MERCER
Human Resource Consulting

Leon County

Funding Alternatives:

Self-Funding vs. Fully Insured Plans

Mercer HR Consulting
3031 N. Rocky Point Drive
Suite 700
Tampa, FL 33607
Telephone: (813) 207-5100
Fax: (813) 207-5190

MMC Marsh & McLennan Companies

Executive Summary

Mercer is pleased to present a summary of the funding alternatives for group health plans, including the differences between fully insured and self-funded health plans, as well as some of the advantages and disadvantages of each funding arrangement, for discussion and consideration for the Leon County health plan in future plan years. .

Based on the *2004 Mercer National Survey of Employer Sponsored Health Plans*:

- 18% of all surveyed companies with 500 + employees self-funded their HMO plans;
- 10% of all Government Entities surveyed self-funded their HMOs; and
- 13% of all County Government Entities self-funded their HMOs.

In general, the advantages of self-funding include: a possible reduction in first year costs due to claims lag time, investment earnings generated from holding reserves, greater flexibility in plan design and the potential for reduced fixed costs due to the unbundling of administrative and risk bearing services. The potential disadvantages include an increase in employer liability (both financially and legally), additional administrative responsibility, greater exposure to claims volatility and the possibility of "run-out" and ongoing claims after contract termination.

Mercer was asked to take available 2003 and 2004 claims data, as well as average administrative and reinsurance costs for a group of Leon County's size and demographics, and estimate any potential savings or increased cost for a self-funded program vs. the current fully insured program. These assumptions only allow a retrospective analysis of a self-funded program, and would not guarantee similar results in subsequent years due to variances in large claims experience, trend, and other factors. Assuming an average monthly enrollment of 3,774 members throughout the year, Mercer estimates total 2004 self-insured costs would have been $10,839,766. Actual health insurance costs, as reported by Leon County, were $11,817,598. This yields a potential savings of $977,832, or 8.27%, retrospectively for 2004.

Executive Summary
Continued

It should be also be noted that because Leon County's 2006 renewal increase proposed by Capital Health Plan is flat, a self-funded program in 2005 or 2006 would likely not have produced the same level of savings, and may have actually cost the County more than the fully insured program. These expected higher costs for a self-funded program are based on factors such as medical trend, paid claims cost increases, and any migration into a different plan than the 2004 plan split. Finally, a self-funded program would utilize a leased PPO network, which not only impacts the claims costs due to lesser discounts (which have been accounted for), but also would create considerable disruption in the current provider network.

At Leon County's request, Mercer also examined the issue of increased volatility of health related employer payments in greater detail. For the time period January 1st, 2003 - December 31st, 2003, Leon County's average paid claims amount was $163.66 per member per month. For the time period January 1st, 2004 - December 31st, 2004, Leon County's average paid claims amount was $193.16 per member per month. Of the 24 months analyzed, there were 10 months in which Leon County's paid claims exceeded these averages, with 5 occurring in each year. The magnitude by which these higher claim months exceeded their respective annual averages ranged from 1.7% to 27.3%. This claims volatility, higher than average claims payments in 41% of the months, and increasing claims costs would have an impact on the rating of Leon County's costs each year at renewal regardless of the funding mechanism used.

In choosing a funding arrangement for your employee health plans, there are generally three alternatives: Fully-Insured (also called conventionally funded), minimum premium, and self-funded/self insured arrangements. Conventionally funded programs can be participating or non-participating. Non-participating arrangements do not have any surplus or deficit at year-end; the insurance company bears the entire risk.

Executive Summary
Continued

Participating arrangements allow the employer to recoup some of the premiums paid if there is a surplus at year-end. However a deficit situation may require additional payments from the employer at some point in the future. Minimum premium plans seek to maximize cash flow by "unbundling" the premium required and giving the employer flexibility on the timing of certain payments to the carrier. Under these types of funding arrangements, the employer's liability is limited to a pre-determined percentage of anticipated monthly or annual claims liability. Self funding or self insurance allows the insurance risk to be fully assumed by the employer. The extent of this risk may be limited by the purchase of stop-loss coverage.

Stop-loss coverage can be purchased at the individual level, in aggregate, or both. Individual stop-loss coverage provides the employer financial protection if any individual claimant exceeds a certain threshold. Aggregate stop-loss protection provides the employer financial protection if, in total, all claims exceed a certain threshold.

