additional levers are important to consider in your initial self-funded analysis.

4. Determine your organization's goals. Is having consistent cash flow at a potentially higher price more valuable than adding volatility and flexibility to the health plan strategy?

MAKING THE TRANSITION

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. Once you decide you want to move to a self-funded health plan, it's important to know how the transition will work.

How do you get from point A to point B? What exactly is the process and how you can leverage your benefits advisor and partnerships effectively?

Third-Party Administrator

The first step in self-funding will be to determine a third-party administrator (TPA). A TPA is the foundation of your self-funded health plan. The TPA you choose will determine your ability to: create custom plan designs, the network that is offered to members, and ultimately how the plan runs effectively day-to-day for members.

Here are some key functions of a TPA:

- Provide access to the provider network
- Operate day-to-day plan administration
- Process all claims for members
- Process eligibility and enrollment
- Offer reporting and claims data
- Provide customer service for members

Third-Party Administrator

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

For more self-funding terminology, see the glossary on page 34.

Your choice in a TPA will also be important when considering how you will effectively control your costs moving forward. Depending on the size of your organization, some TPAs may not allow for additional cost control levers to be pulled. For example, you may be limited on your ability to carve out the pharmacy benefit manager (PBM).

Some TPAs also offer access to enhanced solutions for members. These may include:

- Telemedicine services
- Cost transparency tools
- Chronic disease management programs
- Clinical and utilization management programs
- Wellness products and solutions

TPA fees are typically between 5-15% of your total annual cost.

Most TPAs will charge a per employee per month capitated fee for their services. This is a fixed fee that will remain constant for the duration of the contract (typically 12 months) and only fluctuates with changes to enrollment. Some of the additional services outlined above may add to the overall cost of the TPA's services. The fee is usually between 5-15% of the total annual cost when self-funding a health plan.

Stop Loss

When self-funding a health plan, the claims risk shifts from the insurance carrier to your organization, which naturally becomes a common objection for many decision makers. This is where stop loss comes into the equation. Simply put, stop loss helps limit the risk exposure for your organization in the event of a high claims year.

There are several different ways to purchase stop loss insurance. Primarily, you will partner with one stop loss carrier and may implement specific and aggregate stop loss coverage.

Specific Stop Loss Insurance

Think of specific stop loss as protecting your organization from each individual member on the health plan. You will work with your benefits advisor and stop loss carrier to determine the specific deductible level.

For example, let's say your specific deductible is $100,000. This means your organization is responsible for up to $100,000 in claims for each member. Once a member has surpassed $100,000 in claims, the stop loss carrier is responsible for the claim's liability. As you can see in the diagram below, Member 1 has $250,000 in claims. The organization pays the first $100,000, and the additional $150,000 is paid for by the stop loss carrier.

Aggregate Stop Loss Insurance

Aggregate stop loss is another common stop loss insurance many organizations will purchase. While the specific stop loss protects your organization from each member, the aggregate stop loss protects the organization from total claims by all members.

When quoting stop loss carriers, their team of underwriters will determine the risk of the group. The underwriters use members' health data, claims history, demographics, and several other considerations to project the total claims for the next contract period. Through this process they will determine expected claims and a maximum claims threshold. The maximum claims threshold, or corridor, is typically 120-125% of expected claims. Here is an example:

Expected Claims	$1,000,000
Aggregate Corridor	125%
Maximum Claims	$1,250,000

In this example, the underwriters determined your expected claims for the 12-month contract is $1,000,000. With an aggregate corridor of 125%, the maximum claims for your organization are $1,250,000. You're liable for all claims up to the maximum amount. By purchasing aggregate stop loss insurance, the stop loss carrier is then responsible for the amount over $1,250,000.

Choosing a Stop Loss Carrier

It's important to consider a stop loss carrier that will help accomplish your organization's goals. There are a few factors to consider when determining a stop loss carrier.

DO THEY ALLOW FOR AUTO-REIMBURSEMENT?

If a claim goes over the specific or aggregate level, is the organization responsible to pay the full amount, and then wait on a reimbursement from the stop loss carrier? This could have significant cash flow impact on the organization. Many stop loss carriers offer auto-reimbursement where the organization only pays up to the liability amount (up to $100,000 in the specific stop loss example) and the carrier takes on the rest of the liability immediately.

