MARSH & McLENNAN AGENCY

Association of Alaska School Boards – Law Day

The Business of Health – How Health Insurance Works

December 6, 2019

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Anchorage, AK

COUNT ON US!

It's our business to be there for you in the
MOMENTS THAT MATTER.

WORLD CLASS. LOCAL TOUCH.

Discussion Agenda

I. Back In The Day……

II. Alaska: We're #1 & Trend

III. Funding Basics: What are the options?

IV. Self-Funding: Advantages and Disadvantages

V. Stop Loss: How does it work?

VI. Self-Funding: 1st year and 2nd year Illustration

VII. Key Terminology

Back In The Day…..

Alaska
We’re #1 & Trend

Alaska – We’re #1

We’re #1 in that……

Alaska has the highest per capita cost of health care in the United States

&

United States has the highest cost of health care in the world

Health Care Trend Defined

Trend is the projected increase in cost of a claim from one period to the next.

Alaska's annual health care *trend increase* is in the range of 8% to 10%.

Trend Amplifiers

- General Medical Inflation
- Utilization Increase (including advance in medical technology)
- Specialty Drug Explosion
- Cost Shifting between Gov't and Private/Commercial Insurance
- ACA Fees/Benefit Mandates

Funding Basics
What Are The Options?

The Full Range Of Employee Benefits Funding Options

Least Risk → **Most Risk**

Fully Pooled Community Rated	Level Funded Plans	Self-Funded with Stop Loss (Partially Self Funded)	Fully Self-Funded

Funding Basics

Fully-Insured

Insurance company assumes claims risk and the responsibility for claims adjudication; employer pays fixed expense (premium) to transfer risk and administration.

Level-Funded

Employer funds monthly claims at a pre-set amount then insurer assumes responsibility for excess. If actual claims are less than projected, the employer receives a credit/margin payment.

Partially Self-Funded (*)

Employer assumes the financial risk for providing health care benefits to its employees. Employer funds the claims and typically purchases reinsurance (stop loss) coverage to protect against catastrophic claims.

(*) Most plans that are partially self funded meaning they contain elements/levels of insurance

Alaska Insurance Marketplace

- **Fully-Insured Carriers (including Level-Funded Plans)**
  - Primary Carriers are: Premera, Aetna. Moda Health & UnitedHealthcare

- **Self-Funded Vendor Partners**
  - Third Party Administrators: Meritain, EBMS, AmeriBen & many more
  - Stop Loss Carriers: Sun Life, Symetra, Voya & many more
  - The Fully-Insured Carriers can also offer Self Funded options

- **Association Health Plans for School Districts**
  - Premera's Alaska Political Subdivision Plan
  - Public Employers Health Trust (PEHT) – Operates as a self-funded health plan administered by EBMS. The PEHT establishes the premium rates for their plan design offerings, and employers pay the same rate for the year.

How Do Traditional Fully Insured Plans Work?

- Premium paid to insurance company
- Insurance company accepts full risk
- Insurance company holds reserves
- Any funds “left over” at the end of the year become profit for the insurer
- Claims incurred on or after the effective date, are the insurance company’s responsibility regardless of when they are paid

What is Self-Funding?

- Alternative to Fully-Insured Benefit
- Employer assumes all or a portion of the risk for health benefits
- Benefits to Employer: **CONTROL**, Plan Design Flexibility, Cost Savings, Planning/Budgeting, Reserves
- Self-fund predictable claims: also, larger employers will have less claims volatility
- Buy Stop Loss coverage for the unpredictable, catastrophic losses
- CAUTION: Self-funding is not a short term solution to reducing/controlling benefit costs

How Many Employers Self-Fund?

