Health Plan Self-Funding Overview

January 20, 2015

PINELLAS COUNTY SCHOOLS

Empower Results®

Agenda

- Myths and Truths
- Benefits of Self-funding
- Definition of Terms
- Self-funded Example
- Roles and Responsibilities
- Surrounding Districts Funding Status
- District Case Study
- Q&A

Truths and Myths of Self-funding

- **Truths**
  - Self-funding provides added plan design and vendor flexibility. The District can carve out selected benefits, such as Rx or Behavioral Health, and use a different vendor to create a best in class program.
  - District assumes the risk for claims even if / when they exceed projections (under fully insured the carrier takes all the risk, incurs loss when claims exceed premiums).
  - Claims will fluctuate from week to week and month to month based on the services received: the District must be financially able to fund claims as they are incurred.
  - Self-funding provides component cost transparency with a clear breakdown of claims, plan administration fees, add on programs like disease management, etc…
  - The plan more immediately benefits when experience improves and when utilization patterns improve as a result of education and engagement.
  - Self-funding can foster a greater sense of ownership from all stakeholders, since the experience and performance of the plan is no longer the “insurance company’s problem”.

Truths and Myths of Self-funding

- **Myths**
  - All medical plans will save money under a self-funded arrangement:
    - ✓ **Reality**: actual savings is determined by comparing fully insured premiums with actuarially projected self-funded plan costs. In PCS's case, there is minimal administrative savings due to aggressively negotiated fully insured rates and a strong risk sharing provision. The bulk of the savings will come from the elimination of federal ACA taxes.
  - There is no way to cap the District's liability/exposure under self-funding:
    - ✓ **Reality**: the District can buy reinsurance to limit exposure for both large claims and total aggregate claims.
  - All reserves must be accrued in the first year of self-funding:
    - ✓ **Reality**: Districts can develop a multi year funding strategy for reserves subject to State approval.

Benefits of Self-Funding: Reduced Taxes and Increased Flexibility

- **Financial Impact**
  - 0.5% - 3% State Premium Tax
  - 2% - 3% PPACA Carrier Premium Tax
  - 0% - 3% Carrier Margin (risk and profit)
  - District holds the reserves instead of the carrier, and can earn interest income - income that would be otherwise generated by an insurance carrier through the investment of premium dollars.
- **Plan Flexibility**
  - Do not have to comply with State mandated benefits (such as covering dependents to age 30 versus the federal age limit of 26).
  - Not restricted to “off-the-shelf” plan designs offered by carrier (fully insured plan designs must be filed and approved by the state department of insurance).
  - District may separate the administration of Medical and Rx by using different vendors.
  - Ability to incorporate innovative health promotion, disease management and care delivery models (telemedicine, clinics, etc.) and recognize immediate financial impact.
- **Employee Impact**
  - Since the central feature of moving to self-funding is financial and administrative, there is nothing inherent to self-funding that would cause significant employee disruption (unless there is a concurrent vendor change).

Definitions of Self Funding

- **Administration Fee (Administrative Services Only - ASO)**
  - This is the fee charged by a carrier or Third Party Administrator (TPA) to administer the plan.
  - The fee typically includes all administrative costs, such as: claims processing, member services functions, network access and provider contracting, utilization review, case and disease management, wellness programs, etc.
  - It is typically billed as a per employee per month cost (traditionally ranges from $30 - $65 per employee per month) depending on the programs.
- **Expected Claims**
  - The anticipated claims for the upcoming policy year as projected by the actuary.
  - Expected claims is usually expressed either on a per employee basis or will follow the current rate tier structure.
- **Stop-Loss**
  - Stop-loss insurance protection against catastrophic or unpredictable losses.
  - Under a stop-loss policy, the insurance company becomes liable for losses that exceed certain established limits.
  - There are 2 types of stop-loss policies: individual (specific) stop-loss and aggregate stop-loss.

