Alternative Funding

Exploring Possibilities To Replace Fully-Funded Financing Models For Group Insurance Programs

MY BENEFIT ADVISOR

The experts at My Benefit Advisor have enabled many of our clients the ability to **save on their health insurance premium** while **providing better benefits to their employees** through Alternative Funding Solutions.

These solutions are specifically designed to **reduce costs without reducing benefits** by finding a different way to pay for those benefits.

A Little Perspective

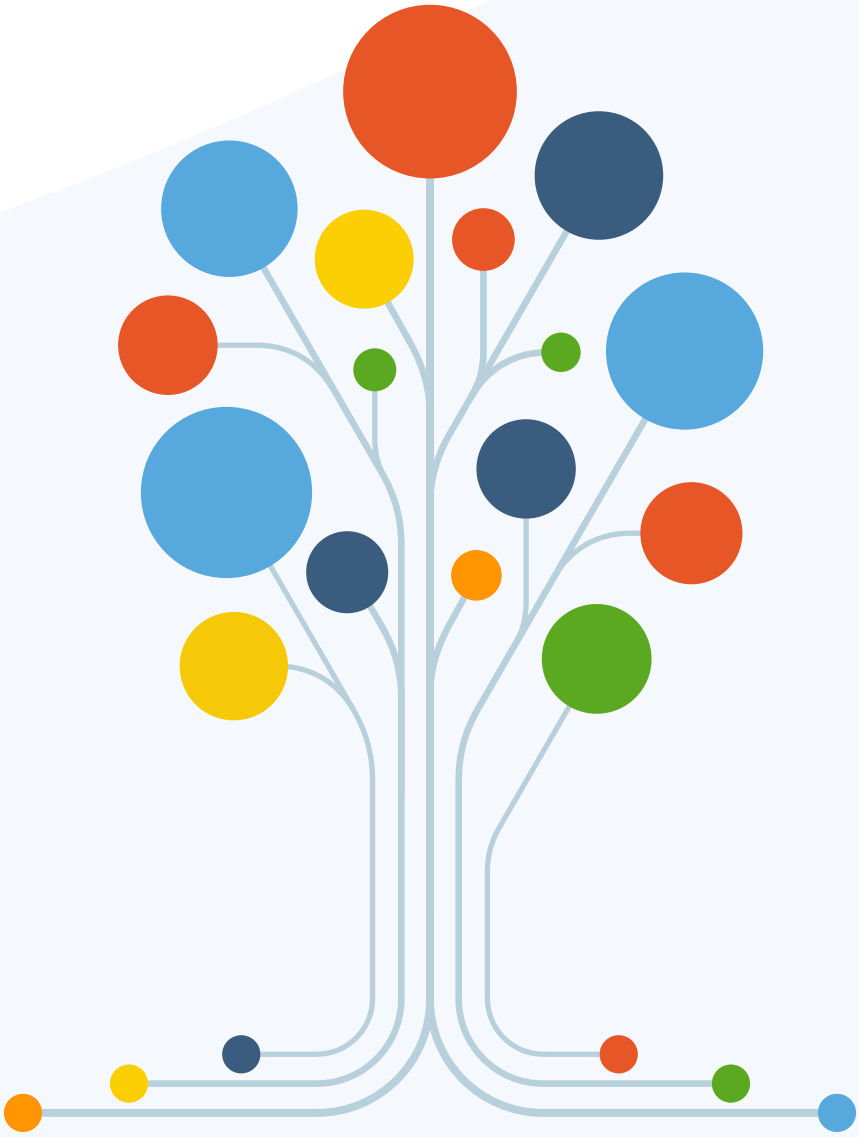
For business owners today, the continual rise in group health insurance premiums have put a strain on their employee benefits budget, forcing them to explore less traditional means of cost containment. Most have already raised deductibles and cost-sharing, implemented high deductible plans and tax advantaged savings accounts and increased employee cost sharing.

As a result, many insurance carriers and third party administrators have answered by creating new ways for groups of almost all sizes to take advantage of funding alternatives as a way to potentially reduce their benefits cost.

Now, whether you own a business with 25, 250 or 2500 employees, there are funding options that may be beneficial for you to consider.

What are these options and how do they work?

Let’s examine alternative funding and provide some guidance.



