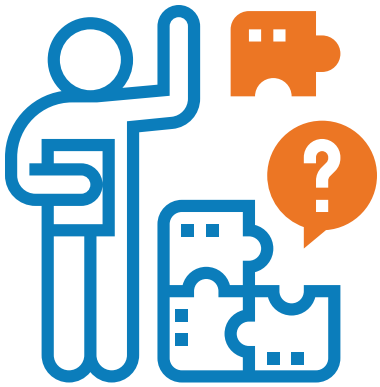
An Introduction to Self-Funding

PINNACLE™
CLAIMS MANAGEMENT, INC.

866.930.PCMI
Quotes@pinnacleTPA.com
www.PinnacleTPA.com

Guide to Self-Funding



Rising health care costs are a key factor in the growing popularity of the self-insurance trend.

An increasing number of businesses are choosing this option to help control costs and have more transparency and control over their health benefits plans.

Today, the majority of plans are self-funded and are comprised of small and large businesses and public organizations of all types.

What is Self-Funding?

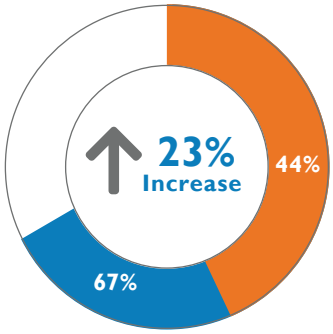
Self-funding, or self-insurance, is the process by which employers choose to financially manage the delivery of health care and the payment of health claims for their employees and dependents.

In contrast, in a fully insured scenario, the employer pays monthly premiums to an insurance carrier. This goes into a larger pool of money to pay claims of a group of employers. In this case, the insurance company assumes the risk.

Self-Funding vs. Fully Insured

One of the biggest differences between fully insured and self-funded plans is who assumes the risk. Self-funding allows smaller and mid-sized businesses to be much more flexible with the benefits they offer. Instead of buying a one-size-fits-all plan, the employer can customize the plan to meet the needs of the workforce. Self-insured employers, with help from a third-party administrator (TPA), select their own medical providers and pharmacy plan.

- All money stays within the self-funded plan unlike fully-insured plans, which keep any savings.
- Rather than pay a set monthly premium to an insurance company for health benefits, the employer sets aside a specific amount each month to cover expected hospital and doctor bills. This amount also includes some administrative fees and stop-loss insurance. The administrator will provide the employer a weekly accounting of adjudicated claims and the employer will fund the claim payments. The funds that are not spent remain in the employer's bank account and under their control. This can result in considerable annual savings.
- Under fully-insured plans, employers are restricted to the plan's drug formulary and network of providers and often have to use their subsidiary-owned companies.



From 1999 to 2020, the percentage of employees covered by self-funded plans grew from 44% to a record high of 67%.

(Statista, 2021)

What is Your Solution?	Fully Insured	Self Funded
Plan Design Flexibility	✗	✓
Claims Information	✗	✓
Reward for Performance	✗	✓
Managable Risk Level	✗	✓

What are the Benefits of Self-Funding?

Greater flexibility in plan design.

- Employers can design their own plan instead of choosing standardized plans from large carriers. Plans can be easily adjusted.

Subject to less regulation and some taxes and fees.

- State-mandated benefits and state premium taxes are eliminated. Self-insured plans are regulated under federal law, Employee Retirement Income Security Act of 1974 (ERISA), and not subject to state insurance regulations and mandates.

Data transparency.

- Unlike fully-insured plans, self-insured clients have direct visibility to their claims. This is very beneficial in analysis of cost drivers as well as the opportunity to develop care management programs to improve the health of members.

Improved cash flow.

- Self-funded employers do not pre-pay the coverage. Since claims are paid only as they are incurred, there can be significant cost-savings as a result from not having to pay insurance company overhead and reserve requirements.

Earn interest from claim reserves.

- Self-funded employers have the opportunity to get money back at the end of the year. Unspent funds remain within the employer.

Savings From Self-Funding	
State premium taxes	1.5% – 3.5%
State-mandated benefits	3% – 6%
Interest on cash flow advantages	2% – 3.5%
Administrative savings	2% – 5%
Utilization review program will yield savings of	5% – 10%

Are There Disadvantages to Self-Funding?

In addition to assuming risk, there are a few other issues to consider when self-funding. The employer will need to assume greater involvement in the management of the plan as well as fiduciary and legal responsibilities. If cash flow is poor or unpredictable to meet the financial obligation, self-insurance may not be the best option.

The Role of the Broker

Along with your TPA, a health insurance broker can help guide their clients through the best options for their coverage and help to optimize plan performance.

The Role of a TPA

A TPA is not an insurance company. They do, however, assist in many ways that go beyond managing the plans and adjudicating claims.

A full service TPA can provide a wide variety of services including:

- Claims processing
- Billing
- Customer service
- Cost analysis and management
- Communication support
- COBRA management
- Eligibility
- Interface with outside vendors
- Stop-loss management
- Regulatory compliance
- Reporting and analytics
- Utilization review

What are the Benefits of Working with a TPA?

Benefit plan administration is complex and multi-faceted and can be daunting for employers. Working with a TPA can provide you the expertise required in plan operations, customer service, regulatory and compliance assistance, and more.