ARE THEY WILLING TO BE CREATIVE WITH LASER LIABILITY?

Applying a laser allows stop loss carriers to target certain members and increase the member's specific stop loss deductible. For example, if a stop loss carrier projected a member would have around $500,000 in claims next year, they could apply a laser to the member, so their specific stop loss deductible is now $500,000 vs. $100,000. Some stop loss carriers are willing to get creative when a laser is needed to find different alternatives that will not put the organization at risk for one high-cost claimant.

DO THEY OFFER INNOVATIVE SOLUTIONS?

Having an innovative stop loss carrier allows for opportunities like shifting laser liability, implementing stop loss contracts, and thinking about the entire risk profile of the organization versus only a few high claimants.

It's important to work with stop loss carriers that are interested in a true partnership for these reasons. Similar to a TPA, the stop loss premium is a fixed cost. In the stop loss contract, it's usually stated as a rate per employee per month and only fluctuates with enrollment. The specific stop loss premium is typically around 20-30% of total spend, while the aggregate premium is usually under 1%.

Captive Stop Loss Contracts

Joining a captive[6] should be a strong consideration for small to mid-market organizations exploring self-funding. A captive is an insurance arrangement consisting of several other organizations that come together to pool the risk of their self-funded claims.

The purpose of a captive is to insure and protect risk.

In an oversimplified explanation, here's how a health benefits captive would work for you: As an employer, you join forces with like-minded employers to invest in a captive and pay into a health benefits risk pool, agreeing that the money in that pool will be used to cover health claims for all captive participants. The captive works with a third party (often a traditional insurer) to provide stop loss protection and any other services the captive desires. The primary purpose of the captive is to insure and protect the risk of its owners.

Your organization can leverage a captive as a strategy for purchasing stop loss contracts, as described in the previous section. The captive will not impact your decision on TPA or any other considerations when self-funding. Some captives offer access to member tools, concierge services, well-being solutions, and pharmacy benefits strategies, but these are not required to be implemented.

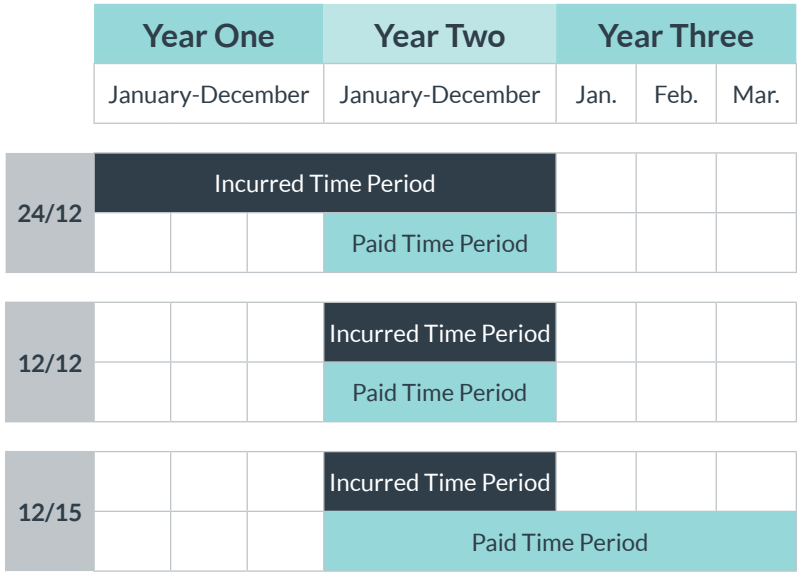
For many small and mid-market employers, a captive is a great way to obtain leverage, stronger contracts and buying power for stop loss contracts. Here are a few contract enhancements that can be obtained by joining a captive:

- **Stop loss renewal limits.** Some captives limit the stop loss renewal increase an organization can receive.
- **No new lasers.** Some captives offer policies with no new lasers in perpetuity. This can be appealing for organizations that are worried about one high-cost claimant driving a considerable amount of the claims spend.