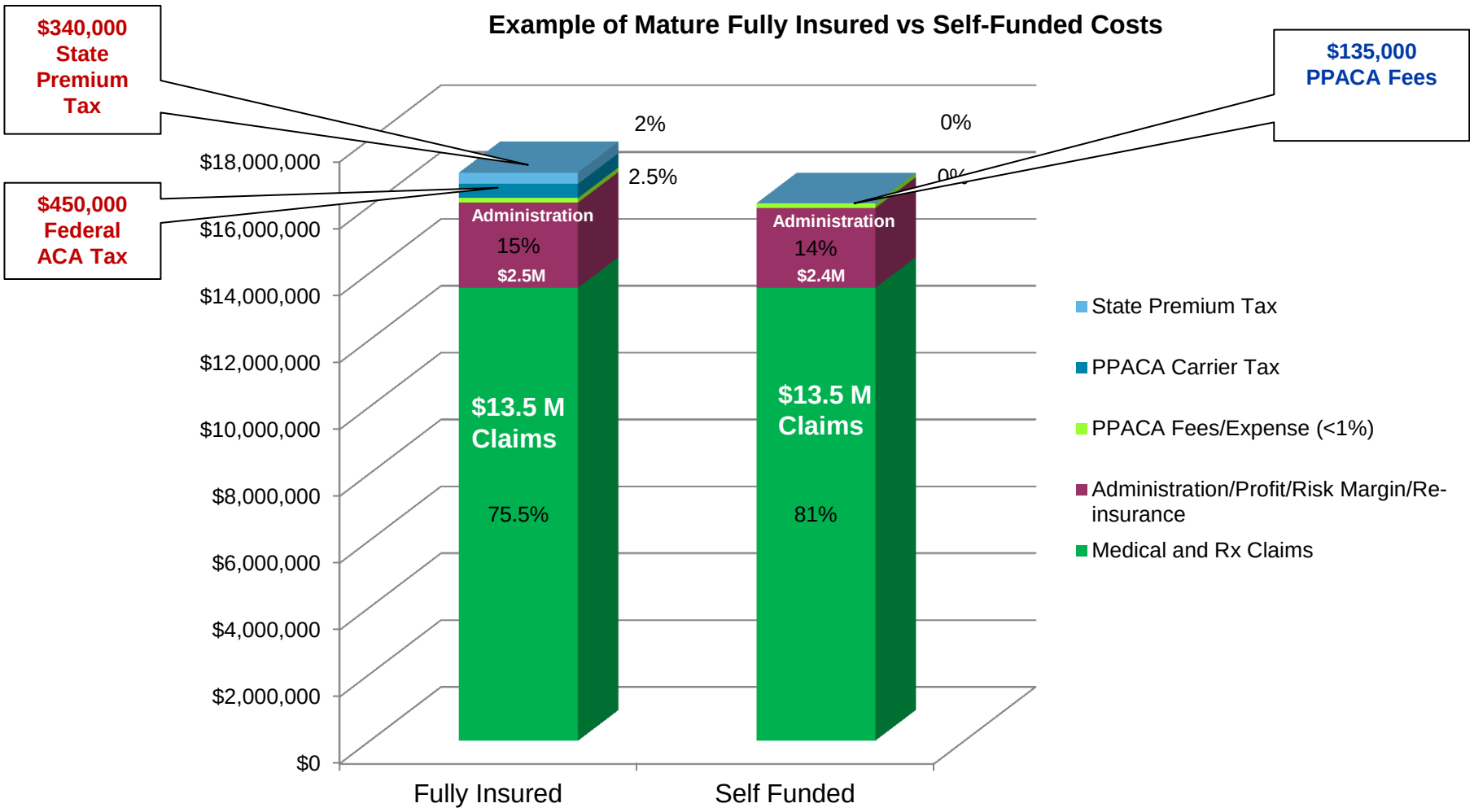
Definitions of Self Funding

- **Individual Stop-Loss:** This is insurance to protect against individual high cost claimants.
  - It protects the plan against an individual's claims that exceed a certain threshold called the attachment point (i.e. $500,000). If an individual's claims reach the attachment point (for example $500,000), the stop loss carrier pays all claims above $500,000.
  - The attachment point and premium are determined based on demographics, location of membership and catastrophic claims experience.
- **Aggregate Stop Loss:** This insurance protects the plan if total aggregate claims exceed expected levels (generally the result of high claims volume versus a few high cost claimants).
  - It is based on the projected expected claims for a given policy year plus a corridor; the most common corridor is 120% - 125% (expected claims plus 20% – 25%).
- **Terminal Liability Reserve (Incurred But Not Reported - IBNR)**
  - Terminal Reserves (IBNR) covers claims for services that were incurred but not yet reported or processed by the carrier within the plan year.
  - This reserve is typically accrued during the first year and adjusted annually after that.
  - It reflects time lag between when a service is rendered and when it is processed and paid by the carrier.
  - The actual reserve is determine based on a claims lag analysis typically running 45 – 60 days of claims (12% - 17% of total annual claims).
  - IBNR or terminal liability reserve should be sufficient to cover all claims costs in the event the plan is terminated.