- Provide access to a large network of providers with competitive discounts
- Work with employers to identify a client's specific needs rather than providing a one-size-fits-all solution
- Provide reporting details regarding medical claims and pharmacy costs, giving employers direct oversight and control into their health care costs

- Assist employers in selecting a Pharmacy Benefit Management (PBM) company
- Work with underwriters to asses risk
- Provide access to multiple provider networks and comprehensive services
- Provide health plan analytics
- Provide cost-control features, including utilization management, disease management, duplicate payment prevention, coordination of benefits, hospital and internal audits, third-party liability and subrogation

What is Stop-Loss Insurance?

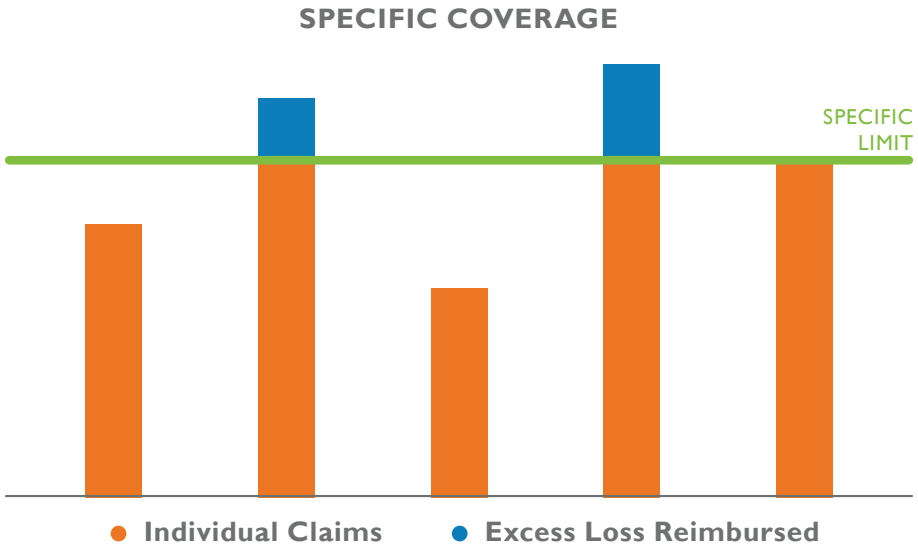
Self-funded employers will need to consider the purchase of stop-loss insurance.

→ Stop-loss insurance provides financial protection against high cost claims. It limits claim coverage for losses above a specific amount. This insurance coverage is for the employer, not the employee.

→ Stop-loss insurance can be added to an insurance policy or purchased independently.

→ Stop-loss coverage is available in two forms, specific and aggregate.

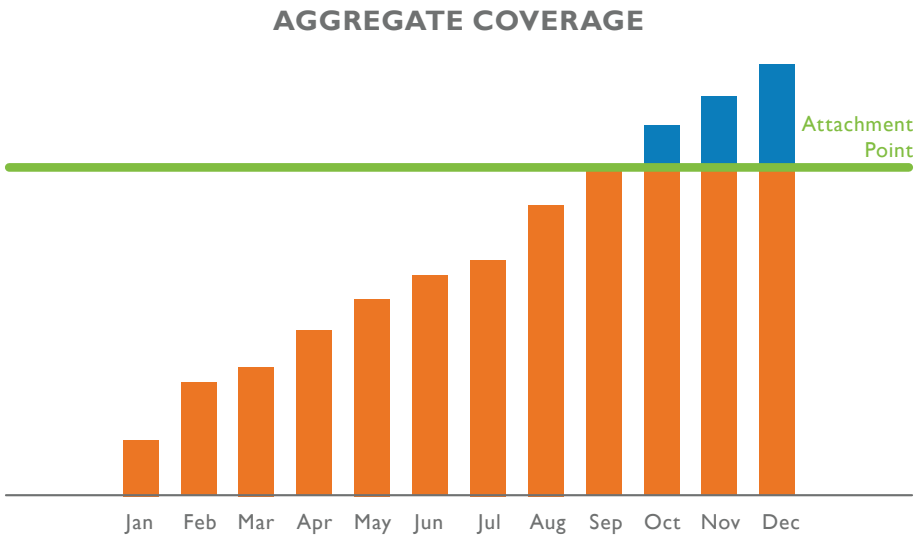
Specific, or individual stop-loss, is excess risk coverage for protection against a high claim on any one individual. This can be for a single claim or frequency of claims. Examples of this type of catastrophic loss are transplants, leukemia, or premature birth. Claims are paid once the deductible is satisfied.



Aggregate stop-loss provides a ceiling on the amount of expenses that an employer would pay in total in during a contract period. It insures the employer against unusually high claims for the entire covered group due to high frequency or an unexpected number of large catastrophic claims. Aggregate claims generally consist of large amounts of ordinary claims, such as flu or prescription drugs. Only claims below the specific deductible on covered individuals are eligible. Aggregate limits are typically 125% of expected claims.

Premiums tend to be lower with higher stop-loss coverage. Having a high stop-loss and a high deductible along with a low coinsurance should keep premiums lower.

The insurance company reimburses the employer after the end of the contract period.



A managing general underwriter (MGU) specializing in health benefits can evaluate the risks and amount of coverage needed to develop a stop-loss policy and provide appropriate financial security.

Find out how Pinnacle Claims Management can help you control your employee health care costs.

Contact us today!

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