Risk Management Guide to Self-Funded Health Care Plans

Part I: Summary of Risk Management Modifications
Part II: Detailed Analysis of Risk Management Modifications

Part I: Summary of Risk Management Modifications

Introduction
Requiring a Plan Amendment
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Risk Management Modifications

Introduction

Risk management modifications are in two parts:

Part 1 – Requiring a Plan Amendment: Such amendments are cost-impacting on the projected claims and the reduction of such projections is shown in the discussion that follows:

Part 2 – Not Requiring a Plan Amendment: These risk management modifications may be made by either the TPA, the employer or the stop-loss carrier.

Excluded from this discussion are the numerous traditional risk management techniques applied to self-funded plans:

- Varying participant contributions by attained age or by compensation
- Offering plan options or a cafeteria plan
- Adjusting plan benefits.

Requiring a Plan Amendment

Demand Management ***Alert: Uses TPA In-House Administration***

Amend the plan to reduce the benefits for any adult covered person who:

- Has a health-impaired habit and has failed to cooperate with plan-paid EAP counseling.
- Has a chronic health condition and has failed to follow the recommended and standard chronic disease management disciplines.

Certain Spouses Not Eligible ***Alert: Ninth Circuit Court Has Approved***

Amend the plan to require that the pay of a spouse must not exceed 50% of the combined pay of the participant and spouse as a condition of spouse's eligibility.

Coordination of Eligibility ***Alert :Similar to COB and for Same Reasons***

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Amend the plan whereby no person may be covered thereunder who is also covered under a similar plan; as an option, extend such condition to dependents who are *covered or could be covered*.

Rx Is Made on an Elective Benefit *Alert: Response to Rx Rising Costs*
Amend the plan to provide the Rx benefit as an *elective benefit*.

Active Participants Over Age 65 *Alert: Current Practice with Employer(s)*
Amend the plan, increasing the minimum hours to qualify for plan eligibility to 35 1/2, e.g., those retirees active, over 65, may, if consistent with other employer goals, be scheduled to work only 35 hours. Being then not eligible for plan coverage, they will look only to Medicare as their primary health coverage. A pay adjustment for parity reasons will usually be needed.

Bifurcated Plan Design *Alert: Best Response to DC Activity by TPA*
Amend the plan to divide it into two parts:
Defined Contribution – for those participants wishing to protect their income.
Defined Benefit – for those participants wishing to protect their assets.
There should be reasonable economic parity between these two parts.

Advance Medical Directive *Alert: Rare in Occurrence – Huge in Dollars*
Amend the plan whereby adult covered persons, who provide the plan administrator with evidence of an advance medical directive (living will), will have their lifetime maximum increased from $1 million to $2 million, e.g. Other adult covered persons have such maximum lowered to $150,000, e.g.

Treat Early Retirees as COBRAs *Alert: Time-Tested and Well-Received*
Amend the plan treating early retirees as COBRAs where the COBRA extension period is from date of early retirement to age 65. COBRA extension terminates when retiree receives a Medicare Card.

Accessibility to Providers and Benefits *Alert: Any First Dollar Coverage is Bad*
Amend the plan to limit the accessibility to benefits and providers (100% in-network benefits, e.g.), otherwise overuse and/or abuse can occur.

Attained Age Funding *Alert: Needed Now, Simple To Do a Systems in Place*
Amend the plan so age is a funding factor. This will usually, but not necessarily, mean participant contributions also vary by age.

Medical Errors *Alert: Expect to Use as Anti-Fraud Tool*
Amend the plan so the providers, as a condition to assignment, agree to refund plan payments when the procedures involve a reported medical error. This means it is a matter of public record. Such refund is not contingent on the establishment of malpractice liability by the provider.

Miscellaneous *Alert: Some Old Provisions, But Still Good*
The following health care expenses must be preauthorized to be covered by the plan:

- Home infusion therapy
- High-risk maternity care

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- Rehabilitation and related
- Durable medical equipment.

The maximum benefit shall be $ _________ for all benefits during the first six months of any covered person's participation in the plan. Unless otherwise provided by plan amendment, retirees or independent contractors are not eligible for coverage.

Recent litigation makes it essential that up-to-date subrogation language be in place. Particularly critical is the handling of (a) common fund practices, (b) make-whole provision and (c) correctly-crafted reimbursement clause. Certain potential sources of recovery need to be considered:

- Malpractice and/or medical errors
- Rx *disgorgement* settlements.

