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MAKING THE SHIFT TO SELF-FUNDING

A guide for employers wanting to free themselves from higher insurance plan costs while improving healthcare outcomes.

TABLE OF CONTENTS

The Self-Funding Option 3

4 Reasons to Switch to Self-Funding 4

Self-Funding Simplified: the Basics

Stop-Loss Insurance 5

Third Party Administrators 6

Case Management and Utilization Review 7

Provider Networks 8

Pharmacy Benefit Managers 9

Beyond the Basics

Specialty Rx 10

Direct Primary Care 11

Direct Contracts 12

Centers of Excellence 13

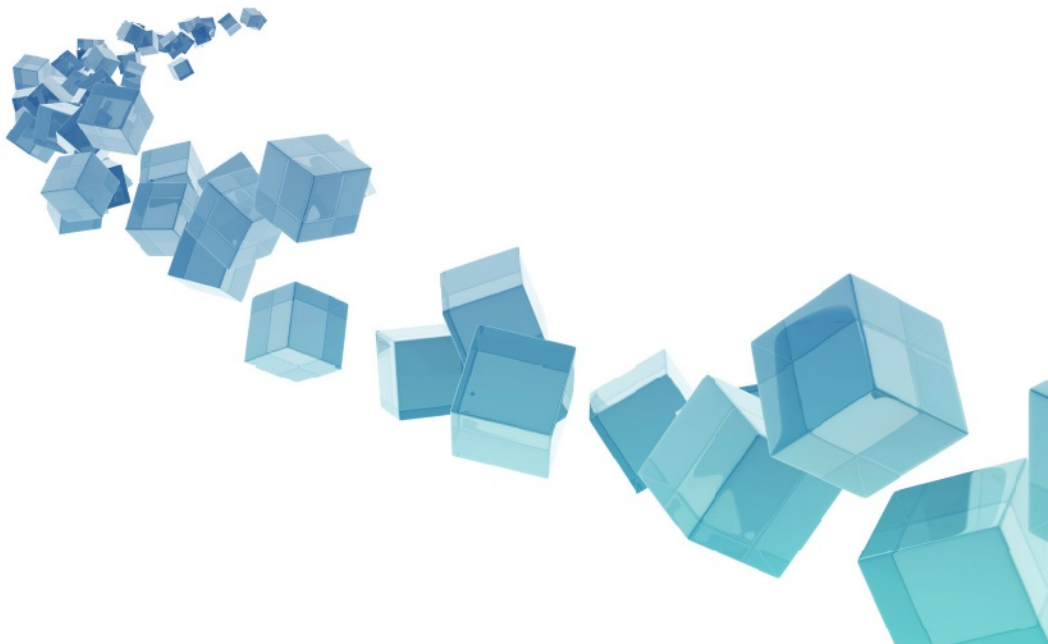
Cash Pay Programs 14

Benchmarking 15

Wellness Programs 16

Referenced-Based Pricing 17

Captives 18



THE SELF-FUNDING OPTION

More employers are switching to self-funded health plans than ever before.

For good reason. Self-funding, or self-insuring, means never having to again blindly pay monthly insurance premiums and, instead, turning to a line-up of health care providers and others that contract directly with the employer.

It's an unbundled, cut-out-the-middleman approach that is helping companies regain control of runaway healthcare spending while improving healthcare outcomes for their employees.

In fact, more Americans already are covered by self-insured health plans (67% in 2020, according to the latest estimate) than through conventional employer plans.

Making the transition to a self-funded plan can sound complicated.

There's the risk-mitigation piece. Another for administration. Another for healthcare providers. Another for pharmacy benefits, and one for utilization.

Those are the **BASICS**.

There also are a few more pieces that should be considered for employers wanting to get the most from the self-funded approach – a **BEYOND-THE-BASICS** bundle.

This guide covers much of what you'll need to know to make the transition, with brief descriptions of each of the pieces that go into building a self-funded health plan.

Making the switch, as you'll see, really isn't that complicated at all, and the savings can be significant.



67%

of Americans are Self-Insured

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4 Reasons to Switch to Self-Funding

The top four reasons you'll want to give self-funding a closer look:

1

Reduced insurance costs

Insurance companies tack on what's known as a risk charge for their policies that amounts to approximately 2 percent a year. Depending on the size of your workforce, this charge can range from thousands of dollars to potentially millions. A self-insured company never has to pay this cost.

2

Reduced state premium taxes

Self-insured programs, unlike insured policies, are not subject to state premium taxes. The premium tax savings is about 2 to 3 percent of the premium dollar value. Again, we're talking about potentially saving many thousands of dollars annually, if not more.