The Growth of Funding Alternatives

There was a time not too long ago when only the largest groups would stray from a fully-funded insurance program to one that they "self-funded". If a company had less than a thousand employees back in the 1970s, they probably wouldn't even think about self-funding their medical insurance plan. But since then, and especially in the past several years since the passage of the Affordable Care Act, many funding options have emerged, allowing nearly any business owner with over 10-25 employees to transition to an alternative funding arrangement based on their financial capabilities, benefit objectives, employee demographics and utilization history.

Funding Method:
Balancing Cost and Risk

Fully-insured

A fully-insured plan removes most risk from the employer, but the guaranteed cost of the program is high.

Self-insured

A self-insured plan moves most of the risk to the employer but also provides the employer with the greatest opportunity for savings.

Level funding

Level funding is a hybrid arrangement that attempts to combine the best of both fully insured and self insured models.

The “best” funding method varies by group and is best determined by experts qualified to review plan design, utilization history and data analytics to arrive at a recommendation.

Alternative Funding: An Overview

There's now a variety of alternative funding models designed to fit the wide range of today's employer needs and financial capabilities.

With the costs of medical insurance continuing on their upward spiral, many employers are looking for creative and more aggressive cost control solutions. One area that's receiving a lot of attention today is alternative funding methodologies.

Group medical plan funding in general can either be fully insured or self-insured. A fully insured program provides insurance with the least amount of risk to the employer.

With a fully insured program, the insurance company evaluates the risk and sets a premium level. The customer is not expected to pay the difference to make the carrier whole if their claims utilization is more than the carrier expected or get any refund of premiums paid if their claims utilization is less than expected.

At the other side of the risk spectrum are self-insured programs. A self-funded healthcare program is one where an employer assumes the financial risk for providing healthcare benefits to its employees. Conceptually, the employer utilizes a third-party administrator (TPA) and establishes a "bank account" to pay each claim from their own funds as they are incurred. Other than paying the TPA a fee for their role in administering the claims adjudication, providing utilization reviews and for "renting" the TPA's negotiated discounts with a particular carrier, the employer's risk is directly tied to the claims experience of their employees and their dependents.

Self-insurance traditionally has worked best for large employers with a healthy group and consistent claim utilization from month to month.

Large, unexpected "shock" claims adversely affect such consistency, and for this, a group usually obtains stop-loss protection, limiting the impact of these large claims. The advantage of self-funding is more control over plan design, improved cash flow and the avoidance of certain taxes imposed on the employer.

In between fully insured and self-insured plans are level funding arrangements. Level funding is a variation of self-funding that addresses a chief concern for employers the variability of cash flow from month to month on a traditional that they might experience on a traditional self-funded arrangement.

In level funding, the TPA's underwriting department sets a fixed rate that the customer pays them each month (along with any necessary administrative fees), greatly assisting them in their budgeting effort since any monthly claim spikes are eliminated.

Additionally, different insurance carriers and TPAs in different regions of the country have developed other variations of self-insured arrangements that may be appealing to individual businesses. The decision to change funding to one of these arrangements needs to be evaluated carefully as there are nuances among each variation that might work out to be an advantage or disadvantage for any particular customer.

Although traditionally limited to larger groups, recent changes and safeguards have allowed groups with as little of 25 employees to consider self-insurance or one of its modified versions.

Characteristics of Key Funding Models

Full Insured

Typical Group Size: 2 or more employees
Degree of Risk/Reward: Low
Plan Design Flexibility: Very Little Flexibility

The employer pays a pre-established premium to an insurance carrier for a specified plan design. The employer carries no risk, even if total claim dollars paid by the carrier exceed premium collected from the employer. Conversely, the employer does not benefit from lower than expected claims utilization.

Out-Of-Pocket Reimbursement

Typical Group Size: 25 or more employees
Degree of Risk/Reward: Fair
Plan Design Flexibility: Very Little Flexibility

These arrangements include Health Reimbursement Accounts, Health Savings Accounts, Flexible Spending Accounts, Medical Expense Reimbursement Accounts and GAP Products. In these plans, the underlying insurance is reduced by utilizing higher deductibles, coinsurance levels and/or copays. The resulting gap in coverage is handled by a combination of employer funds and employee out-of-pocket expense.

Level Funded

Typical Group Size: Varies by state
Degree of Risk/Reward: Moderate
Plan Design Flexibility: Greater Flexibility

These plans combine the cost savings and customization of self-funding with the financial safety and predictability of insurance plans. Fixed monthly costs are typically broken down into two funds: paying claims funding and paying administrative fees. If claims costs come in low for the year, the employer may receive a premium credit.