Liability of Employer

Plans must be prepared to respond to a possible change in federal law by which an employer has a liability stemming from plan-related medical decisions:

- TPA assumes the role of plan administrator or claims adjudicator of last resort.
- Employer shifts entire plan government to a VEBA.
- Employer uses only a defined contribution option.
- A micro-managed plan document is used.

While not requiring a plan amendment, the employer may consider the purchase of ERISA liability insurance.

Not Requiring a Plan Amendment

Originating with the TPA

TPA Anti-Fraud Program *Alert: Similar to Computer Anti-Virus Program*

Increasingly, fraud is becoming a menace to self-funded health care plans. As cybernetics grows in importance, so will high-tech fraud.

Saving the Small Groups *Alert: Small Group Market Must Not Be Lost*

While the regulatory, economic, stop-loss and risk management challenges are greater with small groups than with large groups, the need to have self-funding a viable funding option to small plans is critical to the success and *staying power* of self-funding. One way to save small plans is to use a modified MEWA *look-alike* with a variable specific and no aggregate stop-loss, i.e., a pooled in managing but not in the sharing of gains and losses.

Miscellaneous TPA Measures *Alert: Interesting but Not High Priority*

Several of the risk-management type of measures that may be taken by the TPA are as follows:

- Participate in a consortium for administration or service reasons.
- Create associations that will sponsor plans that offer self-funded death benefits with full IRC §§ 79 and 101 advantages.

Originating with the Employer

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New Employer Economic Paradigm *Alert: Branches Must Bend or Break*

A new paradigm is essential because of the large increase of health care costs as a percentage of payroll costs. Using health care benefits as a method to compete for employees and as a substitute for good pay is no longer financially viable. The financial burdens on the employer as the primary underwriter of the costs of its employees' health and habits must be eased … and quickly. When the present paradigm was first embraced by employers, family coverage didn't exceed $2,000 per month as it does at present for many plans.

Emerging Employer Attitudes *Alert : Employers Help Is Essential*

The employer should have some measure of the total nonpayroll costs of its employees taking into account these items:

- Health plan costs
- Disability and time-loss benefits of all types
- Workers' compensation claims
- Worker productivity.

Employers should recognize that any plan offering *top-of-the-market* benefits is suspect.
Reason: such plans may likely be an *attraction* to persons with health problems.

Participant contributions must (a) make the plan economically feasible to the employer, (b) discourage anti-selection by such participants and (c) foster participant appreciation. This translates to significant participant contributions and avoidance of employer-pay-all funding of plan costs. A corollary of this principle is that with a heavy participant stake in the plan, as an enterprise, which is sponsored and controlled by the employer, such employees have a fiduciary obligation to see that the plan (or enterprise) is properly managed.

The employer should recognize that using multiple vendors (as opposed to one-stop service) is not bad *per se*, but has some risks. Multiple vendors are helpful as long as they are coordinated in an orderly manner. Such is often not the case.

Governing the Plan *Alert: Plan Experience Reflects the Manner of Government*

To a great extent, the plan's financial experience and acceptance will be a direct result of its manner of governance. Logic suggests the best governed plans are those with a controlled balance of the *glove* and the *fist*. Most plans lack a balance of the *glove* and the *fist*. Recognition of this balance should properly be a factor at least cited in the plan's purpose and funding provisions.

TPA-Arranged Block Aggregate *Alert: Aggregate Must Be Handled Better*

All the aggregate coverage with a TPA's block might be replaced with a single block stop-loss contract with improved results for all parties except those who wish to use the aggregate for their interests as opposed to the general good of self-funding. It is possible the cover could be arranged as *reinsurance* and not stop-loss.

Proposed Stop-Loss Changes *Alert: Stop-Loss Is Still a Mystery to Many*

These changes might be improvements:

- Expand the agreement's clerical errors and notification provisions.
- Make the TPA a party to the agreement.
- Clarify the role of disclosure statement.

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- Endorse the micro-managed plan document concept.
- Due diligence avenues must be more wisely used.

Part II: Detailed Analysis of Risk Management Modifications

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Demand Management

Background

Demand management is cost containment before, and not after, a claim has been incurred. There are several reasons, or theories, that bring value to demand management.

Reason Number 1

A high percentage (certainly over 50%) of our health care expenditures is for health conditions attributable to either poor lifestyle habits or failure to follow good protocol in managing certain chronic health conditions. Employers have reason to wish such expenses to be minimized.

Reason Number 2

It is in the best interest of the covered persons that either attention be given or discipline be exerted by the plan to such important issues as lifestyle and good medical care of certain chronic conditions.