Although not a complete profile, below are some characteristics of firms that usually choose to self insure their benefit plans:

- Can accept volatility in claims, has the ability to withstand and fund potentially significant monthly variation in claims levels
- Reasonably smooth claim experience history
- Typically 500 employees or more
- Understands interrelationships and responsibilities among vendor contracts (TPA, Stop Loss Carrier, Case Management, etc.)
- Financial and Human Resources staff understand financial requirements, daily/weekly responsibilities and terminal reserve liabilities
- Higher Risk Tolerance – willing to accept more risk

Executive Summary
Continued

Conversely, the characteristics of firms that typically do not find self insurance to be attractive would be an organization that:

- Is shrinking in employee population
- Historically, has experienced a combination of poor or deteriorating claim experience and large claims
- Does not have a firm grasp of historical claims
- Prefers budgeted cost over increased cash flow and employer-held reserves
- Prefers not to take on any additional claims risk
- Has an inability to easily fund significant monthly claim fluctuations
- Does not desire increased Fiduciary Liability
- Prefers not to have additional burden and responsibility of administration, maintenance and evaluation of self-funded plans

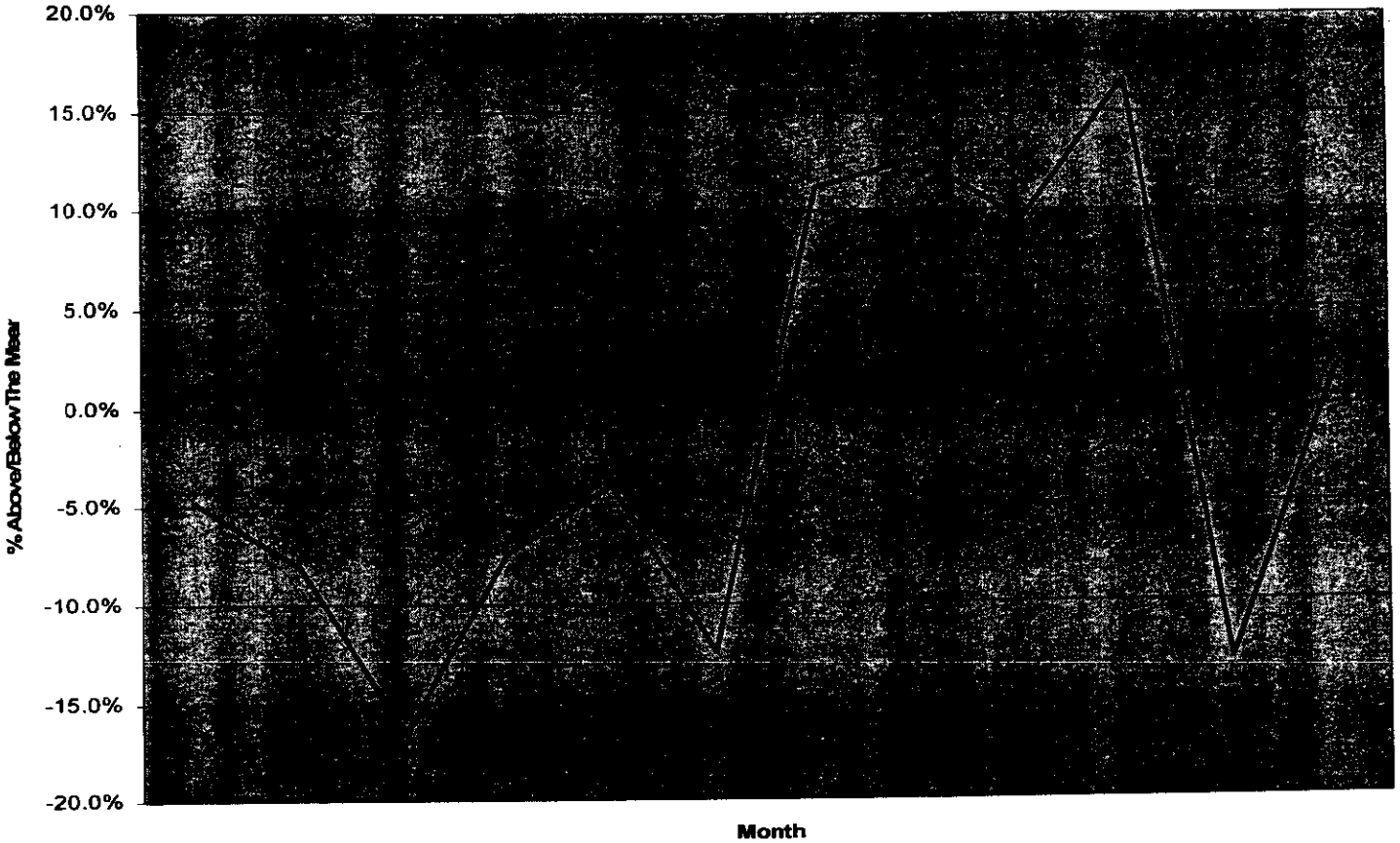
Leon County 2004 Estimated Self-Insured Costs

