Self-Funding Terminology Cheat Sheet

KEY TERM	ALTERNATIVE NAMES	DEFINITION
Aggregate Stop-Loss	ASL, Agg	Aggregate stop-loss insurance provides a maximum claim liability for the entire group.
Aggregating Specific Corridor	Aggregating Specific Deductible, Aggregating Spec	This contract provision is often offered in TPA arrangements. It is an extra form of risk to the employer on large claimant(s) exceeding the ISL, which reduces premiums on their quote. The aggregating specific increases the likelihood of the employer hitting their aggregate claim liability, and reduces the risk on the individual stop loss policy.
Claims Corridor	Corridor Factor, Risk corridor, Attachment Corridor, Attachment percentage	The area that represents the risk corridor above expected claims. For level funding products, this corridor is typically 10 percent except where state mandates require higher. For Graded Funding, this corridor is typically 20 or 25 percent.
Claims Funding (Level Funding)	Claim liability, Maximum claim exposure, Monthly claims funding (MCF), Maximum claims liability	Typically expressed on a per-month basis, the claims funding is used to define the amount which the client will be paying for claims in a plan year. At year-end this number is compared against total paid claims for the year to determine if there is a surplus available.
Contract Period	Incurred Period, Paid Period, Coverage Period, Policy Period	The time covered under a contract designating when a claim is incurred and when the claim must be paid to qualify for reimbursement.

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Contract Type	12/12, 15/12, 12/15, 12/18, 12/27, Paid	Refers to contracts typically seen in self-funded arrangements that are offered through TPAs (third party administrators) in conjunction with a reinsurer. The first number refers to the "Incurral Period" and the second number refers to the "Paid Period". For example, a 12/12 contract covers all claims that are both incurred and paid within the 12 month contract period.
Credibility	-	When underwriting claims experience (either for a prospect or for a renewal), the client's claims experience is assigned a 'credibility' factor. Loosely translates to a "predictability factor". Based on size of the group, timeframe of the experience period (mature or immature experience period), Pooling level and expected large claims. The larger the group, the higher their credibility.
Dual Choice	Dual-Option	An option offered to individuals in a group to choose between two or more health plans.
Eligibility Roster	Census Report, list of covered members, coverage report	Employee listing usually provided by the insurer, in some cases available through the insurer's proprietary online systems.
Expected Claims	Expected	The dollar amount of claims anticipated to be paid based on a plan's characteristics.
Experience Underwriting	Credibility based underwriting	Refers to a method of underwriting both at presale and renewal which factors in the client's previous year's claims experience to predict future claim costs.
Fixed Costs	Admin & Insurance, A&I,Fees, Premiums	Consists of Administration Fee, Commissions (if applicable), Individual Stop Loss Premium, and Aggregate Stop Loss Premium. Paid monthly based on enrollment.

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IBNR	Incurred but not reported/revealed claims	Claims that have been "Incurred But Not Reported". Refers to claims that are in the "lag period" that occurs between a claim's incurral date and paid date.
Individual Stop Loss	ISL, SSL, Specific Stop Loss Level, Pooling Point, Large Claim Deductible	Individual stop-loss insurance provides reimbursement in the event an individual plan participant has claims that exceed the ISL Level during a contract period. In some states mandate minimum stop loss levels.
Lag Report	IBNR report	Usually requested for a client's accounting/audit purposes, this report helps them determine an estimated terminal or runout liability, based on lag times seen on the plan during the preceding 12 month period. Average time for claims paying.
Lagged Membership	-	Refers to a lag applied to membership. Graded Funding applies a 2-month lag to membership for determining monthly claims liability. When underwriting claims experience, it is also typical to see a 1 or 2 month lag applied to monthly membership. In both scenarios, the lag is applied to account for the relationship between enrollment data and paid claims.

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Laser	Exclusion or adjustment of Stop Loss coverage for an individual	This is an additional form of risk to the employer. For large claimants which may be ongoing, the stop loss carrier alters the ISL coverage for certain claimant(s). For instance, if the client's ISL level is $25,000, an individual with a serious ongoing claim may have their own ISL of $150,000. The difference between the $25,000 and $150,000 may or may not accumulate to the employer's aggregate claim liability, which means they will likely reach or exceed claim liability. Some carriers do not mandate lasers; however, many will consider this upon employer or broker request.
Mature Rate	-	Reflects a full, 12-month claims liability.
Minimum Attachment	MA	A provision which sets a minimum claim attachment liability in the event the client's enrollment shrinks. This allows insurer and the client to control costs and risk should the enrollment shrink. Calculated based upon a percentage of enrollment (can be 90%, 95% or 100%) at the time of renewal. This is typically not included in Level Funding products, but is typically included in the Graded Funding product.
Monthly Claim Liability	Claim liability, Maximum claim exposure, Aggregate Liability, MAF = Monthly Attachment Factor (Graded Funding), MCF = Monthly Claim Funding (Level Funding)	The amount, expressed in dollars per employee (and/or dependent) per month used to define the claim liability for each month. See Attachment Factor and Claims Funding.