- More than half of U.S. workers are covered by some type of **self-funded** medical plan
- The larger the company, the more likely it is to self-fund

Partially or completely self-funded plans (i.e. more than 95% of employers obtain stop loss coverage)

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2018

Components of Insured vs. Self-Funded Rates

(Illustrated PPO plan)

Components of a Fully-Insured Premium		Components of a Self-Funded Conventional Equivalent Premium	
TOTAL	**100.0%**		**92.5%**
Margin for Claim Fluctuation	3.0%	Margin for Claim Fluctuation	3.0%
Gross Paid Claims	61.0%	Gross Paid Claims (further cost containment programs to dampen claims possible but not shown)	61.0%
IBNR Reserves (held by insurer)	12.0%	IBNR Reserves (held by employer)	12.0%
Pooled Claims (e.g. > $100k)	-7.0%	SL Reimbursements	-7.0%
Pooled Claim Charges (e.g. $100k)	9.0%	Spec Stop-Loss Premium	9.0%
		Agg Stop-Loss Premium	0.5%
Administrative Expenses	10.0%	Administrative Expenses	8.0%
Risk Charge / Profit	2.0%	Profit	1.0%
State Premium Taxes	2.0%	State Premium Taxes Federal HCR Fees	0%
Federal HCR Fees	3.0%		
Commissions	5.0%	Commissions	5.0%

Fixed Cost via Premium

Variable Cost

Fixed Cost

Self-Funding
Advantages & Disadvantages

Self-Funding: Advantages

Lower Fixed Costs

- Administration of the plan less expensive under a self-funded arrangement without sacrificing a reduction in services
- Insurance companies typically charge 3-10% for margin (for fluctuations in claims)
- Under self-funded arrangement, this component is eliminated

Risk Management effectiveness through Stop Loss Insurance

- Employer may choose the amount of risk to retain and the amount to be covered under stop loss protection. Under an insured arrangement, insurance company sets the pooling level.
- Protection from monthly swings can be controlled through a Monthly Aggregate.

Detailed Claims Data

- Employer owns medical and RX data for data driven analysis work (only large fully insured plans have access to claims data, and it may be limited or costly)

Self-Funding: Advantages (Continued)

Tax Savings

- No premium tax for the self-funded claim fund; thus, an immediate savings equal to the amount of premium tax is realized. (AK state tax is 3.1% for most fully insured plans)

Flexibility in Plan Design

- More options with plan design features
- Self-funded plan not bound by state mandates

Ability to “carve out” pharmacy

- Cost savings opportunity available
- Ability to enhance service and reporting profiles

Self-Funding: Disadvantages & Consideration

RISK ASSUMPTION

Employer assumes risk between the normally anticipated claim level and Stop Loss Coverage level

UNEVEN CASH FLOW

Unlike fully-insured premiums, a self-funded plan can only predict the monthly budget but the claims expense will ebb and flow

MORE RESPONSIBILITY

Greater level of administration and responsibility required of the employer as the plan administrator.

Self-Funded Analysis

Pros/Cons Fully-Insured vs. Self-Funded

	Fully Insured	Self-Funded
Pros	• Risk – risk assumed by insurance carrier and capped at 100% of premium level • Predictability – constant, budgetable premium • Administration – one monthly bill provided by insurance carrier • Fiduciary Responsibility – maintained by insurance carrier	• Cash Flow – pay claims as you go (beneficial in favorable claim years) • Retention – savings due to lack of premium tax and risk charge • PPACA Fees – Not subject to HIF fee of 2-3% of medical premium • Plan Design – greater plan design flexibility; deductibles, copays, coinsurance amounts (cannot carve out covered services) • Stop Loss -- protects against unknown large claimants • Fiduciary Responsibility – transferred to insurance carrier/TPA for an administration fee • Reporting – Comprehensive information for developing a custom benefits strategy based upon actual utilization patterns, as well as customized wellness strategy, disease management, etc.
Cons	• Retention - Higher retention charge due to risk charge and premium tax • Cash Flow – limited cash flow opportunities • Reserve – held by insurance carrier • Plan Design – plan design dictated by insurance carrier and state regulations • Reporting – limited • PPACA HIF of 2% - 3% medical premium applies	• Risk - Employer assumes risk. Stop loss insurance should be purchased (i.e., specific and aggregate) • Predictability – claim volatility from month-to-month ,e.g., specific and aggregate. • Potential for lasering of high cost claimants by stop loss carrier at time of renewal. • Reserve – Employer must establish and fund • Administration – greater level of financial administration required due to claims funding, administrative fees, stop loss, etc.

