Self-Funding and the Management of Risk
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ABOUT SPRING

Spring is an insurance and financial services firm with expertise in a wide range of insurance and risk management disciplines. Captive insurance strategies for employee benefits and property & casualty risks comprise our core competencies, enhanced by best-in-class employee benefits brokerage and wealth management expertise. We partner with clients across the globe to identify and resolve unique challenges that they encounter on a daily basis.

Spring’s employee benefits and captive insurance experience and expertise are exemplified by the fact that we have consulted with roughly 50% of the Prohibited Transaction Exemptions (PTE) granted by the U.S. Department of Labor (DOL) to allow organizations to reinsure their employee benefits in their captives.

In 2000, Spring’s partners were instrumental in gaining DOL approval for the first pure captive transaction for funding employee benefits. As a result, Columbia Energy (now NiSource) was granted approval to place their group disability insurance program into their captive. Since then, Spring has received DOL approval for a number of other firms including, but not limited to, AGL Resources, Banner Health, Memorial Sloan-Kettering Cancer Center, Subaru and United Technologies Corporation for funding various health and welfare employee benefit programs in a captive.

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INTRODUCTION

With nearly one fifth of the U.S. economy tied to health care, costs continue to be a critical topic of concern for the economy. U.S. businesses face competitive challenges in a global market, as a burgeoning portion of operating capital is siphoned away to cover employee health care costs. It is becoming increasingly difficult for U.S. companies to remain competitive in this global market with a growing portion of the cost of human capital being allocated to health care costs.

The Patient Protection and Affordable Care Act (ACA) has been in place now for more than three years and the majority of the provisions are expected to be in place by 2014. Some relief has been granted to employers through the delay of the shared responsibility mandate penalties until 2015 and the excise tax is not effective until 2018. Since the passage of this act, the federal government has promulgated more than 15,000 pages of regulations outlining the requirements, processes, and mandates on employers, providers, insurance carriers, and others that play in the health care arena. This continuous tidal wave of regulation creates a significant compliance liability that generates new taxes and fees, and expands the administrative burden shouldered by employers.

In light of the current environment, employers are asking some important questions about the future of their health care offerings and contemplating whether or not they should continue to offer health insurance coverage to their employees. Recent surveys indicate that a majority of employers will continue to offer health insurance in order to remain competitive. Some employers, however, are reducing employees’ hours in an effort to stay below the 30 hour definition of full-time employees. While this will ultimately save money, employers opting to eliminate, reduce or refrain from offering health insurance will be exposed 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 turning over every stone to uncover ways to control costs. For an employer offering a fully-insured plan, a prime opportunity to decrease costs exists by considering self-funding in 2014 and beyond. By self-funding, employers can achieve savings of anywhere from 5% to 15% depending on their cost structure. We discuss the benefits, considerations, and details of self-funding below.

Note to reader: self-funding and self-insurance are referred to interchangeably throughout the document and should be considered the same thing.
An understanding of a few key terms is essential and will aid in the description of the concepts outlined below.

<table>
<thead>
<tr>
<th>Key Terms</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fully-Insured Plan</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Self-Insured Plan (Self-funded)</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Administrative Fee</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Retention Fee</strong></td>
<td>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 sometimes includes profit.</td>
</tr>
<tr>
<td><strong>Stop Loss</strong></td>
<td>Often referred to as catastrophic insurance, stop loss insurance covers large claim costs that exceed a certain threshold set by the self-funded employer. There are two kinds of stop loss policies: specific and aggregate.</td>
</tr>
<tr>
<td><strong>Specific (Individual) Stop Loss Coverage</strong></td>
<td>Pays out if an individual claim exceeds some threshold amount, typically anywhere from $20,000 to $500,000.</td>
</tr>
<tr>
<td><strong>Aggregate Stop Loss Coverage</strong></td>
<td>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.)</td>
</tr>
<tr>
<td><strong>Lasering</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Attachment Point</strong></td>
<td>The deductible amount that a claim must reach before it can be paid by the stop loss carrier (typical deductibles can range from $20,000 to $500,000). This can also be referred to as the self-insured retention amount or SIR.</td>
</tr>
</tbody>
</table>
SAVINGS OPPORTUNITIES

There are many benefits to self-funding including plan design flexibility, cost transparency, and 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:

- **Escape the Health Insurance Industry Tax**

  A new tax imposed by the ACA, the Health Insurance Industry Tax (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. In short, the total annual fee is $8 billion in 2014, increasing to $14.3 billion in 2018, and indexed to the growth of health care premiums thereafter. Beginning in 2014, most plans will load this fee into the insured plan premiums. Health plans estimate the fee to be about 2% to 2.5% in year one, increasing 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 Texas all for-profit health insurers are subject to a 1.75% tax. 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.