Reason Number 3

As long as medical history has been recorded, one finds these attitudes among physicians: "Live as you will and when you are sick, see me" or "I can prescribe and recommend, but I cannot make you follow good medical protocol." Demand management offers the physician needed assistance.

Overview of the Program

Demand Management reduces the allowable charges by _______% in either of the following two instances:

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Certain Identified Lifestyle Habits

- Use of tobacco in any form
- Testing positive in a substance abuse test
- Significant obesity identified as lifestyle-caused.

Certain Identified Chronic Conditions

Certain chronic conditions are both serious and, if not cared for by treatment protocol, will worsen and result in increased health care costs. Examples of such chronic conditions are as follows:

- Hypertension
- Diabetes
- Chemically-induced mental illness.

Bipolar or Unipolar e.g.

The demand management discipline requires that the participant bring evidence, as set forth in the rules, that a good faith effort has been made (or is being made) to correct deleterious lifestyle habits or follow standard medical protocols in the care and treatment of the identified chronic condition. Where such satisfactory evidence is provided, the participant has regular benefits. If not, benefits are reduced.

Demand Management in Practice

Disease-Related

The steps in the program are as follows:

Step	Action
1	Plan document and booklet are both amended so as to mandate and describe the demand management program as relates to disease management.
2	The TPA, as part of its claims program, prints out at the end of the program's first month of operation, that adult covered person John Doe has a diagnosis code _____ for insulin-dependent diabetes, e.g. John Doe is entered into the demand management database.
3	The program, upon receiving the John Doe data prepares the requested statement for Doe's physician and the transmittal letter, explanations and instructions to Doe.
4	The claims system is notified so that as of the date of the transmittal letter plus 60 days, the allowable charges are accepted by the system for John Doe will be reduced by say 30%. This gives Doe 60 days to go to the physician and get the physician's statement, completed and returned to the TPA in order to keep full benefits.

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5	Where the physician's statement is timely returned and is favorable to Doe, the 30% scheduled reduction is negated; otherwise the scheduled reduction remains.
6	Every six months, John Doe is given another letter and the opportunity to have the 30% reduction removed.
7	An activity report, suitable for reading by the employer, is available from the demand management program.

HIPAA privacy rules must be followed.

Related to Lifestyle and Habits

The steps in this program are as follows:

Step	Action
1	Plan document and booklet are both amended to mandate and describe the program as it relates to the management of certain lifestyle health and habits.
2	The TPA, by means of a joint TPA-employer survey identifies those adult covered persons with health-threatening lifestyle habits. When covered persons are identified, they are entered into the TPA's data base.
3	The program, upon receiving the data, prepares the requested statement from either the EAP, the covered person or another reviewing entity. Such requested statement is provided to the covered person by means of a transmittal letter.
4	The claims system is modified so that as of the date of the transmittal letter plus 60 days, the allowable charges accepted by the system for the covered person will be reduced by, say, 30%. This gives the person 60 days to go to the EAP of choice, or a similar entity, and enroll in a program to modify/correct the health-threatening lifestyle habit. Once this program is begun, the benefits will be restored to full value.
5	The benefits will remain at full value as long as a corrective program is in place. Failure of the covered person to complete successfully the corrective program, will result in benefits being reduced.
6	A new chance to have full benefits is offered once each year.
7	An activity report, suitable for review by the employer, is available from the computer program.

Coordination of Eligibility

Background

The reasons for wishing such a plan provision are as follows:

1. The administrative burdens of dealing with other coverages (group plans and Medicare) are huge. They represent the single most difficult challenge to claims processing. They are the source of many errors.

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2. The handling of other coverages causes arguments and rancor far beyond their worth or value. They are often also the source of cheating and fraud on the part of all parties connected with the plan.

3. They allow the anti-selector to take plan assets from the non-anti-selectors. This is because the selectors of double coverage have a motive to be over insured; they know they are substandard and will arrange their eligibility to obtain a financial gain.

4. There is an inherent bias in allowing double coverage in that the rich and sick can gain a financial gain over the poor and sick. This is contrary to the spirit, if not the letter, of ERISA as an act of imprudency with regards plan assets.

The elimination of double coverage across the board should (a) not favor the prohibited group (if anything, the reverse); (b) will not disfavor the protected group; (c) will conform with the letter and spirit of the ADA, ADEA, Medicare and the Civil Rights laws and (d) will result in both fairer and more prudent use of plan assets.

Coordination of Eligibility

The Schedule of Benefits may provide for any one of the following eligibility restrictions:

Condition Number 1

No dependent is eligible to participate in this plan who is otherwise eligible to participate in a comparable employer-sponsored health care plan as an employee.