Definitions of Self Funding

- **FL Code Section 112.08:** Florida requires additional reserves (in addition to IBNR) to assure the solvency of the plan.
  - In order to obtain approval from the Office of Insurance Regulation of any self-insured plan, each District submits its plan along with a certification as to the actuarial soundness of the plan (prepared by an actuary who is a member of the Society of Actuaries or the American Academy of Actuaries).
  - The Office of Insurance Regulation will not approve the plan unless it determines that the plan is designed to provide sufficient revenues to pay current and future liabilities, as determined according to generally accepted actuarial principles.
  - After implementation of an approved plan, each District must annually submit to the Office of Insurance Regulation a report, which includes a statement prepared by an actuary as to the actuarial soundness of the plan. The report is due 90 days after the close of the fiscal year of the plan.
  - The District must provide annual notices to plan participants regarding the funding status of the plan (highlighting if the plan has not satisfied the reserve requirement).

Self-Funding Example



Self-Funded vs. Fully Insured Responsibilities

Responsibilities	Fully Insured	Self-Funded
Financial		**(w/ Stop loss)**
Financial risk of loss (deficit) or gain (surplus)	C	E
Funds ongoing claims payment	C	E
Payment of state premium tax	C	*N/A*
Establish reinsurance through stop-loss or pooling	C	E
Establish terminal liability reserve fund equal to 45-60 days of claims	C	E
Administrative		
Develop and/or approve SPD (Summary plan description)	C	E
Design Rx benefits and contract with PBM (Pharmacy Benefits Manager)	C	E
IRS Sec 105(h) non-discrimination testing	*N/A*	E
Develop an final appeals process for claims appeals	C	E
Develop banking structure and accrue terminal liability reserve	C	E
Conduct HIPPA training and designate officer for staff who may have access to PHI	C	E
ACA Compliance		
Pay PPACA PCORI fee of $1 PMPY and Transitional Reinsurance Fee of $44 PMPY (2015)	C	E
Pay PPACA carrier premium tax	C	*N/A*
Register for a federal PPACA ID (2014)	E	E
Electronically transmit employee data to IRS in 2015	E	E
Ensure plans meet minimum actuarial value	C	E
Ensure compliant SBC (Summary of Benefits and Coverage)	C	E

(C = Carrier, E = Employer)

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Other Surrounding School Districts

- **Self-Insured**
  - Polk
  - Pasco (Health Clinic)
  - Manatee
  - Citrus (Health Clinic)
  - Charlotte (Health Clinic)
  - Orange
- **Fully-Insured**
  - Sarasota (considering self-funding for 2016)
  - Hillsborough
  - Hernando
  - Hardee
  - Desoto

Example of a Board Policy addressing Reserves

6525 - RESERVES IN EMPLOYEE BENEFITS SELF-INSURED FUNDS

Financial stability of the Board's self-insured employee benefit programs is dependent on setting the appropriate funding rates and maintaining an adequate level of reserves. The primary purpose for establishing and maintaining reserves for the various self-insurance funds is to reasonably guarantee the continuous and proper function of the self-insured fund.

The District may self-insure any or all of its employee benefit programs including but not limited to medical, pharmacy, behavioral health, Employee Assistance Program (EAP), life, etc. The District may also choose to purchase stop-loss coverage to cover catastrophic events. It is the self-insured component that necessitates a reserving policy.

This reserving policy covers the following types of reserves:

A. Claims Reserve – On any given day, the fund has a liability to pay claims that have already been incurred but not reported as of that day (IBNR). The plan is also obligated to cover the cost of administering run-out claims in the event that any of the self-insured programs are terminated. A valuation of the IBNR shall be performed annually by a qualified actuary. The actuary will use methods that conform to the relevant standards of practice as promulgated by the Actuarial Standards Board. The IBNR amount shall be 100% funded at all times.