MEMBERSHIP RANGE			TPA CHARGES	LARGE CLAIM RISK PREMIUM	TOTAL ADMINISTRATIVE COSTS
-	-	60	$2,012	$516	$2,528
60	-	120	$3,689	$774	$4,463
120	-	170	$5,037	$731	$5,768
170	-	290	$8,349	$624	$8,972
290	-	580	$16,211	$873	$17,084
580	-	1,160	$30,801	$1,247	$32,048
1,160	-	3,880	$60,629	$1,124	$61,753
MONTHLY ADMINISTRATIVE COSTS			**$126,728**	**$5,888**	**$132,616**

ANNUAL ADMINISTRATIVE COSTS	**$1,520,739**	**$70,658**	**$1,591,397**
2004 PAID CLAIMS			**$8,746,534**
2004 ESTIMATED CHP IBNR			**$277,121**
2004 ESTIMATED VISTA IBNR			**$224,714**
TOTAL ESTIMATED SELF-INSURED COSTS			**$10,839,766**
ACTUAL FULLY INSURED PREMIUMS			**$11,817,598**
POTENTIAL SAVINGS			**$977,832**
% SAVINGS			**8.27%**

Please note all projections are estimates based on numerous assumptions and information available at a point in time and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate.

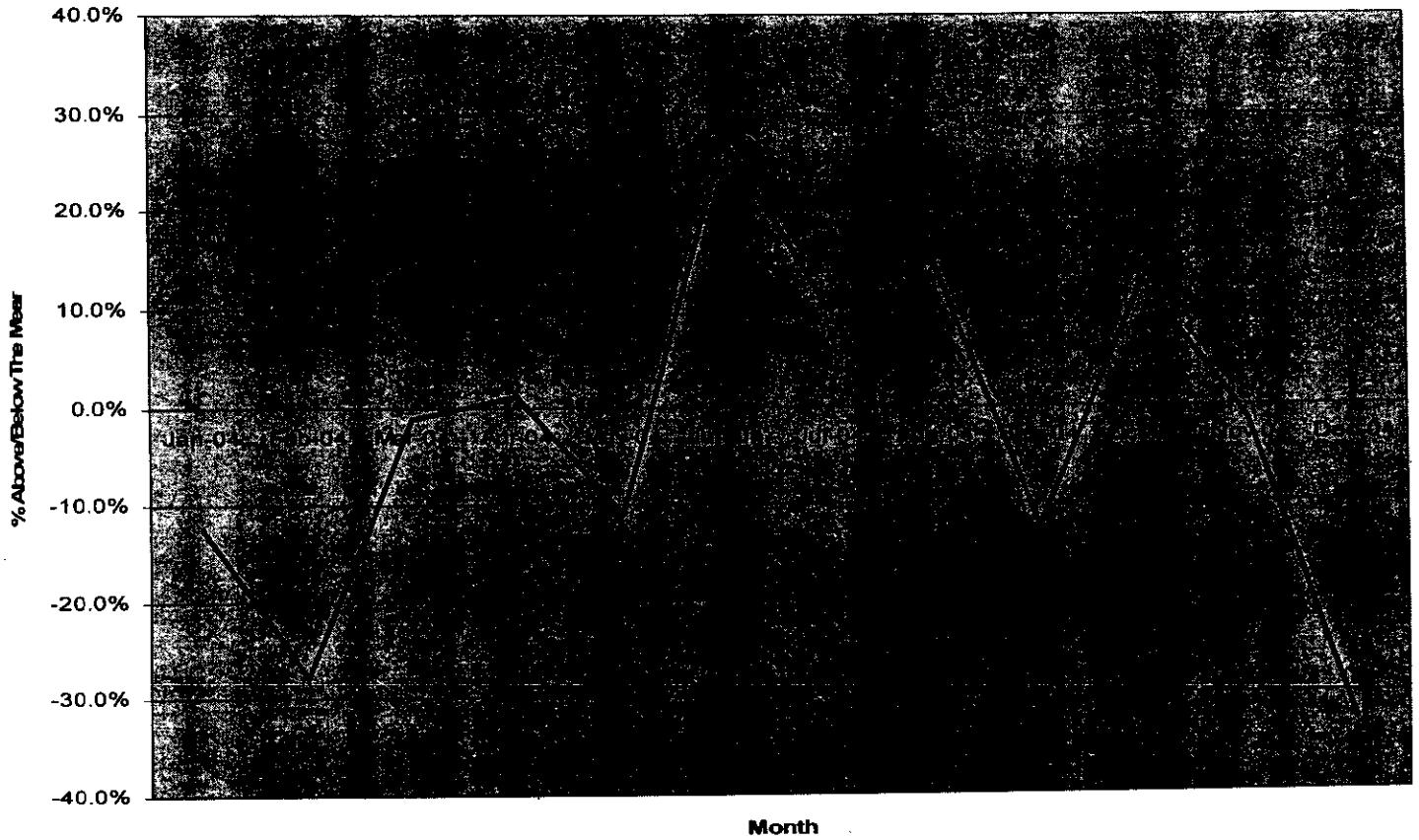
Leon County PMPM* Claims Volatility – January 1, 2003 through December 31, 2003