Stop Loss: How Does It Work?

Protecting Against Excess Risk

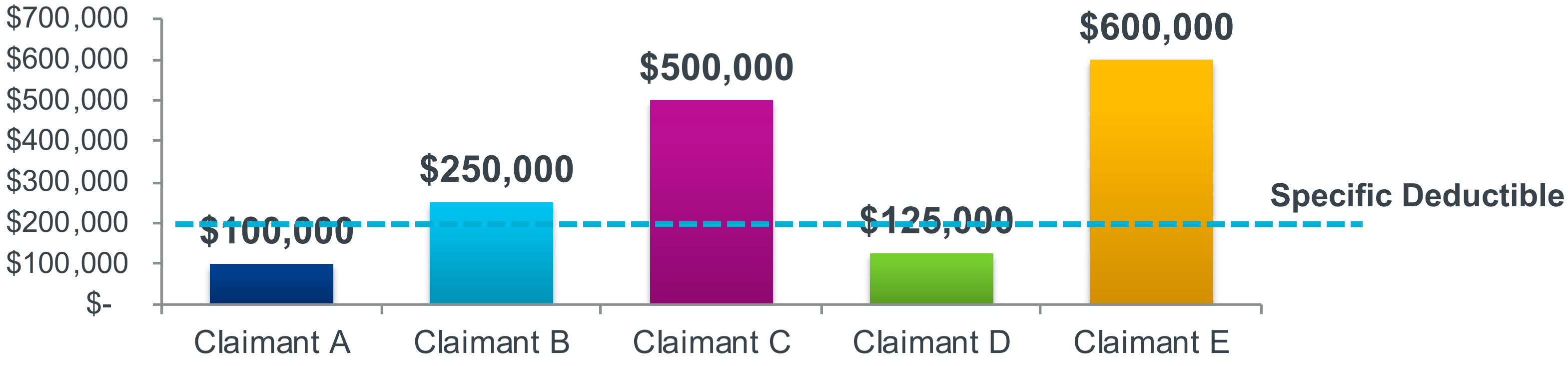
Specific Stop Loss Coverage

- Limits the employer's exposure on any one individual
- Reimburses the employer for claims in excess of a fixed dollar amount called the Specific Deductible
- Typically medical & pharmacy coverage
- Reimbursed as claims occur

Aggregate Coverage

- Limits the employer's exposure for the group's claims as a whole
- Reimburses amounts above the Attachment Point
- Attachment Point is determined by carrier
- In addition to medical, Aggregate coverage typically includes Rx, and can include dental and vision etc.
- Reimbursed at end of contract period

Stop Loss — Specific Deductible



- ✓ **The employer elects coverage at a specific level (e.g. $150,000)**
- ✓ Once a claim for any covered member reaches that limit, all eligible claims paid over that level during the policy period would be reimbursed under the stop-loss policy
- ✓ Since Claimants B, C and E exceeded the specific deductible of $150,000, the stop loss insurer will pay for the claims above $150,000
- ✓ The employer pays a set monthly insured premium for this protection

Median 2018 Specific Stop Loss Levels

Source: Mercer National Survey of Employer-Sponsored Health Plans, 2018

Note: Per Mercer BOB between 18-26% of employers increased their stop loss deductible in 2018

Percentage shown in parenthesis above represents percentage of self-funded employers that carried individual stop loss

Expected Incidence of Large Claimants

ISL Spec Employees	$50,000	$100,000	$200,000	$350,000	$500,000
500	19 - 25	6 – 10	2 – 4	1 – 2	1
1,000	39 – 48	13 – 19	4 – 7	1 – 3	1 - 2
5,000	205 - 225	73 – 85	22 – 29	7 – 11	3 - 6

Source: Mercer Stop Loss Pricing Model

Note: Ranges above represent 25th to 75th percentiles

Actual number of large claimants can vary significantly based on the average age and number of dependents enrolled

Aggregate Stop Loss — Overview

To protect employer from abnormally high claims experience for the entire covered population