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Off-Anniversary	-	Refers to a date other than the plan's original effective month. For instance a 1/1 client renews each year on 1/1, if they terminate on 3/1 they have terminated off-anniversary.
Paid Contract	-	Refers to a self-funded contract which is providing stop loss protection for all claims Incurred under the life of the policy that are paid during the 12 month contract period. Some contracts renew to a paid contract at their first renewal.
Plan Year	Benefit Period	The 12-month period in which deductible and coinsurance accumulates toward a plan participant's out-of-pocket maximums.
Reinsurance Carrier	Reinsurer	This is the stop loss carrier providing ISL and/or ASL protection to an employer. In a TPA arrangement, this is usually a third party/entity, and therefore is not integrated.
Run-In	Bridge Protection, 15/12	Claims incurred prior to the first contract year and received after the new effective date. These claims can be paid under a "current year" contract that includes a run-in provision. Some insurers can offer run-in protection on ISL, and must be coordinated/priced for with underwriting. Pricing differs for bridge protection versus a 15/12 contract (15/12 is more protective and therefore has a higher premium, typically).

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Run-out	Terminal Liability Period, Incurred but not paid claims, Run-off liability	The run-out period refers to the period of time immediately following termination, during which time all claims incurred prior to the termination date are being paid. Timely claims submission, determination of medical necessity, clarification of issues and claims processing all contribute to the run-out period. Most contracts provide 3 months or 6 months of run-out protection. Some insurers will allow 12-15 months.
Total Costs	Maximum Liability, Fully Funded Rates	Total amount of liability each month consisting of administrative and insurance costs plus monthly claim liability. For level funding clients, this represents the total payment they will budget for and pay to insurer each month. For graded funding clients, this represents the total liability they will budget and may have to pay to insurer each month.
TPA	Third Party Administrator, Administrator	Refers to the third party/entity administering a plan (plan documents, paying claims, servicing). May or may not coordinate with employer and broker on other 'pieces' such as Rental Network, Disease Management, Wellness Programs, Reinsurance.

DEFINITIONS

- **Employees Covered** refers to the total number of employees the employer has on staff that is eligible for medical coverage.

- **Exclusive Provider Organization (EPO):** "An Exclusive Provider Organization (EPO) Plan is a managed care plan where services are covered only if you go to doctors, specialists, or hospitals in the plan's network (except in an emergency)." (Health Insurance Marketplace. https://www.healthcare.gov/glossary/exclusive-provider-organization-EPO-plan. Retrieved on 7 July 2018.)

- **High Deductible Health Plan (HDHP):** "A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

  For 2019, the IRS defines a high deductible health plan as any plan with a deductible of at least $1,350 for an individual or $2,700 for a family. An HDHP's total yearly out-of-pocket expenses (including deductibles, copayments, and coinsurance) can't be more than $6,750 for an individual or $13,500 for a family. (This limit doesn't apply to out-of-network services.)" (Health Insurance Marketplace. https://www.healthcare.gov/glossary/high-deductible-health-plan/. Retrieved 29 July 2019.)

- **Health Maintenance Organization (HMO):** "A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness." (Health Insurance Marketplace. https://www.healthcare.gov/glossary/health-maintenance-organization-HMO/. Retrieved on 29 July 2019.)

- **Point of Service (POS):** "A point-of-service plan (POS) is a type of managed care plan that is a hybrid of HMO and PPO plans. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services. When patients venture out of the network, they'll have to pay most of the cost, unless the primary care provider has made a referral to the out-of-network provider. Then the medical plan will pick up the tab." (Small Business Majority. http://healthcoverageguide.org /reference-guide/coverage-types/point-of-service-plan-pos/. Retrieved on 29 July 2019.)

- **Preferred Provider Organization (PPO):** "A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost." (Health Insurance Marketplace. https://www.healthcare.gov/glossary/preferred-provider-organization-PPO/. Retrieved on 29 July 2019.)

- **Health Savings Account (HSA):** "A health savings account (HSA) is a tax-exempt trust or custodial account you set up with a qualified HSA trustee to pay or reimburse certain medical expenses you incur. You must be an eligible individual to qualify for an HSA." (Internal Revenue Service. https://www.irs.gov/publications/p969/index.html. Retrieved 29 July 2019.)

- **Health Reimbursement Account (HRA)**: "An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Code § 213(d)) incurred by the employee, or his spouse, dependents, and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period. IRS Notice 2002-45, 2002-02 C.B. 93; Revenue Ruling 2002-41, 2002-2 C.B. 75. This reimbursement is excludable from the employee's income. Amounts that remain at the end of the year generally can be used to reimburse expenses incurred in later years." (Internal Revenue Service. https://www.irs.gov/pub/irs-drop/n-13-54.pdf. Retrieved 29 July 2019.)

Questions to ask your HR Administrator if you have a Self-Funded Major Medical Plan.