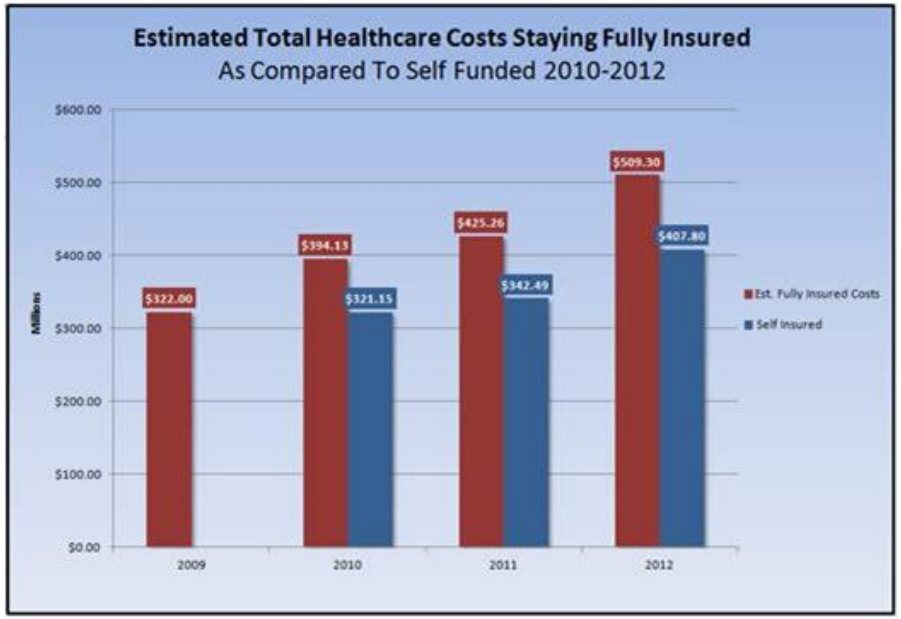
B. Surplus/Contingency Reserve – This reserve represents an estimate for an event that may occur. Even if the District continues to fund at the expected claim level (based on standard actuarial practices), there is a risk that claims can be higher. The Contingency Reserve covers costs associated with these unexpected claims that have not met the specific stop-loss threshold. The amount of the Contingency Reserve shall be maintained at the value of two (2) months (sixty (60) days) of average claims expense paid over the prior fiscal year (twelve (12) months) for each self-insured program, as required by the Florida Department of Financial Services, Office of Insurance Regulation (OIR). This Contingency Reserve also allows for the following:

1. maintaining cost effective and competitive benefits during periods of economic downturn, reduced revenues or tightened budgets
2. maintaining cost effective and competitive benefits during periods of high medical trend, substantial insurance/reinsurance rate increases and an ability to absorb multiple catastrophic medical claim situations occurring simultaneously
3. maintaining flexibility in the fund regarding calculating the degree and amount of risk it is willing to assume on a self-funded basis
4. maintaining the fund's ability to respond proactively and confidently in its function rather than being a reactionary, passive entity controlled by economic and insurance market fluctuation

In addition to this reserving policy, it is affirmed that any reserves in the fund shall not be subject to a transfer out of the fund without recommendation from the entire Insurance Committee and approval by the Board.

Self-Insured Case Study: Miami-Dade (1/1/2010)

- **Carrier:** moved from UHC fully insured to Cigna self-funded for both medical and Rx.
- 1st, 2nd and/or 3rd year financial Impact:



- **IBNR and 112.08 reserve accrual:** They were not able to accrue the total reserve amount to cover the IBNR the first year. They reached the appropriate amount after two years and currently are reserved to cover the 112.08. For the years they were not they utilized, a general asset letter was provided to the Insurance Department of Florida.

Self-Insured Case Study: Miami-Dade

- **Stop Loss:** They had specific and aggregate the first year and then dropped aggregate in the second year. Stop Loss was a very low single digit increase after the first year. Stop Loss is with Cigna at inception and currently.

- **Staffing Requirements:** Benefits staff has experienced increase communications with Budget, Accounting and Treasury Management offices due to the increased administrative responsibilities and accordingly, the Benefits staff was increased by the following two positions:

  Claims Compliance Officer – Oversees financial aspects of the self-insured medical insurance program, recovery of Stop Loss reimbursements, compliance with State laws, rules and School Board policies.

  Accounts Receivable Supervisor – Oversees billing, collection and accounting of direct paying insured members (COBRA, retirees, part-time employees, etc.).

- **Employee Impact:** No, employees have not experienced changes in access to medical providers, pharmaceuticals and other covered benefits.

- **Anything they wished they had done differently?** No, but we credit our success to the coordinated efforts contributed by all District offices, external consultants and the cooperation of the District's collective bargaining organizations that bought into the Self-Insured program.

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Q & A

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