* Per Member Per Month

Note: Percentages above zero indicate paid claims greater than the average, below zero indicates paid claims less than the average.

Leon County PMPM* Claims Volatility – January 1, 2004 through December 31, 2004



* Per Member Per Month

Note: Percentages above zero indicate paid claims greater than the average, below zero indicates paid claims less than the average.

Advantages of Self Funding

- Cash Flow
  - In the first year, 60 to 90 days lag between when services rendered and the time claim is paid.
  - In Year 1, plan pays 9 - 10 months of claims. Incurred but not reported (IBNR) claims attributable to the period are calculated, and often funded.
- Reserves
  - Incurred but not Reported (IBNR) reserves are held by the group. If the reserve is funded, the investment earnings will accrue to the benefit of the plan. If unfunded, capital remains as part of general assets.
- State Regulations
  - Plan can be designed without interference from state insurance department regulations, including state mandated coverage provisions.
- Third Party Administrator
  - Function as agent of the employer to pay claims.
  - May perform other functions such as utilization management and network management.
- Premium Taxes
  - Eliminated.
- Reduces Fixed Costs
  - Purchase services unbundled.
  - Captures fully insured surplus, if any.

Limitations of a Self-Funding

- Increased Liability
  - Employer retains all claim liability.
- Additional Administrative Responsibility
  - To the extent that services are unbundled.
  - May include HIPAA and COBRA administration.
- Terminal Liabilities
  - The employer assumes the liability of terminal runoff claims and usually all large ongoing claims.
- Legal Defenses
  - The employer is generally the plan fiduciary and assumes responsibility for legal liability.
- Cash Flow
  - Claims have to be funded by the company up to the Individual Stop Loss or Aggregate Stop Loss limits.
  - Fluctuations in monthly claims can vary significantly.
  - First year savings are eroded with maturation, and will be non-existent if reserve is funded unless claims liability is lower than expected.

Limitations of Self-Funding
Continued

- Renewal Stability
  - Reinsurance is one piece of the fixed cost, is more responsive to adverse claim experience.
  - During periods of adverse claim fluctuation, securing coverage or negotiating with reinsurance carriers may prove difficult.