- **Retain and Redeploy Health Plan Marketing and Retention Fees**

  All health insurers include expenses loaded in their fully-insured premiums for new business sales, marketing expenses, and retention of current customers. These costs can be as high as 2% to 4% depending on the carrier and do not exist in a self-funded environment other than a de minimis amount of cost built into stop loss insurance, if this is used.

- **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 10% to 12% of insured premiums. 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 every three to five years, and identifying the most cost effective administrative carriers in the marketplace.
Capture and Invest Reserves

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.

Receive a Cash Flow Advantage as the Self-Funded Plan Reaches Maturity

For employers moving from a fully-insured model to self-insurance, there will be a period of two months or so before claims mature. 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 a quarterly basis or loaded into the premium to account for the IBNR claim liability.

Escape the Cost of State and Federal Mandated Benefits

Over the past several years, states have begun mandating very specific employer health care benefits. Each state has their 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 tools 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.

Create Advisor Fee Transparency

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 resident in their population. Based on these findings, targeted programs can be implemented to impact costs. Obtaining detailed claim information in a fully-insured environment is challenging, if not impossible, because of privacy concerns and the fact that carriers do not consider this data employer property.

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 risk 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?
Of course, no one can predict the future with absolute certainty, but actuaries attempt to predict future risk and liabilities by observing historical performance. They start with current health care claim costs then make certain assumptions, such as expected trend cost increases, claim fluctuation, plan design adjustments and administrative fees, and can then project costs forward.

Actuaries can also conduct certain risk analyses such as a Monte Carlo simulation which provides additional data on the odds of the worst case scenarios that may occur and helps employers set their retention levels. A Monte Carlo simulation models thousands of scenarios using random variables to provide the decision maker with a probability distribution of risk. It can also be valuable to an employer considering self-funding as it provides a picture of risk. It is a tool that can predict, within a certain confidence level, the possibility and probability of the worst-case scenario that may occur. See Monte Carlo results summary chart below.

### Expected Claims Severity

<table>
<thead>
<tr>
<th>% of Expected Claims</th>
<th>$ Amount Annually</th>
<th>Likelihood of exceeding this level of excess claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>One Year</td>
</tr>
<tr>
<td>2.5%</td>
<td>$387,000</td>
<td>27.3%</td>
</tr>
<tr>
<td>5.0%</td>
<td>$773,000</td>
<td>16.0%</td>
</tr>
<tr>
<td>7.5%</td>
<td>$1,160,000</td>
<td>8.3%</td>
</tr>
<tr>
<td>10.0%</td>
<td>$1,547,000</td>
<td>3.8%</td>
</tr>
<tr>
<td>15.0%</td>
<td>$2,320,000</td>
<td>0.6%</td>
</tr>
<tr>
<td>20.0%</td>
<td>$3,094,000</td>
<td>0.1%</td>
</tr>
<tr>
<td>25.0%</td>
<td>$3,867,000</td>
<td>&lt;0.1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% of Expected Claims</th>
<th>$ Amount Annually</th>
<th>Likelihood of achieving this level of savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>One Year</td>
</tr>
<tr>
<td>5.0%</td>
<td>($773,000)</td>
<td>27.6%</td>
</tr>
<tr>
<td>10.0%</td>
<td>($1,547,000)</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

This table represents 10,000 claim simulations. Expected claims used in this example is $15.47 million. In the top portion, we see that the likelihood of exceeding 2.5% of expected claims in year one is 27.3%. As time elapses from one year to five years across the top and the “% of expected claims” increases from 2.5% to 25% down the left column, we see the likelihood of exceeding the expected claims levels decreases to less than 0.1%. In the lower portion of the table we see the probability of achieving a 5% or 10% savings. The probability of achieving large savings decreases over time.
When an employer self-funds their health insurance, they assume all of the risk of medical claims incurred by their employees. With this assumption of risk, comes the month-to-month variance or fluctuation in claim costs. As employees receive health care services, these costs can change substantially from month to month. The health care trend chart illustrates this example below.

**TREND MANAGEMENT**

Experience with many self-funded employers has shown that there are immediate cost savings. Over time the cost savings can be substantial. The illustration above demonstrates this principle. To begin with, the taxes, mandates, and fees mentioned previously are eliminated as soon as the self-funded model is implemented, so the employer starts at or below the fully-insured starting point. The initial savings increase over time as the employer includes additional cost savings initiatives such as wellness and consumer driven plans, and splits out certain areas such as working with an independent prescription drug vendor.
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 a daunting 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 or eliminate this risk.

Typically, the employer contracts with a health plan or third party administrator to administer the plan. Often, the employer and employees contribute to a trust and the trust arranges to 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.