3

Full control over healthcare spend

Subject only to the Employee Retirement Income Security Act, or ERISA, self-funded plans can choose whatever benefits they want to offer their employees as long as they meet the federal government's "essential health benefits" minimums.

4

Improved cash flow

Self-insured employers do not have to pre-pay for coverage (that's the premium paid to an insurer), and claims are paid only as they become due. Better still, significant savings can be realized in low-claim years.

SELF-FUNDING SIMPLIFIED: THE BASICS

Stop-Loss Insurance

It's the scenario employers worry about most: An employee enrolled in their self-funded plan falls seriously ill, incurring hundreds of thousands of dollars in medical bills. So, what's the employer's liability? How much of the expense will the company have to shoulder? The reality is that the exposure is limited, thanks to stop-loss insurance. This form of reinsurance coverage is a built-in safeguard that reimburses companies when medical claims exceed a certain, agreed-upon level.

In other words, with a stop-loss policy in place, the stop-loss insurer would cover any claims above a company's deductible.

For small and midsize businesses, this limit can be as low as $10,000.

Stop-loss comes in two forms: **specific** and **aggregate**.

Specific Stop-Loss protects an employer against a high claim on any one individual.

Aggregate Stop-Loss provides a ceiling on the dollar amount an employer would pay, in total, over the span of a contract period.

Specific stop-loss premium typically amounts to 20-30% of total spend, while the premium for aggregate stop-loss usually is under 1%.

The Benefits of Stop-Loss Insurance

- **Allows employers to self-fund, eliminating monthly premiums, and increases cash flow.**
- **Provides a cap on expenses in case of catastrophic losses.**
- **Helps employers protect their financial reserves and their bottom line.**

Third Party Administrators

A third-party administrator, or TPA, is a services provider that does most of the work for self-insured health plans.

TPAs take on administrative burdens including eligibility, customer service for members, insurance claims processing and payment, reporting, and record-keeping.

TPAs also can provide support coordinating services from vendors such as actuaries, claims adjusters, claims analysis firms, or legal counsel, when necessary.

Typically, TPAs charge a fixed per employee per month capitated fee for their services. The fee is usually between 5-15% of the total annual cost of a self-funded health plan.

The Benefits of TPAs

- Lower overhead costs overall.
- Reduced cost of claims management.
- Improved control over claims outcomes.





Case Management and Utilization Review

The two are related, though the difference is that case management occurs *before* and *during* a patient's admission, procedure or treatment, while utilization review is *retrospective*.

Thus, case management is the review of services to ensure they are medically necessary, provided in the most appropriate care setting, and at or above quality standards.

Utilization review is the mechanism used by some insurers and employers to evaluate healthcare after it's been administered on the basis of appropriateness, necessity, and quality.

It is essential that case management and utilization review be performed by individuals who have a clinical background rather than by administrative staff.

The Benefits of Case Management and Review

- Both help to prevent unnecessary costs and claim denials.
- Improved quality of care for members on the plan.

Provider Networks

Just like those that work with insurers, these networks include primary care physicians, specialty physicians, hospitals, urgent care clinics, labs, X-ray facilities, home healthcare companies, hospice, medical equipment providers, infusion centers, chiropractors, podiatrists, and same-day surgery centers.

With the insurer out of the picture, a self-funded employer contracts directly with a network to access their contracted facilities and physicians.

The Benefits of Provider Networks

- Access to a broad choice of providers.
- Employers realize discounts the networks have negotiated with providers.



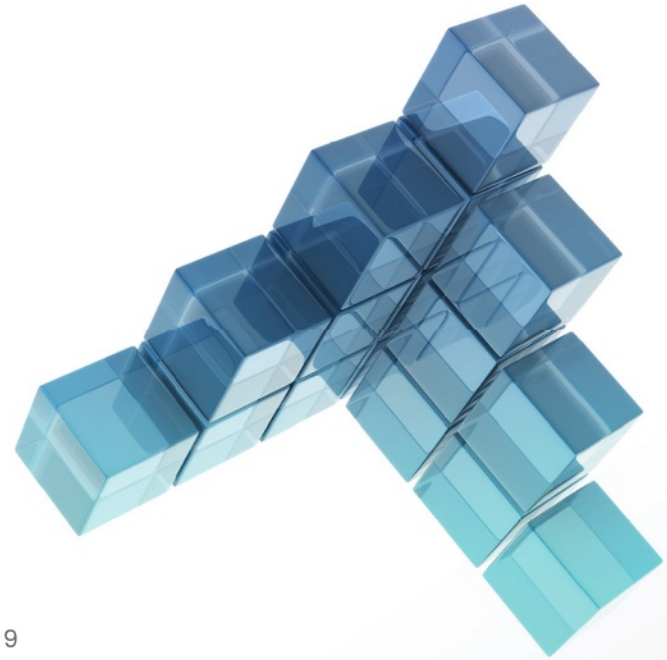
Pharmacy Benefit Managers

Pharmacy benefit managers, or PBMs, are companies that manage prescription drug benefits. At the moment, PBMs do that for more than 266 million Americans with health insurance from either their employers, Medicare Part D drug plans, or other payers and sponsors.