Considerations of Self-Funding

- Important Considerations
  - "There is no such thing as a free lunch".
  - The ultimate cost of the plan will be the claims paid plus administration, less any investment return on plan assets accumulated over time.
  - Not a short-term "quick fix".
  - Health care cost trend factors are still an issue:
    - Proper plan design
    - Employee communication and participation
    - Network access costs and administration
  - Majority of plan cost is to pay claims and this is not significantly affected by method of financing.

Profile of a Company Attracted to Self-Funding

- Growing in employee head count
- Good plan participation (75% or higher)
- Reasonably smooth claim experience history
- Typically 500 or more employees
- Can accept volatility in claims, is able to fund large claims and wait for reimbursement
- Prefers to decrease non-claims expenses (state taxes, insurance company profit, administrative fee) in exchange for more claims risk and administrative responsibilities
- Desires more control over banking procedures
- Desires more control over claims and utilization reporting, monitoring and evaluation
- Desires more control over plan design

Profile of a Company Attracted to Self-Funding
Continued

- Willing to review managed care, subrogation, case management and provider patterns on an ongoing basis
- Has higher than average costs in current managed care plans
- Desires a uniform national program
- Understands interrelationships and responsibilities among vendor contracts (TPA, Stop Loss Carrier, Case Management, etc.)
- Financial and Human Resources staff understand financial requirements, daily/weekly responsibilities and terminal reserve liabilities
- Risk Tolerance – willing to accept more risk

Profile of a Company Not Attracted to Self-Funding

- Shrinking in employee population
- Historically, experienced a combination of poor or deteriorating claim experience and large claims
- Does not have a firm grasp of historical claims
- Prefers budgeted cost over increased cash flow and employer-held reserves
- Prefers not to take on any additional claims risk
- Does not desire increased Fiduciary Liability
- Prefers not to have additional burden and responsibility of administration, maintenance and evaluation of self-funded plans

Basics of Self-Funding

- All major aspects of the medical plan are unbundled, i.e., services are provided by several vendors (Third Party Administrator, reinsurer, disease management vendor, etc.) rather than a carrier. This is less true when carrier is providing ASO (A
- Most mid-sized employers the size of Leon County use a third-party-administrator (TPA) or insurance company (ASO).
- Reinsurance is purchased by the group to guard against significant aggregate or individual losses.
- Reinsurance premiums depend upon risk retention. Claims must exceed certain, pre-determined thresholds before the reinsurer will be liable. Lower thresholds equate to higher premiums. This method is not considered "insured" in the traditional sense.
- Reinsurer does not assume liability for claim payments to group members in the event of a default by the group.
- Self-funded groups are not required to provide mandated benefit levels required by "insured" contracts by the state insurance department.
- The employer group assumes direct and ultimate (Fiduciary) responsibility for providing health plan benefits

