Executive Summary

There is a resurgence of interest in self-funding. More employers are taking a new look at self-funding to replace their HMOs and fully insured health plans. As a broker, if you have not done much self-funding recently, it is important to be aware of current market conditions.

DRC has an experienced reinsurance department which works with dozens of reinsurers, reviewing several hundred large groups annually. We are seeing big changes. There are fewer quality reinsurers remaining in the marketplace. Last year, numerous insurers left the business unable to make a profit. In January of 2001 30% of the U.S. stop/loss markets were lost. In July 2001 another 7-10 markets left.

Because of this compression of the marketplace, those insurers still offering medical stop/loss are deluged with proposal requests. Underwriters often decline to quote if they do not know the broker, if the broker does not have a substantial block of business or if it looks like the risk is not profitable. More underwriters work only with a handful of distributors who have large blocks of business with them and are their ongoing "business friends." Many brokers, including large national consulting houses, now use intermediaries or stop/loss specialists to shop and place stop/loss.

Stop/loss underwriters previously would offer rates far under manuals, (i.e., tables their actuaries set). Because of recent losses, reinsurers, including many reinsurers from Europe, have step ped in a required U.S. underwriters and MGUs to offer rates at manual or higher levels. Many rates have doubled over the past three years.

Lower stop/loss deductibles, such as $5,000, $10,000 and $15,000 are a thing of the past with many reinsurers setting minimum specific deductibles of $20,000 or higher. This makes it less feasible for smaller groups (especially those with under 100 employees) to self-fund. At Capitol, we do not recommend self-funding for groups under 100 employees. Our average group size is 1000-10,000 employees. Groups with 300 or more employees can consider self-funding feasible and we can help you explore the feasibility by reviewing the group data.

We have attached a list of items to help brokers pre-screen which groups are good candidates to self-fund. Call us with your questions. We are glad to share what we know about the market and assist with your groups.

Advantages of Self-Funding Your Health Benefit Plan

- **Customized Benefit Plan Designs** Self-funding enables groups to design benefits based on needs vs. restrictive canned plans currently offered by insurers and HMOs. PPO, EPO, and Out-of-Area benefit plan designs are most popular.
- **Lower Administrative Overhead** Self-funded fixed costs (both administrative and premiums) are typically much lower than fully insured and HMO plans. Often times self-funded plans have 50% lower administrative overhead costs than highly managed plans.
- **Customized Networks** PPOs, EPOs and custom employer sponsored provider networks are available. We have the ability to use custom, national and local networks or a combination thereof to service large territories with differing needs. These networks have enjoyed considerable stability with few doctors leaving the networks. Many networks have been highly publicized as of late because hospitals and doctor groups are pulling out of those networks and/or are refusing to treat additional HMO patients. Some have even gone bankrupt or have otherwise had cease operations.

Financial Incentives

Fully funded plans and HMOs base their premiums upon fixed costs (administrative costs) plus expected claims. If claims are low, the insurer or HMO keeps 100% of the savings. The insurer and/or HMO will raise its rates if claims or administrative costs for the previous year were beyond their expected levels. Insurers will recover losses and deficits from prior years in higher renewal rates.

Self-funded plans are based upon the concept of risk sharing. The client determines and assumes an acceptable level of risk. Specific and Aggregate coverages are purchased through insurers to cover amounts in excess of the exposure amount the client is willing to assume. Premiums for stop/loss coverage represent a small percentage of the total cost.

Normally, stop/loss is based upon expected claims plus a 25% corridor. For groups with no experience history (such as groups coming from an HMO or fully funded plan which will not provide claims data), the aggregate attachment point will be based on higher manual rates. Without loss experience, it is sometimes difficult to get reinsurers to quote aggregates. In such situations, aggregate estimates can be provided. Once the group has at least six months of actual claims experience carriers will often make aggregates available for the next renewal.

Brokers and groups should keep in mind that aggregate levels are set by underwriters in a manner so that they are rarely are reached. This is illustrated by the fact that aggregate premiums tend to be fairly low. Thus, while there is a risk to operating without an aggregate for a limited period of time, we feel the risk is minimal. If such circumstances arise, brokers and groups should strongly consider this alternative. If claims exceed Specific or Aggregate limits, insurance covers claims above those limits. If claims are below the Specific or Aggregate attachment points, the client funds only the lower actual benefit payments. Thus, claims below the Aggregate limit represent savings to the client.

- **Build Reserves** Self-funded plans allow groups with good experience to build reserves in their budget allowing a cushion to level claims experience when it is above normal. Under self-funding, clients hold their own reserves and have the choice of funding them or merely carrying the liability on their books. Under an insured plan, the insurers bill reserves, adding reserves to rates and keeping them from year to year until the client cancels. Thus, insurers can enjoy the use of 25% or more of a year's premium for their own cash flow and investment benefit.
- **Ability to Adjust to Conditions and Market Changes** Because of the customized nature of self-funded plans, plans can grow or change from year to year based upon needs, new offerings in the market such as new and better PPOs, added services available through qualified vendors, etc. A change in benefit plan design or a change in a PPO can be made without the need to scrap or cancel the entire plan.

Benefit Of Using DRC To Manage Your Self-Funded Benefit Plan

- **Reporting** Company has a wide variety of reports available to its clients to track benefit utilization and claims history to help clients make educated decisions regarding their benefits. Many HMOs and fully funded plans offer limited or no reports regarding utilization and/or claims history. Such lack of reporting denies the client the ability to evaluate the fairness of their rates and hampers their ability to get competitive bids at renewal. Most insurers build rates around a group's actual experience which is now customarily unavailable through most HMOs.
- **ERISA Compliance** Many groups elect to self-fund to avoid burdensome State insurance requirements. Self-funded plans fall under less restrictive federal ERISA guidelines and are not subject to State insurance laws. (Municipalities and Non-Profit Organizations, i.e., Counties, Churches, Schools, etc., are exempt from ERISA.) ERISA Self-Funded Plans allow for conformity of benefits across State lines for business with multiple locations across the country. Employees who transfer from one state to another do not have to change benefit plans.

- **Consolidated Services** Company can tailor plans to each client's needs and incorporate medical, dental, vision, prescription drug, flex, COBRA/HIPAA, and other services all under one contract. Company will coordinate vendor services, i.e., utilization review, prescription benefit managers, case management, PPO services, etc., submit appropriate data and eligibility to each vendor and submit consolidated monthly billings to the client for those services.
- **Vendor contracts Based on Volume** Company negotiates contracts with vendors, such as Prescription Benefit Managers, PPOs, Case Management vendors, etc., based upon large blocks of business in order to negotiate favorable rates and discounts for its clients.
- **Customized UR and Case Management Services** These services can be tailored to suit the client's needs and can help offset claims costs without requiring a gatekeeper concept. Various levels of UR are available.
- **Account Management** An Account Manager is assigned to each group. The Account Manager works with the group from implementation forward and is responsible to assure client satisfaction with Capitol's services as well as with the services of the vendors associated with the plan. Account Managers are available to make benefit and plan design recommendations and to assist the group with enrollment meetings, amendments and day-to-day issues involving the plan.
- **Performance Statistics** Performance results such as financial, payment and turnaround time statistics are based upon in-house auditing activities and are available to our clients. Our performance results meet or exceed industry standards including those standards of fully funded plans and HMOs. Furthermore, we are willing to negotiate performance guarantees with our clients.