Stop Loss Contracts

Stop loss contracts are written to cover claims within a specific period. The claims are broken down into when they were incurred and when they were paid. These are always written as Incurred/Paid. For example, a common first-year contract when transitioning to self-funding is a 12/12 contract. For the first 12 months of the contract, claims are covered only if they are incurred and paid during the policy term.

At the first renewal heading into the second year of self-funding, it will be important to mature the contract to a 24/12. This will cover any claims incurred prior to the effective date and paid during the current contract period. Maturing the stop loss contract could increase the stop loss premium.



Estimates are usually in the range of a 25% premium increase, but it's important to include an additional time period for incurred claims. This will be helpful for your organization, especially when considering potential reimbursement amounts from specific or aggregate stop loss.

To your left is a diagram of how these time periods and contracts would work.

Pharmacy Benefits Managers

Another important consideration when self-funding your health plan is choosing a pharmacy benefits manager (PBM)[5]. In a nutshell, PBMs are the "middlemen" that negotiate prices with drug manufacturers, allowing pharmacies to sell drugs at lower prices. Due to your organization's size, this may not always be available. Some TPAs limit an organization's ability to carve out the PBM from the TPA's service model.

If you partner with a TPA that allows flexibility with PBM partnerships, it will be important to do an in-depth analysis and determine the best PBM for your organization's strategy. If the TPA you choose does not allow flexibility, you will be required to partner with the PBM of their choice.

Here are some of the key functions of a PBM:

- Process prescription drug claims for members
- Develop and maintain preferred drug lists (formulary lists)
- Negotiate rebates and discounts from drug manufacturers
- Contract directly with pharmacies for reimbursement of drugs dispensed

All PBMs have different operating and cost structures. It's important to understand these nuances and partner with a PBM that aligns with your organization's health plan strategy. Is cost and pricing transparency important to you? What about a large pharmacy network? Are specialty drug programs valuable? It's imperative to determine these factors and many more when analyzing PBMs. Here's a quick overview of the three types of pharmacy benefits manager:

TRADITIONAL

The traditional model usually contains the elements described above: spread pricing, rebates and administrative fees. The 'carved-in' option is easy and simple. It's typically administered by one vendor. It has the disadvantages of hidden cash flows as well as lack of transparency and control. However, it is easy and simple. And with a strong contract, you can still generate great results.

The 'carved-in' option in a traditional setting usually includes one of the large prescription benefit plan providers like Express Scripts, Optum, Caremark or Ingenio. It allows for little to no control over formulary or mail-order provisions and contract terms and definitions. Performance guarantees can be added and are common.

TRANSPARENT

It is exactly what it says it is. Hidden PBM cash flows are eliminated in this model. The PBM's revenue is generated through administrative and dispensing fees with a full disclosure of each. There are full accounting and auditing provisions. These arrangements can typically offer better contract terms or ability to manage definitions, some flexibility in custom clinical programs, more detailed analytics and greater transparency. It's the clearest cost.