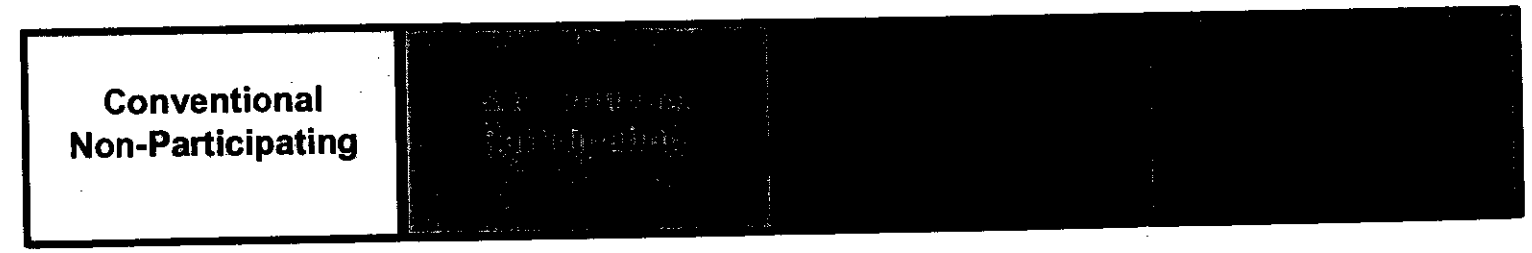
Funding Issues Comparison

ISSUES	INSURED PLANS	ASO PLANS OR SELF-FUNDED W/STOP LOSS
Budgetability	Premiums are predictable and easily budgetable from month to month	The cost to the employer is actual claims plus administration fees; the costs can vary from month to month
Employee Attitudes	An insured plan creates stability when backed by reputable carrier. However, there is little flexibility in the plan, and insurance claims personnel are less personal with larger companies.	Employees need to understand the concept of their cost being directly tied to the claims. Plans can be much more flexible, however, and communications can create a more positive attitude.
Legal Implications	The insurer is the fiduciary and settles any disputes which result in court action.	The employer as the plan sponsor is the final arbitrator of claims disputes.
Claims Adjudication	Administration is provided by the insurer who has a financial stake in proper administration of claims. Savings realized through discounts, coordination of benefits, etc. are returned to insurer	Administration is provided by either a Third Party Administrator (TPA) or insurance company who contracted to provide Administrative Services only (ASO contracts). Savings realized reduce the cost to the employer
Accountability	Responsibility for all services rests with the insurance company.	Services are unbundled and employer may be dealing with several vendors, including TPA, reinsurer, PPO networks.
Premium Taxes	Insurance company pays a percentage of the overall premium in the form of taxes. This is part of the plan cost to the employer.	In most states (including Florida) premium taxes do not apply to uninsured plans.
Reserves	Insurance companies are required to maintain adequate reserves to fund incurred but not reported claims. These costs are reflected in premiums paid by the employer.	Any incurred/unpaid claims would be the liability of the employer.

PROGRAM FUNDING ALTERNATIVES

Carrier Risk

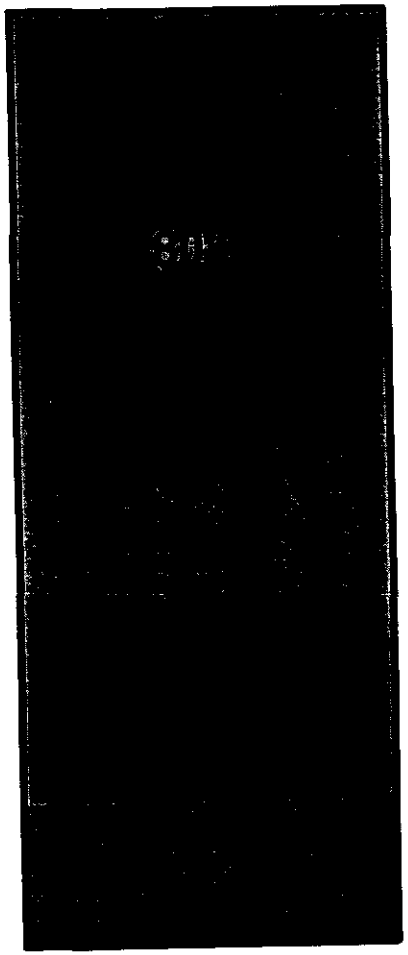
Employer Risk



Current Leon County Funding Mechanism

PROGRAM FUNDING ALTERNATIVES

Conventional Premium Plan - Non-Participating



Expected Claims

- Full Premium remitted monthly includes:
  administrative expenses,
  claim reimbursements, reserves
- Fully pooled
- Least cash flow fluctuation for the employer
- No deficits/No surpluses