Condition Number 2

No person is eligible to participate in this plan while also a participant in a comparable employer-sponsored plan.

Condition Number 3

No person is eligible to participate in this plan while also a participant in an employer-sponsored health care plan or on Medicare (Part B) and over age 65.

Condition Number 4

No person is eligible to participate in this plan while also a participant in a comparable employer-sponsored health care plan or on Medicare (Part B) and over age 65.

Eligibility Elections mean:

The Coordination of Eligibility Condition is __________________

Certain Spouses Not Eligible

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Background

J.C. Penney Company became financially overburdened by having to pay the excessive medical claims of the head-of-household, dependent spouses. When it amended its plan to cover such spouses only when the income of the spouse was less than 50% of the combined spouse and employee's income, the matter went to litigation where sex discrimination was the issue.

As background to the court's decision, J.C. Penney Company showed that (a) the amendment had financial urgency, (b) was made for reasons of overall equity and (c) while it may have been sex-discriminatory by result, it was not sex-discriminatory by intention.

Court's Decision

The court held that J.C. Penney Company plan amendment was not sex discrimination despite the female employees' prima facia showing that policy had a separate impact on them. J.C. Penney showed that keeping the cost of the requisite plan contributions to employees as low as possible and providing benefits to the largest number of workers and those with greatest need are legitimate and overriding business justifications for the amendment. See *Wambheim v. J.C. Penney Co., Inc.* 705 F.2d 1492 (9th Cir.1983), *cert. denied*, 467 U.S. 1255 (1984).

Rx Is Made An Elective Benefit

In General

The international drug companies, along with managed care practices, have had a profound effect on our health care delivery system, mostly good but some bad. While the influence of managed care is waning, the influence of the drug companies is accelerating. Not too long ago, Rx was a minor throw-in cost of some 3-5% of the total. At present, it comprises some 15-20% and is rapidly rising. While Rx has become a dominant cost factor, its growing influence on how medicine is practiced must also be carefully noted.

Many practices of these drug companies could be questioned; e.g., monopolistic pricing and over-aggressive marketing. Of greatest concern is the trend of elevating the *practice of pharmacy* to the level of the *practice of medicine*. There is no *Hippocratic Oath* with the pharmacists. Such practices are not challenged, but our risk management tools are being called upon to control the costly practices of the drug companies.

As actuary and risk manager, this writer asserts that the greatest good for the greatest number will come from offering Rx in self-funded plans on a *pick and choose* basis, and at once. The reasons for this suggestion are compelling as further discussed.

Philosophic, Ethnic, Etc.

Not all people subscribe to the goals of the drug companies:

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- Our hyphenated-populations want different health care benefits and suffer from being burdened with the huge Rx benefit costs, a benefit generally not appreciated or wanted. They are suffering from significant discrimination as a result.
- The belief that life's problems can be *solved with a pill* is horrifying to large segments of the participant population.
- The trend in self-funded plans of providing *freedom-of-choice* should be extended to Rx benefits.

Actuarial and Risk Management

Equity demands that Rx be treated separately and apart from medical. The practice of pharmacy has entirely different risk, underwriting, rating, anti-selection, legal and administrative characteristics than the practice of medicine. The forcing of these two dramatically disparate risks under the same *rating tent*, violates basic actuarial and risk management principles and should be discontinued.

Compassion for Medical Needs of the Participants

With Rx such a dominant factor in the cost of medical care, some people will be denied needed care because they cannot afford it. By electing medical (at much reduced cost) and paying their Rx out-of-pocket they will experience significant savings in health care costs. Not all people need or want those Rx items that are only palliative or reproductive-related; they want those Rx items for acute conditions.

Administrative

Everything at the present time is in place for Rx *pick and choose* as far as plan administration is concerned. Self-funding is poised and ready for this needed change.

Active Participant Over Age 65

Background

Federal law and regulations require that where the plan and Medicare are both available, the participant may not be induced, either directly or indirectly, to choose Medicare over the plan. Such instance would be when a participant, over age 65, is told that if such participant opts off the plan and looks to Medicare as primary, that the employer will *bankroll* the participant's Rx expenses or will *sweeten* the participant's pay. The federal law does not preclude the participant's electing Medicare as primary; it only says the choice must be totally free of any employer encouragement or inducement. Since in so choosing, the participant will lose Rx coverage, such choice is generally unlikely. Violation means the plan becomes a nonconforming plan and loses its favorable tax status. See IRC § 5000.