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 catastrophic loss. 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 pre-mature 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 green bar is the employer liability and the orange bar is the insurer’s responsibility.

![Excess Loss Diagram](image)

**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, but want to 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.

**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 A WORKING RATE?

The self-funded premiums are called working rates and are the equivalent of premiums under an insured model. Working 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. Working rates are developed annually by actuaries or underwriters to provide a calculated estimate of the claims projection, administrative fees and other plan expenses anticipated in during the plan year.

The working 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 80-90%. Prescription costs typically comprise about 10-20% 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 2-4% 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 working 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. Often 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 well, and bad years when claims are running high.

PLAN DESIGN FLEXIBILITY

Employers can modify their plan designs each year and their actuaries will adjust expected claims based on those modifications. For example, if an employer increases an office visit copay from $10 to $25 dollars, 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. Actuaries use tables and models to determine plan relativities and the value of plan design changes over time.

Additional adjustments to working 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 child-bearing ages, and older males. As females age out of child bearing 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 all together 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, working 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

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.

## Transitional Reinsurance Tax¹

A tax assessed on health insurance issuers and third party administrators used to finance state run nonprofit high risk pool reinsurance entities for individuals with pre-existing conditions.

### Key Elements

<table>
<thead>
<tr>
<th>Comparative Effectiveness Research Fee</th>
<th>Transitional Reinsurance Tax¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1 PMPY in year one; $2 in year two</td>
<td>Estimated per participant fee:</td>
</tr>
<tr>
<td>Indexed to 2019</td>
<td>○ 2014: $63 ($12B)</td>
</tr>
<tr>
<td>Insured: Carriers are responsible (IRS Form 720)</td>
<td>○ 2015: $40 - $60 ($8B)</td>
</tr>
<tr>
<td>ASO: Employers are responsible (IRS Form 720)</td>
<td>○ 2016: $25 - $35 ($5B)</td>
</tr>
</tbody>
</table>

1. The Transitional Reinsurance Tax is under review. Current proposals minimize this tax to 2014 only.

The working rate is a proxy for premiums and provides a self-funded employer the flexibility to manage costs and contributions effectively over time.
OTHER CONSIDERATIONS FOR EMPLOYERS

USING CAPTIVES TO MINIMIZE HEALTHCARE COSTS

Mid-size and large employers may want to self-fund stop loss coverage rather than pay a premium to an outside insurance carrier for additional savings. There are alternative funding vehicles, such as a captive insurance entity, that 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 anywhere from 5% to 10%.

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

<table>
<thead>
<tr>
<th>Type of Captive</th>
<th>Ownership</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Parent (Pure) Captive</td>
<td>Single Employer</td>
<td>Cost savings and investment retention</td>
</tr>
<tr>
<td>Group Captive</td>
<td>Group Members</td>
<td>Pool risk and decrease the cost of stop loss with a captive</td>
</tr>
<tr>
<td>Risk Retention Groups</td>
<td>Group Members</td>
<td>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.</td>
</tr>
<tr>
<td>Association Captives</td>
<td>Association</td>
<td>Created for the use of like employers</td>
</tr>
<tr>
<td>Agency Captive</td>
<td>Broker</td>
<td>Established by brokers on behalf of their clients</td>
</tr>
<tr>
<td>Rent-a-captive or cell facilities</td>
<td>Owned by a sponsor or sponsors</td>
<td>Allows employers or groups of employers to have captive benefits without a captive</td>
</tr>
</tbody>
</table>

For a benefit captive, the stop loss premiums and risk are held and managed by the captive program and paid out as catastrophic claims are incurred. In the table below, we see that 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.

<table>
<thead>
<tr>
<th>Captive Stop Loss Premium</th>
<th>Claims Paid by Stop Loss Reinsurer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Claims Paid by Captive in Excess of Expected Covered by Captive Risk Margin</td>
</tr>
<tr>
<td></td>
<td>Expected Losses Paid by Captive</td>
</tr>
<tr>
<td></td>
<td>Retained by Business</td>
</tr>
</tbody>
</table>

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

As well as the 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. Other advantages of a captive are listed in the graphic below.

In short, 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 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 tax 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 purposely, 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 procedure to fully comply.
CONCLUSION

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 of anywhere from 5% to 15% depending on their cost structure. Self-insurance remains a powerful weapon in the war on burgeoning benefit costs. Employers who make the change can reap immediate benefits and avoid, or at least slowdown, some of the significant and inevitable cost increases on the horizon.

Our Consulting Team is made up of a number of highly trained risk funding professionals. We help employers navigate the self-funding waters and help them develop the best funding strategy to meet their individual needs.

Please contact us (insight@springgroup.com) if our team can be of assistance to your company or if you have any additional self-funding questions that we can help answer.