Partially Self-Funded

Typical Group Size: 50 or more employees
Degree of Risk/Reward: Moderate to High
Plan Design Flexibility: Greater Flexibility

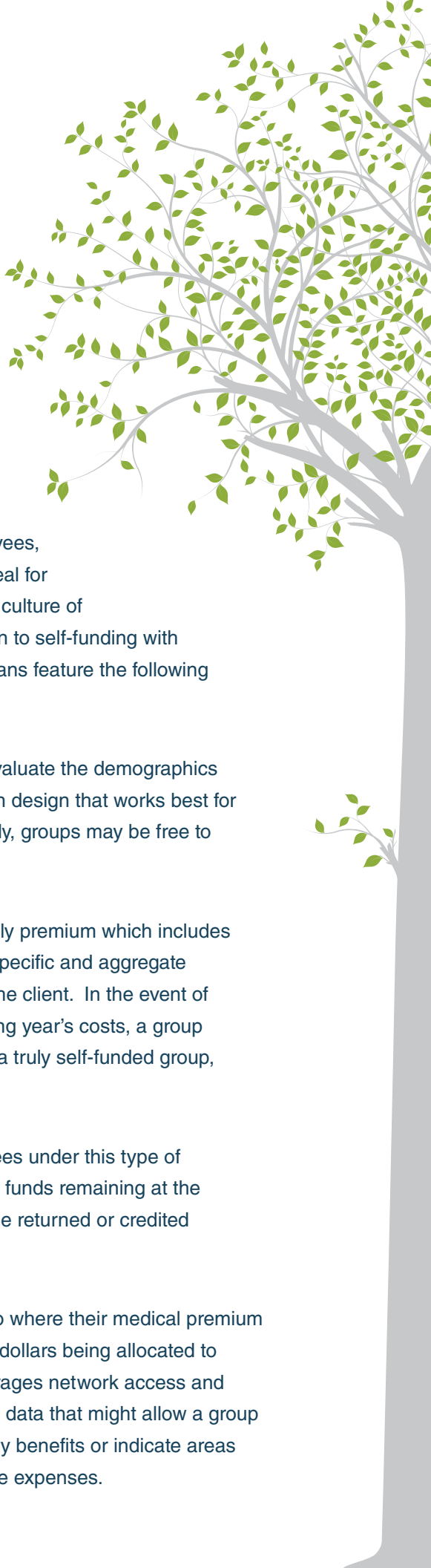
Similar to minimum premium in many respects, but not as an insured product. The employer takes on more liability, which reduces administrative costs but increases risk/reward. Employer typically purchases individual and possibly aggregate stop-loss insurance.

True Self Insurance

Typical Group Size: 100 or more employees
Degree of Risk/Reward: High
Plan Design Flexibility: Greatest Flexibility

Employer takes on all liability, paying all claims without the use of any stop loss insurance.

Level Funding:
A Great Option for Many Small to Mid-Size Groups



The passage of the Affordable Care Act has made it difficult for smaller employers to obtain affordable healthcare coverage for their employees. The cost of a fully-insured program has become prohibitively high, even after implementation of high deductible programs and other, more traditional means of cost-containment.

For many of these businesses, and especially for those with less than 100 employees, level-funded health plans may be a worthwhile solution. A level-funded plan is ideal for employers with 25 or more fairly healthy employees who have created an internal culture of engagement and well-being. Level funding allows these groups to safely transition to self-funding with a predictable monthly claim funding level and limitations to their liability. These plans feature the following advantages over more traditional funding methods:

- **Greater Employer Control Over Plans and Premiums** — Employers can evaluate the demographics and utilization history of their group and determine the appropriate health plan design that works best for their specific needs. And since certain ACA coverage mandates may not apply, groups may be free to decide what they want to include or exclude in their benefit programs.

- **Managed Risk** — Under these arrangements, employers pay a preset monthly premium which includes a component for administration and a separate component for claims. Both specific and aggregate re-insurance is available to provide protection against large claim liability for the client. In the event of a bad year, when facing the likelihood of a substantial increase for the following year's costs, a group with minimum premium can do something that is much more difficult than for a truly self-funded group, they can transition back to a fully-insured plan.