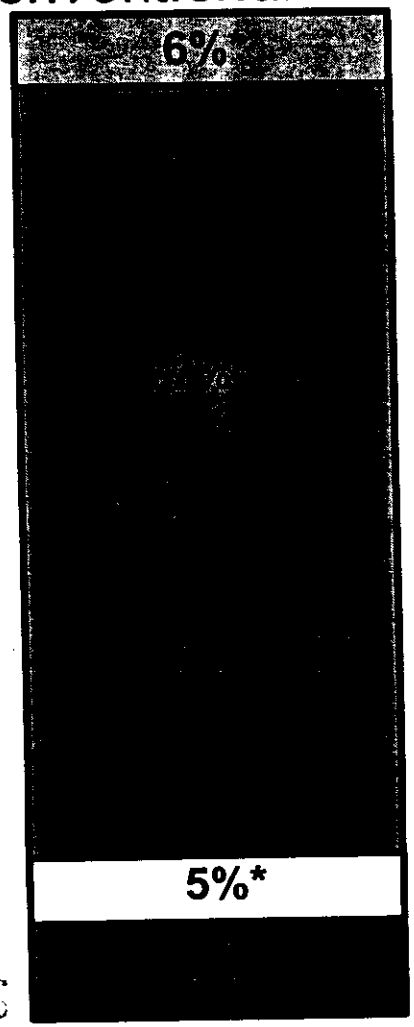
Retention →

Claims Adjudication
Pooling Charges
Taxes
Administration
Profit

*Approximate – varies by insurer

PROGRAM FUNDING ALTERNATIVES

Conventional Premium Plan - Participating



Margin

Expected Claims

Catastrophic Pooling

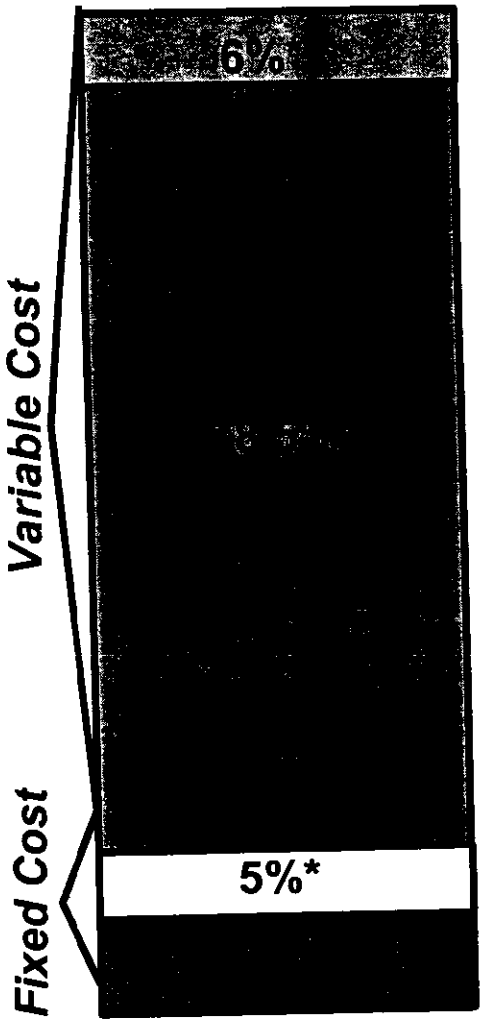
Retention

- Full Premium remitted monthly
- Retrospective accounting completed 3-4 months after plan year
- Surplus returned or deficit is carried forward for future recovery
- Margin included
- COBRA rates and contributions should be set based on maximum liability and not expected claims

*Approximate – varies by insurer

PROGRAM FUNDING ALTERNATIVES

Minimum Premium Plan



Margin

Expected Claims

Catastrophic Pooling

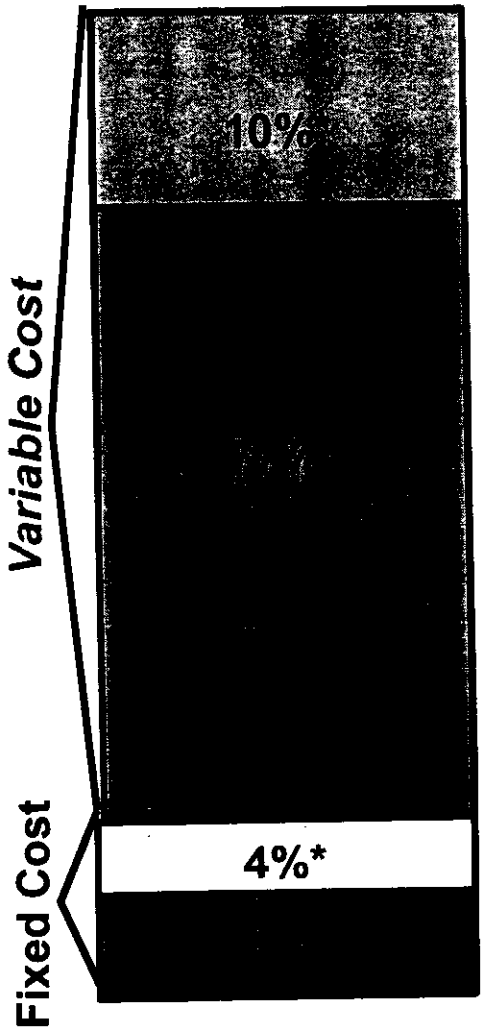
Retention

- Premium is unbundled
  - Administrative expenses and pooling remitted monthly
  - Claim reimbursements (wire transfer, EFT, check)
  - Reserves - held by the employer or remitted as premium
  - Margin only if needed
- Maximizes cash flow for the employer
- Unused money allocated for claims retained by employer
- Savings of premium tax (approximately 1.5%)
- Monthly maximum liability provides budgetable cap
- Insurer retains legal and fiduciary responsibility