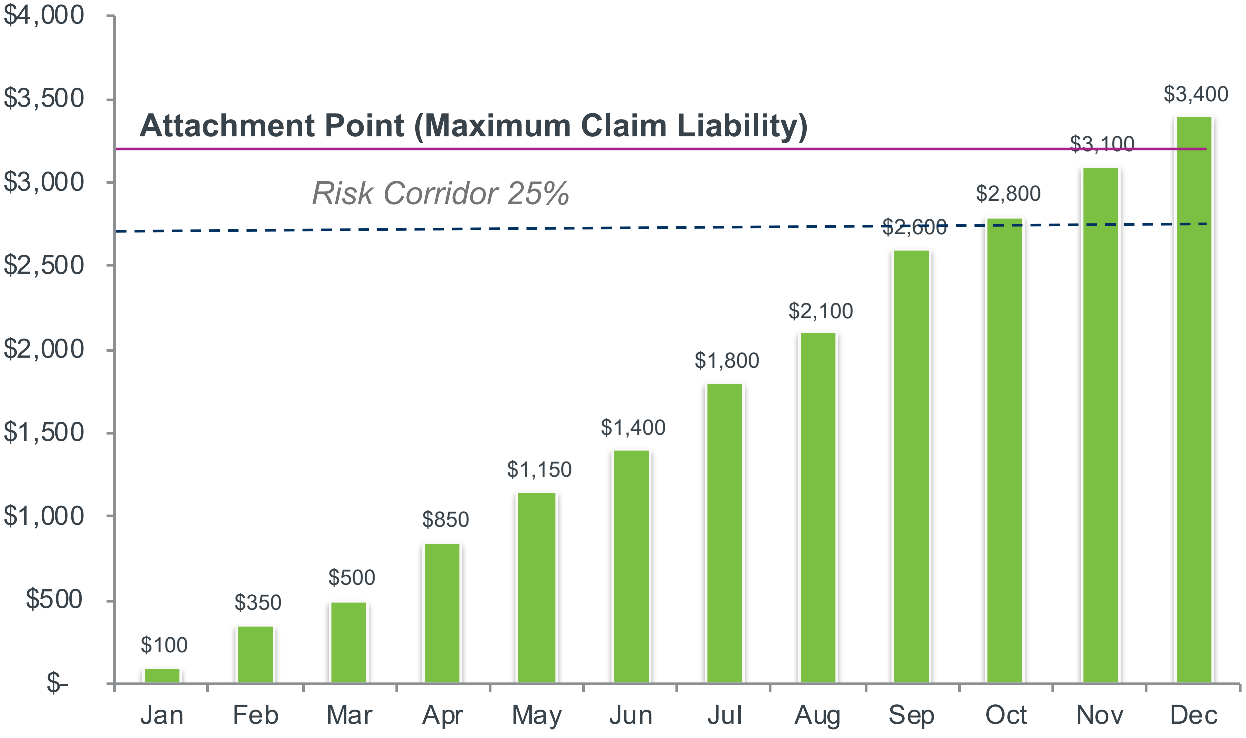
- “Sleep at Night” or “Board of Directors” insurance. While likelihood of a claim is remote, some employer’s prefer to report to the board that they do not have an unlimited liability under the self-funded medical plan.

Employer and insurer agree on an expected Per Employee Per Month (PEPM) claims cost for the policy period

- If the annual PEPM claims exceed that projection by more than the aggregate corridor (e.g., 125%), then the stop-loss insurer would reimburse the employer for all claims over that threshold

Aggregate Stop Loss — Overview (Continued)

