ONESOURCE
STOPLOSS INSURANCE MARKETING

Hospital Self Funding Case Study

Solution Strategy

The goal of our client was to implement a self funded HMO style plan with a narrow network utilizing their facilities and IPA. The goal must be achieved with minimal disruption to plan participants, while effectively steering utilization, managing large claims and specific disease states. The end result would improve overall plan satisfaction while reducing costs.

Negotiations with the incumbent HMO focused on establishing a plan utilizing the client's facilities and IPA as a narrow network. This was successfully negotiated and the HMO agreed to manage the administrative and claims components of the plan. Additionally, the negotiations included accessing the remaining HMO network on a wrap-around basis with a different level of benefits thereby creating the desired steerage.

To help control large claims, the client contracted for high dollar specialty disease management with the HMO. These cases will be reviewed by the client's internal medical review staff to ensure care is appropriate for the specific disease state.

The final component was controlling the potential catastrophic risks. This was to be accomplished through a medical excess of loss (stop loss) insurance policy. The incumbent HMO offered a stop loss policy with a $300,000 deductible, which is their internal pooling limit. They would then reimburse the client for claims in excess of the deductible at contracted HMO rates for all hospitals. The costs for this coverage exceeded $4.5 million per year. Recognizing the client's domestic claims accounted for approximately 75% of all utilization and the reimbursements under the HMO contract would not be significant, we had to wonder why buy stop loss at all.

To determine the true risk associated with the plan, we conducted a large claim frequency and severity study, along with an assessment of ongoing large claimants. Based on the data, we determined that the client did not need stop loss reinsurance. Although this was our actuarial interpretation, we understood that the client did not want to assume 100% of the risk at this time. In response, our underwriters and actuaries developed what they interpreted as an expected rate for the stop loss reinsurance. The rate assumptions along with a significant amount of data were submitted to stop loss insurance companies for pricing. The proposals that were requested from the insurance companies covered a wide range of options. With domestic claims being such a high percentage of their "medical spend" and current HMO reimbursements being low, we considered a variety of scenarios.

First, would a deductible above the HMO pooling point be acceptable? Then should the domestic claim reimbursement under the stop loss policy be set at 0%, 50% or 100% of the HMO schedule? Finally, should the client reimburse itself for any domestic claim costs regardless of the amount?

In discussions with the client, it was decided that we would focus on a higher deductible and set the domestic reimbursement for stop loss claims at 50% of billed or HMO contracted rates, whichever is less.

As underwriters and actuaries, our team focused our negotiations on reducing or eliminating each component cost of the stop loss pricing model. While most consultants focus on the total dollar of a stop loss policy, we look into each layer to determine if an insurance company is working off of the smallest margin possible.

In many cases we find excess expenses in the following areas:

- Incurred But Not Reported (IBNR) reserves,
- Loads for large ongoing claims, yet many times these are already completed claims,
- Administrative and fee loads on top of the commissions (can be 6%-8%),
- Hidden compensation in retention amounts,
- Commission dollars for large case management,
- Incorrect trend factors,
- Incorrect loads based on plan design, provider network and industry.

Sample Stop Loss Premium Breakdown

	Percent of Total	In Dollars
Core Premium/Claims Expectation/IBNR	60.65%	$500,000.00
Premium Tax (California)	2.35%	$19,373.45
Underwriting Fees (Direct and MGU)	12.00%	$98,928.28
Fronting Fee	5.00%	$41,220.12
Carrier Margin	10.00%	$82,440.23
Broker Commission (Net)	10.00%	$82,440.23
	100.00%	**$824,402.31**

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Introduction

Today hospital organizations provide employee health plans through a variety of financial mechanisms;

- Insured Health Maintenance Organizations (HMOs),
- Insured Preferred Provider Organizations (PPOs),
- Partially self-funded,
- Fully self-funded.

These mechanisms do provide access to health care for employees, yet many do so at great cost to the hospital employer. As an employer, a hospital organization is uniquely positioned to maximize their health plan budget while delivering the greatest level of care to its members. So, why do so many hospital organizations struggle with runaway costs in their employee health plans? This is a great question and one that every hospital employer should be asking themselves and their consultants. Unfortunately, in our experience, the questions and concerns of the employer are not being properly interpreted, thereby resulting in incorrect risk and financial solutions. The communication breakdown between hospital organizations and their external vendors often results in poor plan performance, increased costs and employee dissatisfaction.