- **Opportunity for Annual Refunds (or Dividends)** — If a company's employees under this type of arrangement incur fewer than expected claims and there are claims-allocated funds remaining at the end of the benefit period, a refund for some portion of the unused funds will be returned or credited to the company.

- **Greater Transparancy** — Employers are able to get greater transparency into where their medical premium dollars are being spent. Most carriers will outline the percentage of premium dollars being allocated to the payment of claims and toward fixed (administrative) costs, stop loss coverages network access and broker compensation levels. Additionally, the carrier normally provides claims data that might allow a group to modify their benefit design to target certain areas of need, trim unnecessary benefits or indicate areas where additional resources might be needed to assist employees and manage expenses.

Why True Self-Funding Works Best With Larger Groups

Self-funding is generally not a good option for small groups due to the laws of probability and statistics. If a coin is thrown in the air 3 times, the results are very unpredictable. There's a good chance it could land on heads all three times, tails all three times, or some combination of heads and tails. If the coin is thrown in the air 100 times the odds increase that the coin will land on each side closer to half the time. When thrown up 1000 times, it is very likely the results will come up within a couple flips of 50/50. The greater the number of flips, the greater the predictability of outcome.

Insurance works the same way. As the number of employees in a group increases, not only does the predictability of any large claim increase, but the ability of the group to "pool" funds to compensate for the large claim increases. A group of 5 employees couldn't predict that they wouldn't have just have one person with a large claim… and the resulting financial impact would be immense. A group with 500 or 1000 employees wouldn't have the same problem, as the company would be able to predict claim utilization with a fair degree of accuracy. The expected number of individuals with large claims would be offset by the majority of people who have little or no claims, spreading the financial risk across a large pool.

Working within this concept, the insurance industry has created "hybrid" funding arrangements that combine certain aspects of fully-insured and self-insured funding models, creating more options for smaller sized-groups. These plans are typically referred to as "minimum premium," "level-funded," or "partially self-funded" arrangements.

3 Key Reasons To Consider Alternative Funding:

1. Increase Cash Flow

2. More Control Over Plan Design

3. Reduce Taxes and ACA Fees

What Prevents More Small Groups from Considering a Level Funded Program?

Actually, a great number of fully insured groups have already migrated over to level funded programs, but there are a few reasons why not all smaller groups have done so. Here are a few of the roadblocks:

1. The Insurance Department in some states do not allow the low attachment point for stop loss levels required for these funding arrrangements, rendering the plans unavailable.

2. The plans are underwritten, pressuring groups with higher claim usage to remain fully insured.

3. Level-funded plans are more complex than traditionally funded plans, requiring brokers and benefit consultants to be more trained on their structure, implementation, and costs.

4. For many groups, it is simply easier to renew with the plan type and funding model more familiar to them.

Case Study:
Changing Funding Method to Control Costs

The Issue

A firm we had worked with for several years had expressed a concern that the cost of their employee benefits package was threatening the financial stability of their business. With a little over 150 employees, their annual benefits cost was exceeding $1.5 million and increasing at a rate of 8-15% each year. Even more concerning was that the benefits cost represented 32% of the company's operating revenue. They had contemplated making plan changes including an increase in deductibles, copays and co-insurance limits, but they cared about the well-being of their employees and felt compelled to keep a competitive level of benefits.

Our Solution

We took the approach that a change in funding options might accomplish their objectives with better financial results and minimal employee impact. After reviewing claims utilization data from their current insurance carrier, we explored a variety of different options and settled on a self-funded arrangement with a $25,000 deductible. We presented our recommendation to the company and they agreed to move forward, choosing a plan design similar to the one they currently had in place but with a few minor tweaks designed to further control costs. We projected that not only should the new plan produce immediate savings, but it should also suppress the significant increases the company had been receiving each year.

Impact/Result

After one full year on the program, the company's total annual cost came in at $1,157,455, which was not only $350,000 less than they had spent the previous year, but also lower than our projections. In addition to the 23% savings, the insurance company also provided the group with a $15,000 wellness fund. Needless to say, the client was satisfied with the results and the employees welcomed the addition of a wellness program!

MY BENEFIT ADVISOR

About My Benefit Advisor

My Benefit Advisor (MBA) is an employee benefits platform designed to guide employers through the complexity of planning, communicating and managing a successful employee benefits program.

To learn more about My Benefit Advisor, visit us online at

www.mybenefitadvisor.com