1. What financial institution are the funds being held?
2. What is the current rate of return on investments?
3. What fees are paid for administration of investment account(s)?
4. What is the adjusted annual rate of return on investments?
5. Are these dollars being shown flowing back in the trust?
6. What was the annual balance and percent rate of return for each of the past three year(s)?
7. How often does the municipality put out RFP's?
8. When did the last RFP go out for bid?
9. Does the political subdivision allow for Health Insurance Opt-Out under IRS Code #125?
10. What is the percent offered to the employee to opt out?
11. It that amount based on single or family rate?
12. If the political subdivision doesn't allow for IRS Code #125 Opt-Out, provide the reason why?
13. What criteria was used to award any and all medical insurance contracts including Brokers, Advisors, TPA's, Vendors and any other agencies that contract with the trust?
14. Does a Health Insurance advisory committee exist? If not, why?
15. If the elected officials reject the recommendations of the Health Insurance advisory committee, what limitations are in-place for employees exposed to excessive premium increases or under funding if the advisory committee's recommendations had been accepted?
16. Can we have a copy of all contracts / agreements related to the trust.
17. How many members/employees participate in the plan?
18. How many lives are covered?
19. Are the premiums calculations separated for the rest of the employees?
20. Does the municipality audit the participants who should be excluded? Ie: dependence who are older than 26 and divorced spouses as an example.

21. Are health re-imbursement claims submitted by the employee, audited against the dispersal sheet provided by the plan administrator? i.e. over payments or discounts offered for payment in less then 30 or 45 days?
22. How many claims were filed against the trust for all city employees each of the last three years?
23. How many claims were filed for IAFF members?
24. What percentage of these claims were auto adjudicated?
25. How many cases were subrogated in each of the past three years?
26. Are the subrogated cases visible to the trust participants? (HR and the Local)
27. What was the subrogated dollar amount returned to the trust in each of the past three years?
28. Does the accounting show subrogated dollars flowing back into the trust for matters involving for other liability claims, things like personal injury and auto accidents?
29. What affiliation, if any, does the TPA (Third Party Administrator), the Advisor, Broker and the Medical provider have?
30. Are there or has there ever been any dollars exchanged between four entities' due these affiliations?
31. What does the trust pay the TPA per member per month?
32. What does the trust pay the Advisor per member per month?
33. What does the trust pay the Broker per member per month?
34. What does the trust pay the Medical provider per member per month? (Excluding claims)
35. What was the annual spend for each of the previous three years for the TPA?
36. What was the annual spend for each of the previous three years for the Advisor?
37. What was the annual spend for each of the previous three years for the Broker?
38. What was the annual spend for each of the previous three years for the Medical provider? (Excluding claims)
39. Does the trust carry any stop loss insurance?
40. If so, what was the stop loss number set at for each of the previous three years?
41. What was the per member per month cost for stop loss in each of the previous three years?

42. How many claims reached the stop loss cap, in each of the previous three years?
43. What formula was used to set the stop loss cap?
44. Who is making the recommendation for the amount of stop loss needed?
45. Were there any members lasered out of stop loss?
46. What is the projected stop loss for next year?
47. What is the actuarial value of the plan for each of the previous three years?
48. What was the cost of COBRA (Consolidated Omnibus Budget Reconciliation Act) for each of the previous three years?
49. How many members, if any, were on COBRA for each of the previous three years?
50. Is the municipality self-insured for BWC? (Bureau Workers' Compensation)
51. If so, were there any medical claims converted from insurance to BWC?
52. If so, does the accounting show these dollars flowing back into the trust?
53. Are the surplus dollars carried over at years end or do they return back to the general fund?
54. What was the total spend for spousal coverage for each of the previous three years?
55. What was the total spend for family coverage for each of the previous three years?
56. How are the premium rates calculated for single vs spousal vs family?
57. What was the total spend for single coverage in each of the previous three years?
58. What was the total spend for spousal coverage in each of the previous three years?
59. Who if anyone, is advising both the municipality and the union as to projected increased cost prospectively?
60. What were the prospective projected cost increases for each of the previous three years?
61. What were the actual cost increases in each of the previous three years?
62. In what mouth are the prospective predictions available to both the municipality and the union?
63. Who is the PBM? (Pharmacy Benefits Manager)
64. How is the PBM compensated? Per member per month? Annually? Percentage of spend?
65. What were the discount for pharmaceuticals for each of the previous three years?
66. What were the rebates for pharmaceutical for each of the previous three years?

67. Does the accounting show these rebated dollars flowing back into the trust or are they simply going into the general fund?
68. What was the total spent on pharmaceuticals in each of the previous three years?
69. How many prescriptions were filled in each of the previous three years?
70. Is there a mail order option available to the members?
71. Does the member see the actual cost of the medication to the trust at the time of purchase? (i.e. on their receipt.)
72. Is there a formulary?
73. Are there any pre-authorizations for certain medication? Example: experimental drugs, compound drugs, orphan drugs or other medications that do not conform to industry standards.
74. What if any cost saving tools does the medical insurance company provide the member?
75. Are there any cost saving tools available on the fully insured side of the medical insurance company that are not available on the self-insured side?
76. What is the run-out time for processing claims, if a change in broker is to occur?