Situational Assessment

Our client, a large hospital organization with more than 9,500 covered employees in Southern California, has been purchasing employee health benefits on a fully insured basis for the past several years through HMOs. Premium costs have continued to escalate at an average rate of 12% per year with a total premium spend of $81,000,000 in 2010.
During this same period, on average, more than 25% of health plan costs were paid to competing hospitals in the client's general service area. While health plan trend costs soared, the HMO contractual reimbursements increased by only a few percent per year. Many of the larger claimants were treated in competing hospitals, which prevented the client from effectively managing the claim internally. Instead, standard HMO case management prevailed resulting in increased overall claim costs and higher renewal premiums.

A group of this size should have had a plan design that steers patients into their owned facilities and IPA. Unfortunately, steerage is not always possible with a commercial HMO. In a review of the claims data, we noted that several types of service categories had spiked in utilization. As an example, the client waived Emergency Room co-payments for employee receiving treatment on campus resulting in significantly higher cost for what should have been a standard office visit. If you consider that most EDs in California are staffed with contracted ER doctors, then you begin to understand that even though these were processed as domestic claims, they were actually hard dollar claims that were being paid to outside providers.

Hospital Utilization: Domestic vs. Non-Domestic

2008	**Total**	**Domestic**	**Non-Domestic**
Total Facility	$32,351,613	$19,234,126	$13,117,487
%	**100.00%**	**59.45%**	**40.55%**
2009	**Total**	**Domestic**	**Non-Domestic**
Total Facility	**$32,605,281**	**$18,616,602**	**$13,988,679**
%	**100.00%**	**57.10%**	**42.90%**
2010 (thru July)	**Total**	**Domestic**	**Non-Domestic**
Total Facility	$17,472,766	$13,352,477	$4,120,289
%	**100.00%**	**76.42%**	**23.58%**

Further conflict occurred with the state mission of the client. They qualify as a "church plan" thereby allowing exclusion or modification of certain benefits. Under a fully insured commercial HMO, many of these potential exclusions were disallowed. The plan is now in conflict with the church's stand on select benefits interpretations.

The client needed to transition from a commercial HMO to a "narrow network" PPO or HMO type of plan and a self-funded strategy. The concerns over the transition included plan administration, access to non-narrow network providers for employees living outside the employer's service area, tertiary referrals for services not provided by the client facilities, plan language, high dollar claim exposure, case and disease management, employee satisfaction and budgetary constraints.

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Case Study Cost Outcome

Stop Loss Cost Comparison

	Current HMO Pooling	HMO Alternative	Commercial Alternative
Deductible Level	$300,000	$500,000	$500,000
Contract Period	12/36	12/36	12/36
Contract Coverage	Medical Only	Medical Only	Medical & RX
Domestic Claim Reimbursement	100% of Contracted Amount	0%	50% of Contracted Amount
Monthly Enrollment	9,651	9,651	9,651
Stop Loss Rate (PEPM)	$38.97	$8.00	$13.44
Annual Stop Loss Premium	$4,512,194	$926,496	$1,556,513
Additional Project Claim Liability*	$0	$1,141,273	$735,363
Net Cost	$4,513,194	$2,067,769	$2,291,876

Under the commercial alternative the client facility would receive reimbursements for large claims on patients treated domestically.

Additional Claim Liability*
(Reported in Stop Loss Cost Comparison)

	Current HMO Pooling	HMO Alternative	Commercial Alternative
2007	$0	$922,648	$463,821
2008	$0	$1,311,690	$1,041,491
2009	$0	$1,189,481	$700,778
Average	$0	$1,141,273	$735,363

**Projected claim costs represent an average of the past three years. Due to reporting limitations by the incumbent carrier, we were unable to fully break out domestic vs. non-domestic for each of the years.*

Concluding Summary

The employer referenced in this study is an active client with more than 18,000 benefit eligible employees. The focus of this project centered on facilities in Southern California only. The key concerns for this client were to improve on the existing financial model, while maintaining quality benefits for the members at large and enhancing the management of specialty disease states.

The commercial medical stop loss savings of $2,221,317 generated through OneSource are a result of in-depth knowledge of healthcare clients and healthcare financing. Through data analysis, we were able to determine the actual risk to the client and modify the stop loss provisions to maximize premium savings. The client selected the commercial alternative, as it provided the greatest hard dollar savings while preserving their ability to capture reimbursements from the stop loss policy. Additionally, we successfully negotiated an opportunity to place the client's captive reinsurance company the issuing insurance company in subsequent years.

The Southern California locations will continue to experience reductions in health plan costs as we provide treatment more efficiently through the narrow network and specialty disease management programs in the coming years. At present we are working with the client on new plan document language that may significantly reduce costs associated with expensive dialysis treatment, transplantation and subrogation.

OneSource has an experienced team of underwriters and actuaries that understand all levels of risk. From the plan design through the plan document and medical stop loss policy, our team dissects each client's situation and develops a customized strategy specific to the needs. This client's other locations have experienced millions of dollars in savings through our work as well.