In doing their work, PBMs act like giant buying networks for drugs, representing consumers from multiple employers and insurers. In economic terms, they aggregate demand, which gives them leverage in the market.

In other words, PBMs use their buying power, combined with utilization management strategies, to lower the cost of pharmaceuticals.

By negotiating rebates with drug manufacturers and discounts from large pharmacy companies, PBMs have had a significant impact in slowing runaway drug costs.



The Benefits of PBMs

- **Offer home delivery of medications and select networks of more affordable pharmacies.**
- **Encourage the use of generics and more affordable brand medications.**
- **Manage high-cost specialty medications.**
- **Reduce waste.**

BEYOND THE BASICS

Specialty Rx

PBMs have different operating and cost structures. Those that include specialty drugs include a wider choice of drugs in their formularies – medications that treat complex diseases, including cancer, multiple sclerosis, rheumatoid arthritis and hepatitis C.

These drugs typically don't have generic, low-cost alternatives, and the prices can be high – into the tens of thousands of dollars for a single course of treatment.

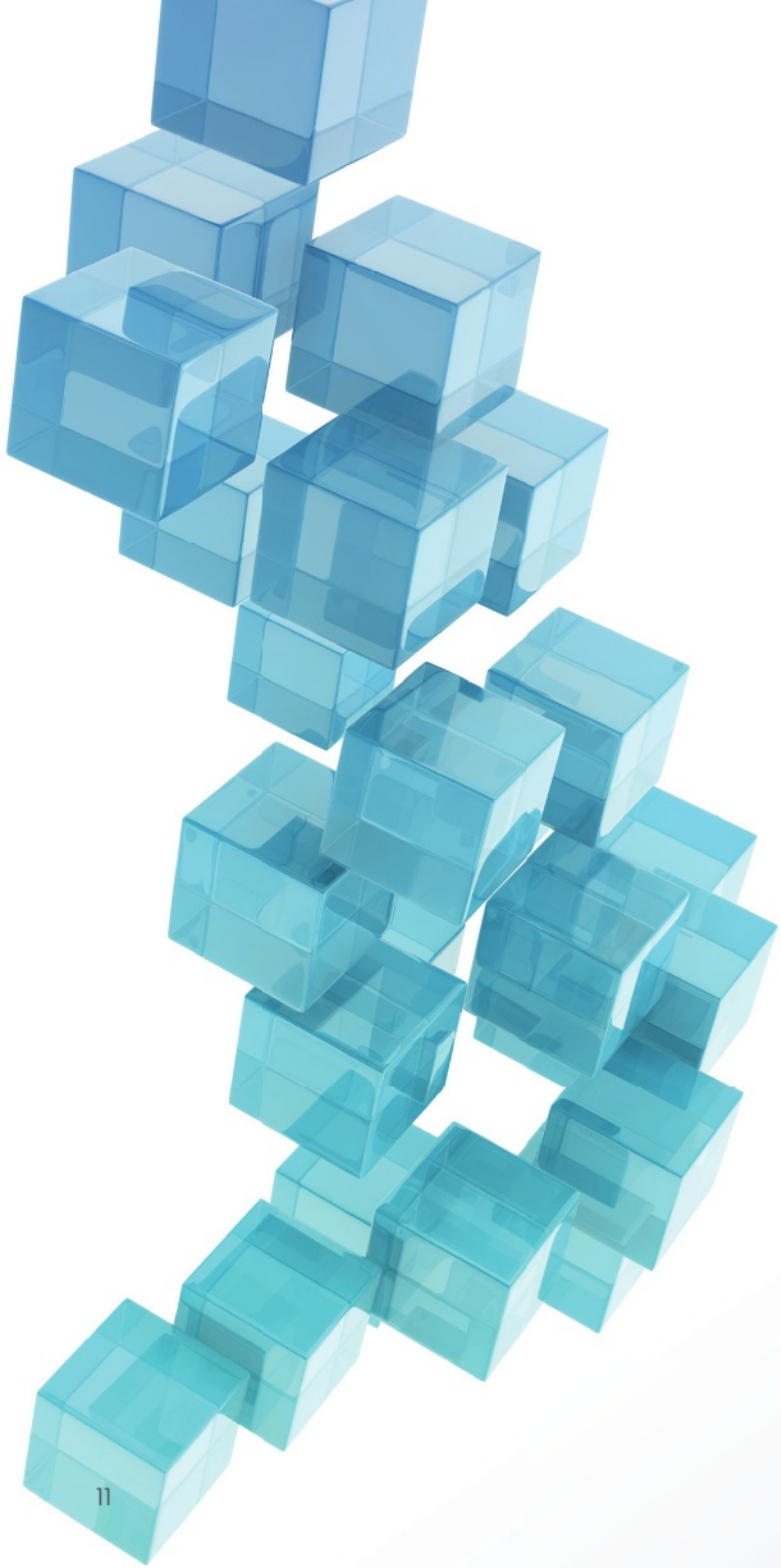
Because of that, specialty drugs can be typically carved out of a primary Pharmacy Benefits Manager's list of available drugs.