Expected Claim Liability of $2,640,000

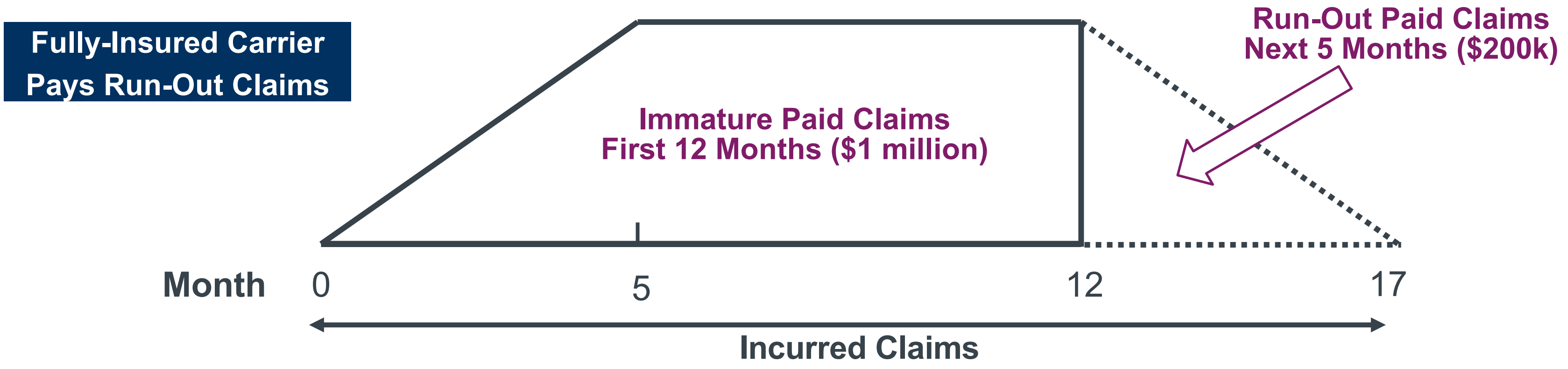


If cumulative claims exceed the Aggregate Attachment Point of $3,300,000, the insurer will pay for the claims that exceeded $3,300,000

Self-Funding
1st year and 2nd year Illustration

Incurred Claims Analysis

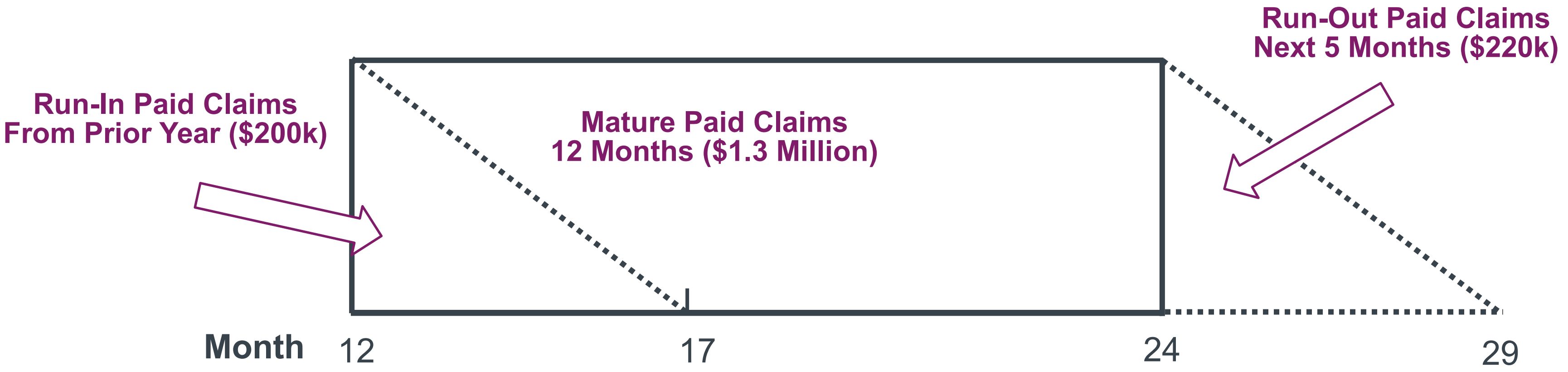
1st Year of Self-Funded Plan – Immature Year



First Year Immature Paid Claims	**$1,000,000**
Less Beginning of Year Reserve (Run-In Claims)	**None**
Plus End of Year Reserve (Run-Out claims are 20% of Paid Claims)	**$200,000**
Incurred Claims First Year	**$1,200,000**

Incurred Claims Analysis

2nd Year of Self-Funded Plan (Trend of 10%)