*Approximate – varies by insurer

PROGRAM FUNDING ALTERNATIVES

Self-Funding/Administrative Services Only (ASO)



Margin

Expected Claims

Catastrophic Pooling

Retention

- Unbundling of services is possible
- Claims adjudicated by third party administrator or insurance company
- Plan costs equal:
  - Administrative expenses
  - Claim reimbursements
  - Specific and aggregate stop-loss
- Risk charges are eliminated
- State mandated benefits not required
- Lower cost for administration and stop-loss premiums
- Reserves are employer's responsibility

*Approximate – varies by insurer

The Cost Component of a Self Funded Arrangement

Fixed Costs

- Administration (Retention) fees for claims adjudication and services (generally including preparation of plan document, booklet printing, eligibility, network access, utilization review, etc.).

- Excess Stop Loss (Reinsurance) - Premium paid to insurance carriers to protect financial integrity of plan against catastrophic or "abnormal" claim occurrence.

Variable Costs

- Claims.
- IBNR (Incurred but not Reported claims) Reserves.

Types of Excess Stop Loss Insurance

- Specific
  - This coverage pays a reimbursement to the plan after the plan pays claims for an individual member over a certain deductible amount during one policy year
- Aggregate
  - This coverage pays a reimbursement to the plan after total non - specific claims paid during the entire policy year exceed the aggregate deductible level.

Types of Stop Loss Policies – Individual Stop Loss (ISL)

- Individual Stop Loss (a.k.a. Specific Stop Loss) – ISL
  - Reimburses the employer for claims incurred by a single individual that exceed a certain dollar amount (deductible) in the policy period (e.g. claims in excess of $50,000, $75,000, $100,000, etc.)
  - Typically only covers medical (and Rx) claims
  - Rates usually provided on two tier basis – Employee Only or Family
  - Individual stop loss rates typically higher than aggregate stop loss rates
  - Reimbursements are usually paid at the time the claims exceed the deductible

Types of Stop Loss Policies – Aggregate Stop Loss (ASL)

- Aggregate Stop Loss (ASL)
  - Reimburses for claims exceeding total annual "expected claims" by a predetermined percentage that is known as the "corridor".
  - Typically covers medical/Rx claims only.
  - The corridor usually ranges from 20% - 25% above "expected" claims:
  - The corridor is added to expected claims to determine the attachment factor.

    Example (Composite Monthly Factor):

Exp. Claims PEPM		Corridor		Monthly Attachment Factor
$300	x	125%	=	$375

Specific and Aggregate Contract Types

Contract Types - Based upon the Incurred and Paid dates of the claims reimbursed by the employer's plan.

- Incurred Date of Claim - date service was performed.
- Paid Date - Usually the date when claim draft or check has been mailed by administrator.

Specific (ISL) Stop Loss Contract - Reimburses Employer for claims exceeding the individual deductible level up to the overall maximum specific benefit (which is normally the individual plan maximum in plan document less the specific deductible). Pays 100% over deductible to maximum. Common contract terms include:

- Incurred in 15 / Paid in 12 - Common for Takeover from self-funded contract with no run-out protection
- Incurred in 18 / Paid in 12 - Also used in Takeover contract, but not as common as 15 / 12
- Incurred in 12 / Paid in 12 - Common for Takeover from a Fully Insured Plan
- Paid in 12 - Common in Renewal years of Specific contracts
- Incurred 12 / Paid 15 - Common for Takeover from existing 12/15 contracts

Aggregate Insurance - This coverage reimburses the plan after claims reach a certain dollar level for the entire plan for one plan year. The aggregate deductible is usually set at 120 - 125% of claims expected by the underwriter.

- Same types of Incurred / Paid contracts as Individual Stop Loss contracts.