A Specialty Rx benefits manager will make those medications available at deep discounts unavailable elsewhere. Some of these programs include manufacturer coupons and copay assistance programs.



The Benefits of Specialty RX PBMs

- Regular communication with prescribing doctors and patients.
- Enhanced quality of care.
- Better service.
- Lower out-of-pocket cost for the member and lower net cost for the employer.



Direct Primary Care

The direct primary care model has helped strengthen the relationship between patients and their physicians, allowing care providers to have more control over how many patients they see, practice staffing levels, and care delivery questions.

In the direct primary care model, instead of receiving reimbursement for each service rendered, physicians receive a per-patient amount per month, quarter, or year. This fee can range from $75 per month to thousands or more per year, depending on the practice's level of service and operating model.

The Benefits of Direct Primary Care Providers

- For patients, direct primary care means a greater degree of access to, and time with, physicians (usually same-day or next-day appointments, no waiting room time and 24/7 on-call doctor in the same medical practice).
- Improved communication and more regular, engaged care leads to fewer unnecessary tests, fewer hospital visits, and lower total cost of care.

Direct Contracts

More than physician groups, these agreements are comprised of hospitals and other healthcare facilities, providers, suppliers, and caregiver organizations with which an employer has contracted to deliver health care services to enrollees in its health plan.

These direct contracting arrangements provide new opportunities to collaborate on efforts to control costs and to address the specific health needs of the employer and its workforce.

These arrangements may apply to the entire spectrum of health care services for which health care benefits are provided, or they may be tailored to a specific subset of services, such as joint replacement surgeries, cardiac catheterization procedures, or other high-volume, high-cost procedures.

Regardless of scope, direct contract arrangements represent a commitment by the provider to proactively and effectively coordinate and manage the delivery of health care services to employees, with the goal of controlling the employer's costs while improving quality of care and increasing employee satisfaction.

The Benefits of Direct Contracts

- **Direct contracting arrangements offer self-insured employers the chance to gain control over the quality of health care benefits their employees receive.**
- **Working directly with providers, self–funded employers can develop custom-tailored care options to meet the specific needs of their employee population.**
- **Employers and employees pay less when contracting directly with providers that have lower costs for procedures based on the frequency they perform the service and better-quality outcomes.**

Centers of Excellence

Access to world-class specialists. A full range of services. Coordinated care. An exceptional patient experience.

All that and more is what patients can expect from a Center of Excellence, or COE.

In health care, a center of excellence accreditation is awarded to medical programs that treat complex conditions while meeting the most rigorous quality, safety and patient experience standards. COEs most often include specialties like cancer care, heart care, neurology and orthopedics to name just a few. To become a COE, a health care program must:

- Be committed to providing the highest level of care to every patient, every time.
- Conduct research that translates into improved treatment options and patient outcomes.
- Demonstrate quality differentiation of their services, equipment and technologies.
- Enact a culture of continuous improvement.



The Benefits of COEs

- **Help employers save money on their health care, in part through better outcomes.**
- **Lower re-admission and post-surgical complications.**

Cash Pay Programs

For many Americans, deciphering a doctor or hospital bill can be practically impossible.

Deductibles, co-pays, and co-insurance all make the job complicated. In fact, most people have no idea what their final financial obligations might be.

Cash pay, on the other hand, means the employer or the member pay for medical care on the spot, like you would a hamburger at a restaurant.

Many hospitals and other providers are willing to accept a reduced fee if the patient or health plan pays with cash, because the money comes through immediately, helping them avoid time-consuming paperwork, collections and insurer adjustments.