Second Year Mature Paid Claims increase of 30% (20% Run In + 10% Trend)	**$1,300,000**
Less Beginning of Year Reserve (Run-In claims)	**$(200,000)**
Plus End of Year Reserve (Run-Out claims adjusted for 10% Trend)	**$220,000**
Incurred Claims Second Year	**$1,320,000**

Key Terminology

Self-Funding
Fixed Costs

- **Administration Fees (ASO)**
  - Fixed costs charged on a per employee per month (PEPM) basis. These costs are consistent during the plan year and generally include;
    - Claims administration / payment
    - Access to carrier networks
    - Health promotion, disease and case management
    - Consulting fees
    - Via a carrier or TPA
- **Specific Stop Loss Insurance (Individual Stop Loss or ISL)**
  - Protects employers from large catastrophic claims generated by individual employees or dependents
  - Individual deductibles will vary by group
  - After an eligible employee/dependent exceeds the deductible in a policy year, covered expenses above the deductible are reimbursed to the employer
  - ISL premiums much more expensive than ASL premiums

Self-Funding
Fixed Costs (Continued)

- **Aggregate Stop Loss Insurance (“Agg” Coverage or ASL)**
  - Protects you from eligible claims for the entire group that exceed the annual aggregate liability limit (often claims for a plan population exceeding 125% of expected claims)
  - If eligible claims for entire group exceed the aggregate liability limit, the stop loss carrier will reimburse employer for those claims.
  - Many insurance companies offer “accommodation agreement” for monthly fee
  - Special contract provision provides monthly reimbursement of aggregate claims
  - Coordinates with ISL to avoid “double reimbursement”. Therefore, only claims up to ISL deductible count

Self-Funding
Variable Costs

- **Expected Claims**
  - Total claims underwriter expects you to have in one policy year. Actuarially determined from your past claims experience and future trend and risk projections
  - Annual Funding Accrual Rates (sometimes called “premium equivalent rates”) determined by MMA actuarial team, based on expected claims plus fixed expenses
- **Maximum Claim Liability (based on ASL policy)**
  - This is 125% above your expected claims level
  - Medical and Rx claims that exceed this level are reimbursed by Stop Loss carrier
  - 125% = Aggregate Attachment Factor; percentage can vary, but 125% is most common
  - Aggregate Attachment Factor is set by the stop loss carrier (not MMA), since the carrier is taking the risk for possible aggregate reimbursements

Self-Funding

Other Terms to Know

- **Incurred but not reported (IBNR claims)**
  - Claims have a “lag”, this lag will create IBNR accounting requirements.
  - Typical claim lag is 1.5 months (medical lags, Rx claims are more immediate)
  - A “Claim Lag” will determine the amount of IBNR reserve required.
  - IBNR reserve can be modified during the plan.
  - MMA will provide an analysis that determines the reserve requirement
  - The formal IBNR report may be required in the event of an audit.
- **Third Party Administrator (TPA)**
  - A “bundled” approach uses a carrier, while an “unbundled” approach uses a TPA
  - TPA rents a carrier network (to obtain network discounts) and processes claims
  - TPA provides robust reporting and interacts with other 3rd party vendors such as a PBM or stop loss carrier
- **Run-Out**
  - The period of time immediately following termination, during which time the claims incurred prior to the termination

Self-Funding

Other Terms to Know (Continued)

- **Carve-In / Carve-Out Pharmacy**
  - Carve-In “bundles” the medical and pharmacy with one carrier
  - Carve-Out “unbundles” the medical and pharmacy, using a 3rd party Pharmacy Benefit Manager (PBM).
  - In either situation best practices negotiate contract terms on an annual basis and allow the employer to collect brand name drug rebates.
- **Laser**
  - Stop loss carriers can apply a larger specific stop loss level on a particular member for large anticipated losses.
- **Leveraged Trend**
  - The projection of how much the cost of claims will rise over time
- **Network Discounts**
  - As the carrier or TPA processes or adjudicates in-network claims, they only pay a percentage of the providers allowed billable charges. That is, the difference between the billed charge and the amount paid is the network discount. Network discounts are typically around 50-55% for facility claims, and somewhat less for professional services

Self-Funding

Other Terms to Know (Continued)

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Questions ?

(But not about the picture)

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