CONSORTIUM

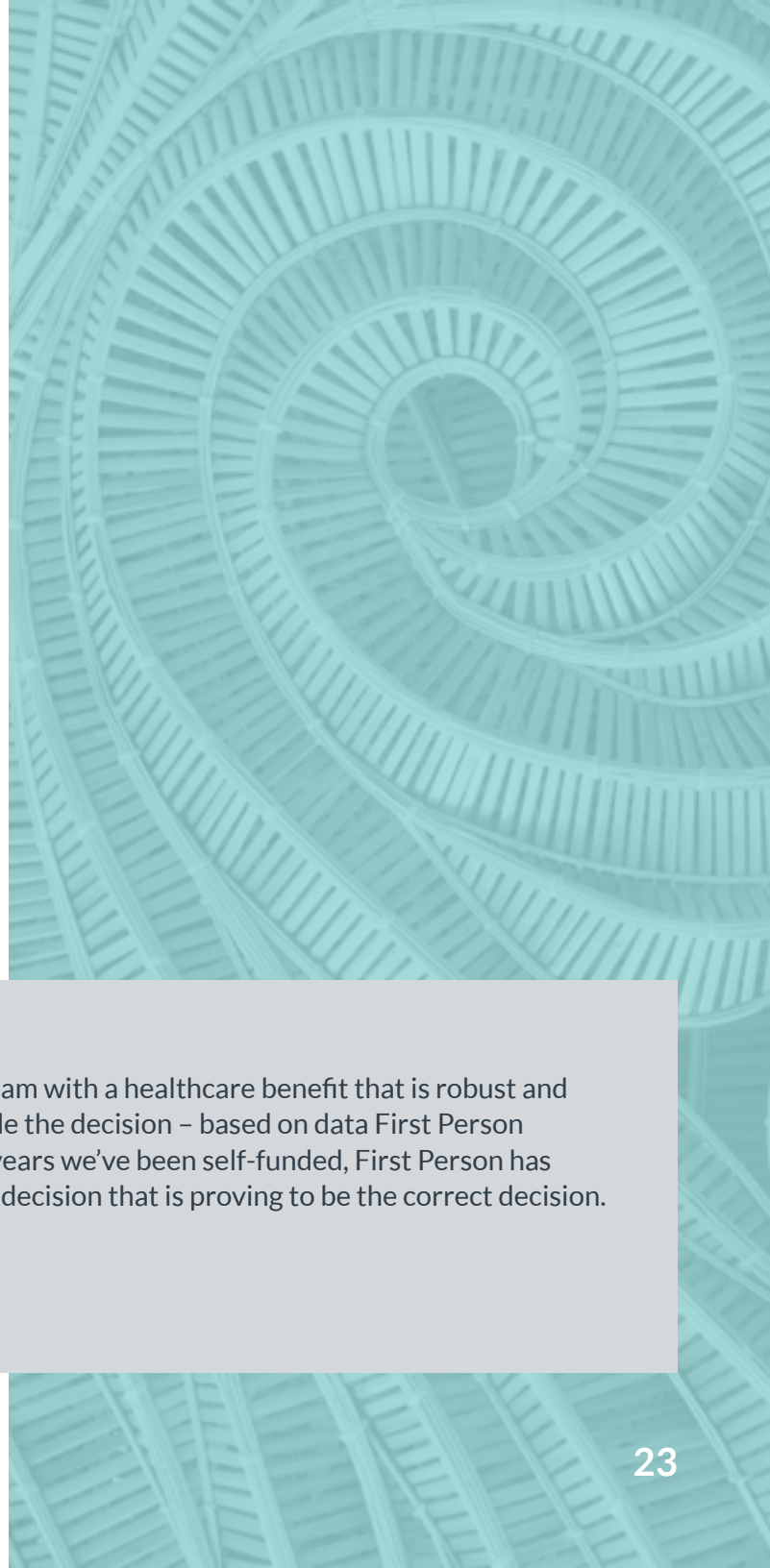
This is a newer option. These companies, like Rx Solutions of NFP Benefits or Rx Benefits, will aggregate contracts with three of the big PBMs. With their scale/size, they are able to maximize rebates, slightly reduce spread and provide better service.

Our team has developed tools and resources to identify network comparisons, PBM revenue models, rebate analysis tools and clinical program comparisons to identify which PBM partners are best for an organization.

Claims

The most important cost consideration when self-funding is the claims incurred by members. This can range anywhere from 60% to 90% of the total annual spend on a self-funded health plan.

Unlike in the fully insured market, cash flow is more volatile when self-funding. Some months may incur large spikes in financial liability, while others may not see much claims activity at all. It's important to work with your benefits advisor and financial team to establish a cash flow strategy. The premium amounts you budget as an organization and deduct from members' paychecks will need to be set aside to pay for the claims as they are incurred. This is called a "reserve" account. First Person provides several reports to our clients to easily track cash flow month-to-month and ensure the reserve always has a surplus.



> It has been our focus for several years to always provide our talent team with a healthcare benefit that is robust and cost manageable. Through our partnership with First Person, we made the decision – based on data First Person provided – to transition to a self-funded health plan. Over the three years we've been self-funded, First Person has provided education and actionable data to help us make an informed decision that is proving to be the correct decision.
>
> *Chief of Staff at the City of Westfield*

WHAT TO EXPECT YOUR FIRST YEAR

Once you've made the transition to a self-funded health plan, there's more work to be done. How should you adjust your approach to managing your health plan? While self-funding a health plan is (almost) always a wise financial decision, it does present challenges and new opportunities to direct the course your plan will take. When it comes to your first year with a self-funded health plan, you'll want to be prepared and create a plan for the following areas.