The Benefits of Cash Pay Programs

- **Patients using cash-pay healthcare are able to save between 20% and 65% on the cost of healthcare services.**

Benchmarking

Healthcare organizations collect a vast amount of data. Benchmarking that data allows hospitals and medical practices, individual clinicians, and other healthcare organizations to assess and compare their performance against their peers.

Doing that allows these providers to drill down into performance gaps to identify areas for improvement.

Benchmarking typically examines a variety of metrics including:

- Mortality rates;
- hospital length of stay;
- re-admissions;
- post-operative complications;
- patient wait times;
- adherence to established protocols, such as hand-washing;
- patient satisfaction;
- pharmaceutical side effects and outcomes;
- outcomes following the use of medical devices.

The Benefits of Benchmarking

- **Better care decisions, resulting in improved patient safety and satisfaction and cost-savings.**
- **Provides a guideline for providers to develop a standardized set of processes and metrics.**
- **Enables a mindset and culture of continuous improvement.**





Wellness Programs

Wellness programs typically include activities such as weight-loss competitions, exercise, stress management or resiliency education, smoking cessation programs, and wellness assessments that are designed to help individuals or employees eat better, lose weight and improve their physical health.

A survey from the International Foundation of Employee Benefit Plans found 66 percent of employers offering wellness programs reported increased productivity. Another study suggested that employee participation in wellness programs improved productivity equivalent to an extra full day of work each month.

The Benefits of Wellness

- Participation by employees encourages healthier behavior, reduces elevated health risks, and improves productivity.
- Reduces employer's health care costs.
- Improves employee recruitment and boosts retention of quality employees.

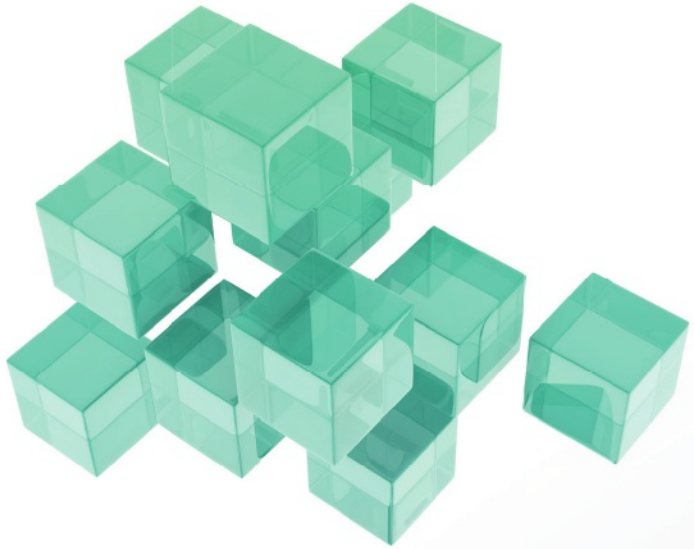
Referenced-Based Pricing

Administered by what are known as claims re-pricers, reference-based pricing, or RBP, plans work by setting a cap on how much they will pay for all medical procedures.

For example, we know that while an echocardiogram may be billed at $1,500, a PPO will have negotiated discounted rates that reduce the price to, say, $900. A reference-based pricing plan, however, would pay just $425 because its "allowable" rate is based on how much Medicare will reimburse healthcare providers for their services.

Medicare, in other words, is the "reference" point for the RBP's price.

Medicare, however, is able to set relatively low prices because of its buying power and access to hospital cost data. That's why most reference-based pricing plans add a 20%-70% markup to the Medicare rate, although even with that, their reimbursement to providers – and cost to employers – is less than any discounts available through a standard PPO network arrangement.



The Benefits of RBP

- Less than 20% of employers at the moment are using an RBP. But those that have are realizing substantial savings — cutting claims costs from 25% to 40%.
- Because prices are capped in advance, both the employer and the participants are better able to estimate their expenses.

Captives

A captive insurance program consists of a group of companies that together create a fund to act as its own insurance company. Combining employee claims experience with other like-minded businesses helps these employers spread the financial risk between them.

The captive provides an added layer of funds for protection against high-dollar and catastrophic claims that rise above the stop-loss ceiling.

Because the owners are also the insureds in a captive plan, they have the ability to exert greater control to negotiate terms at renewals.



The Benefits of a Captive

- **Captives can help reduce and stabilize the fluctuation employers often see with year-over-year rate increases.**
- **Captives also offer more reporting and transparency when making health care decisions.**
- **Participant companies are not punished for bad claim years.**
- **Special contract terms can be included in the captive such as no new lasers, or exclusions, with a rate cap.**

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