SELF-FUNDING 101

SELF-FUNDING EMPLOYEE BENEFITS EMPLOYER CERTIFICATION

In an effort to control rising costs, employers are examining ways to improve cash flow without sacrificing coverage. Budget considerations, bargaining agreements, geography and plan design all have an effect on the way a health plan is funded. Self-funded plans make it possible for an employer to reduce operating costs significantly, while obtaining the control of their claims reserves.

COMPONENTS OF A SELF-FUNDED PLAN:

Stop-Loss Insurance:

- **Specific Stop Loss Insurance:** Specific insurance provides protection for the employer against unexpected, high dollar claims on any one individual. Your proposal will reflect the amount offered to your group. Eligible claims above the specific deductible are reimbursed by Stop Loss insurance. (Not applicable for Aggregate only groups)
- **Aggregate Stop Loss Insurance:** Aggregate insurance provides a ceiling on the dollar amount of eligible expenses that an employer would pay, in total, during a Contract Period. The amount may change from month to month, based upon employee enrollment, but will never be less than the “minimum attachment point” determined at the beginning of the contract period. Aggregate Excess Loss coverage accumulates each month to the end of the Contract Period.

Third Party Administration (TPA): The TPA administers the plan on behalf of the employer. This includes all aspects of running the plan:

- Processing, Paying Claims and Issuing Explanation of Benefits (EOB)
- Preparing and providing comprehensive claims reports
- Produce Summary Plan Descriptions (SPD) & ID Cards

Claims Fund Surplus: If an employer has a positive claims fund balance after the run out period, 100% of that unused money is returned to the employer via check.

Health Audits: To ensure your group is receiving the best possible rate based on your company’s data, we collect Personal Health Questionnaires (Health Audits) on each covered employee and their dependents. In addition to providing underwriters with enough information to properly assess risk, health audits are helpful in determining whether or not self-funding or fully-insured is the best option for your group. Please let your broker know if you are aware of major health conditions in your population to determine whether it makes sense to continue underwriting.

- **Non-Disclosures:** Failure to disclose any ongoing OR past conditions, treatments or surgeries during the enrollment/underwriting process may result in denial of claims.

MARKETED AND ADMINISTERED EXCLUSIVELY BY:

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ON YOUR TEAM.

AmWINS Group Benefits

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Enrollment & Participation: We are able to send the Health Audits to multiple stop loss carriers. Each carrier has its own rules for participation and enrollment. In order to move forward with a self-funded plan we need a minimum of 10 eligible employees enrolling, (state permitting).

Contract Period: The Contract Period provided determines how medical claims are processed. GBS Health Plans provide:

- **12/18 Contract Period:** Eligible medical claims incurred within the Contract Period (12 months) and paid within the Contract Period, or paid within six months immediately following the end of the Contract Period (18 months), are covered by the plan or Excess Loss coverage. The plan's total maximum costs for a 12/18 Contract Period include the costs for the six months of run-out claims (i.e. medical claims incurred but not processed and paid before the end of the Contract Period). Maryland requires a 12/24 contract period for groups under 50 lives.

Networks: Clients utilizing the CIGNA PPO Network will be subject to a one month access fee following termination of their contract. This will be determined by taking the number of enrolled employees in the 12th month and multiplying it by CIGNA's monthly PPO access fee.

Minimum Attachment Point (MAP) (12 X the 1st month's claims fund): The minimum annual amount of claims the group is responsible to pay before the aggregate stop-loss insurance reimburses for the plan year. If the MAP claims fund falls below the minimum (due to enrollment changes) by the end of the contract period, the group is responsible for the difference if the claims exceed the amount funded.

Rating

- Final Rates are based on Final Enrollment.
- Rates are guaranteed for a 12 month period.
- Underwriters reserve the right to adjust stop loss or aggregate factors (claims fund) if enrollment changes by 10% or more throughout the year.

Process Timelines: Once a complete case submission is sent to GBS, it can take approximately 3 weeks for all ID cards to be sent out and for pharmacy benefits systems to have all members showing as active. We request that all the groups' paperwork with check, be submitted by the 12th of the month prior to the effective date.

Patient-Centered Outcomes Research Institute (PCORI) Fees: The fee, required to be reported only once a year on the second quarter Form 720 and paid by its due date, July 31st, is based on the average number of lives covered under the policy or plan. GBS will use the actual count method to provide the amount owed but it is the responsibility of the employer to pay the fee. For 2020 the PCORI fee is $2.45 per employee.

The Employer named below certifies that he/she has read and understands the above information and that the program being offered through Group Benefit Services, Inc. is a self-funded program and not a fully-insured program.

Employer:___________________________ **Date of Certification:**_______________________________

Authorized Employer Representative: ____

Title: ____

Signature: X____

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