Cash Flow Management

The first change—and it is a big one—is cash flow management. Fully insured plans are easy (except when your renewal comes in at more than 20%). You pay your premium with the only variability coming by way of changes in your enrollment. This is a simple and predictable way to pay for healthcare, but only for each year. The renewals are what present the challenge.

The good news is that cash flow management can be done in a similar manner to your old fully insured plan. Part of self-funding is working with your consulting or actuarial partners to establish something called premium equivalents or fully insured premium equivalents. These premium equivalents are developed to help you budget your health plan and depend, to a degree, on how conservative or aggressive you want to budget. For first year self-funded health plans, most groups prefer their premium equivalents be set at a fairly conservative (higher to support higher costs) during their first year.

	Aggressive	Moderate	Conservative
Stop Loss Premiums	$250,000	$250,000	$250,000
TPA Admin. Fee	$50,000	$500,000	$500,000
Expected Claims Cost	$1,000,000	$1,000,000	$1,000,000
Maximum Claims Cost	$1,250,000	$1,250,000	$1,250,000
Budget	$1,300,000	$1,425,000	$1,550,000

Managing your cash flow effectively as a self-funded plan is critical. Fixed costs (administrative fees and stop loss premiums) make up only about 10-30% of your total costs. The actual medical and pharmacy claims make up the lion's share of the

Fixed costs make up 10-30% of your total costs.

expense. Your third-party administrator will bill you on a regular cycle, often weekly for these claims expenses. The first few months will seem too good to be true, because they are! Claims volume and expense are likely to be light the first month and will start to tick up each week. This is due to the timing of when claims occur versus when they are paid, which is typically 30-90 days.

How you account your plan is up to you and depends on what makes the most sense for your business. Some groups choose to cash account their plans, but accrual accounting is more common.

During the first 30-90 days of the plan year, it's important to take advantage of the lighter claims expenses and build a reserve of funds to pay future claims. If you are accrual accounting, this is pretty simple in that all you need to do is accrue the entirety of premium equivalents (employer + employee premiums) into an account to be used to pay claims. If you choose to cash account your plan, be sure to set aside a cash reserve sufficient to cover a specified amount of claims expense, often determined using an incurred but not yet reported calculation of one to three months-worth of estimated claims.

Your First Stop Loss Renewal

Once you've got a handle on cash flow management, you'll want to prepare for your first stop loss renewal. Yes, right after you've just self-funded. You're going to begin preparing for your first renewal much earlier in the year than you did when you were fully insured to stay ahead on your budget and renewal.

An illustrative stop loss renewal or soft quote should be available to you approximately three or four months before your renewal date. This will give you an indication as to where that renewal will land in terms of rates and will allow your consultant to model out some rate scenarios. Final stop loss renewal rates will be available 90-120 days before the new plan year begins and can be locked in by signing the proposal.

The stop loss contract you have in your first year as a self-funded plan is a 12/12 contract. As we mentioned previously on page 19, the 12's refer to the period of months when claims are incurred and paid that are covered on the stop loss policy. In a 12/12 contract, the stop loss policy only covers claims incurred and paid in the policy year.

Stop Loss

If you remember from earlier, stop loss is a type of insurance that covers health plan claims in excess of a predetermined amount.

For more self-funding terminology, see the glossary on page 34.

For your second year, it's highly recommended that you "mature" your stop loss contract to a 24/12. This type of contract will give you better financial protection due to the latency of claims processing. (See page 18 for more on stop loss contracts.)

Maturing a stop loss contract most commonly comes with a stop loss premium rate increase of at least 20%, regardless of how your plan performed in the first year. If your plan performed exceptionally well (low claims) during the first year, then you might see a number lower than 20%.

It's common for your first stop loss premium to increase at least 20%, regardless of plan performance.

If your plan had a rough year with high claims, you should expect to see your stop loss premiums increase by more than 20%. It's important to have this second-year rate increase in mind now so you're prepared to make the financial adjustment necessary to accommodate this increase in premiums.

Now that we've discussed some of the critical financial management aspects of having a self-funded health plan, there are some additional considerations a plan administrator can take on.

Access to Healthcare Claims Data

One of the biggest changes as a self-funded health plan is that you have a dramatic improvement in access to claims data that help you understand what exactly is driving your plan expenses. Typically, the available data is separated into two categories: financial and clinical. Financial data is exactly what it sounds like and only includes information for you to understand the cost elements of the claims on your plan. Clinical data includes the actual nature of the claims, such as primary patient diagnoses.

You may be wondering: Do you really want access to any clinical patient information? The answer might be "yes "and "no". Generally, your benefits advisor will have access to this type of data and can help dig into any details to answer questions you might have on a particular claimant.

A good example would be when evaluating plan performance and high-cost claimants that might be approaching or over your specific deductible amount. You'd want to inquire as to the forecasted risk or cost potential for that claimant's condition and treatment needs. That said, if you'd like to have one or more members of your team have access to Protected Health Information (PHI), consult with your benefits advisor regarding appropriate safeguards to protect your business and employees.

Protected Health Information (PHI)

PHI is any information about an individual's health status, provision of healthcare or payment for healthcare such as names, geographical identifiers, social security numbers, medical record numbers and more.

For more self-funding terminology, see the glossary on page 34.

Contain Costs and Mitigate Risk

Perhaps the most important element of managing a self-funded health plan is crafting a strategy to contain costs and mitigate future risk. This is another place where having access to both financial and clinical data is helpful. That information can help you determine which strategies will most effectively help you manage your costs and future risks.

For instance, if your pharmacy costs are a higher-than-normal percentage of your overall spend, then you might want to consider working with a different pharmacy benefits manager (PBM). There are many levers to be pulled and several strategic partners with whom you can align to drive the outcomes your plan needs. Your data will tell you a story. It's important to use that story to craft the appropriate strategies.

Determining Employee Contributions

Ahead of Open Enrollment, you'll need to determine employee contributions or premiums you will charge your employees to be covered on your health plan. To arrive at these numbers, you first need to have your fully insured premium equivalents. These equivalents will take into account your stop loss and administrative fixed costs for the next year, along with your forecasted claims expenses. Based on your plan offerings, the premium equivalents will also be reflective of the actuarial values of the plan designs, meaning that each plan will utilize different premium equivalents based on the "richness" of the plan (i.e., coinsurance, deductible and out-of-pocket levels).

While there are no specific regulatory guidelines in setting the premium equivalents, they must be set within reason for the value the plan provides. When set properly, the premium equivalents are typically also used when setting the COBRA rates for your plans. For First Person clients, our analysts leverage plan modeling tools from actuaries and use the decrements created to input data into cost projection tools. The primary use is to create fully insured equivalents and COBRA rates that plan sponsors can have confidence in.

With this information and an understanding of how aggressively or conservatively you want to budget for the next plan year, you can get your premium equivalents in line. Once you have these equivalents, you can determine your employee premiums and move into Open Enrollment.

SUMMARY

Operating a self-funded health plan is quite different than having a fully insured plan. In most cases, a plan sponsor will experience financial wins when self-funding their plan when evaluating it over time. There are likely to be more ups and downs in the experience, but the long-term benefits are significant in terms of potential cost savings, and most importantly flexibility and a much higher degree of control.

Our actionable advice is for you to:

1. Do your research and leverage what data is available to you – alongside your trusted benefits advisor
2. Dedicate time to discuss options and dig in
3. Spend time understanding and learning more about potential partners (TPAs, PBMs, and stop loss options)
4. Clarify your well-being strategy and how it can support your transition with ROI on the health plan
5. Create a transition strategy and let data be your guide

HOW TO $AVE MONEY ON YOUR HEALTH PLAN

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1. "Why self-fund my health plan?"
2. "How do I transition from a fully insured plan?"
3. "Now that we're self-funded, how do I measure results?"

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GLOSSARY

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.

CAPTIVE

An alternative stop loss arrangement consisting of multiple organizations that come together to pool the risk of their self-funded 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

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 BENEFITS 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.

PROTECTED HEALTH INFORMATION

Any information about an individual's health status, provision of healthcare or payment for healthcare such as names, geographical identifiers, dates, social security numbers, medical record numbers and more.

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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