These circumstances do not include the instance where the participant is on the plan with a Medicare card in which event the plan is simply primary and Medicare is secondary.

Option of Employer and Participant

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The employer may amend the plan to increase the hours required to meet the definition of full-time. The employer may limit the hours worked by a participant over age 65 even if such cutback means the over-65 participant is no longer eligible for the plan. By doing so, the participant must look solely to Medicare for coverage. In order to achieve parity or to meet the needs of both the employer and the over-65 participant, adjustments in pay are often made. This amendment, while less than ideal, does go a long way in meeting needs of the employer and over-65 participant.

Bifurcated Plan Design

Introduction

A bifurcated plan offers these options on each plan anniversary to each participant:

Defined Contribution (DC) (or Medical Reimbursement Accounts)
Designed for those participants who wish the plan to protect their income.

Defined Benefit (DB) (Traditional Health Care Benefits)
Designed for those participants who wish the plan to protect their assets.

In our discussion of this design, we consider only a plan where the employer pays all of the costs. Each of the options should be treated as separate ERISA plans with its own name, sponsor, DOL number, plan year, document, SPD, etc. The employer amends its present health care plan to accomplish the following:

1. Each participant may elect on each plan anniversary to have the employer's contributions used in either of two ways:

   - **Fund the present health care plan**
     This is referred to as the defined benefit option.

   - **Fund the new health care plan**
     This is referred to as the defined contribution plan.

2. **Projected Employer Costs**
   Such costs are projected to be as follows (as an example):

	Monthly Costs by Plan Option	
Attained Age	DB	DC
To 29	$150	$150
30-39	175	175
40-49	200	200
50-59	250	250
60-64	300	300
Over 65	350	350

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The order of events with the plan costing is that the DC costs are first set and the DB plan design is modified to gain parity between the two. Parity must contemplate the effect of anti-selection. Will the participants with health problems *rush, slide* or be *indifferent* to the selection of a DB or DC option? Present experience does not give a clear picture.

3. <u>Defined Benefit Option</u>
This option is managed in the traditional way.

4. <u>Defined Contribution Option</u>
For tax, ERISA and other reasons, certain rules for the DC option are needed.

- When the employer makes the first contribution, such contribution is deposited in the participant's account in a master trust and becomes a plan asset. The master trust has the TPA as grantor and trustee; has the bank or trust company as the custodian; has the participant as beneficiary; has the contribution as property. The trust agreement would show the bank or trust company as the successor trustee if the TPA no longer is plan supervisor.
- Under trust empowerment, the TPA will direct the bank to disburse, as the TPA directs, to the participant or provider-assignee, trust money for participant-incurred health care costs. Such costs are defined in the plan document to be those acceptable by IRC § 213 or for individual health insurance premiums for plan-approved health care policies.
- Participant trust balances may be used only to reimburse health care costs without a time limit except that a *de minimis* balance of under $200 may be paid to such participant with an IRS Form 1099 at the option of the trustee.
- A DOL/IRS Form 5500-C (or 5500) is required because of the presence of plan assets.
- Trust income is anticipated to exceed trust expenses.
- Because the participants may never use such employer contributions except for health care costs; because the DC option is established as an employer-sponsored ERISA plan and because the participants have no choice in the amount set aside in the trust on their behalf, there is no applicability of IRC § 220 (Archer savings accounts), IRC § 125 (flexible spending accounts) or the IRC § 106 amendment (for health reimbursement account).
- Many participants will be attracted to the DC option because of their expanded choices (the IRC § 213 definition of health care costs is broad) and empowerment; the contributions are instantly 100% vested and literally money in the bank (subject to their use only as health care reimbursements).
- An amount (over $200 by *de minimis* rule) in the participant's trust will eventually escheat to the state and not revert to the participant as income.
- <u>Potential IRS Challenge</u>
  For the DC to be deductible by the employer and not taxable to the participant, it must be used to reimburse the participant for health care expenses. There is no nexus between the $1 which the employer contributes and deducts and the $1 of intended medical expense with either fully insured (insurer, prepaid or capitation) or trusteed self-funded arrangements.

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- The DC option may be easily modified to include dependents. Also participant contributions may be accepted but, to keep the plan noncontributory, such participant contributions must be accepted through an IRC § 125 premium option plan.

5. At each plan renewal, costs between the two options are redetermined and parity is reestablished.

Advance Medical Directive

Introduction

The prudent plan sponsor of a self-funded medical plan should have an interest in adult plan participants having a living will (i.e., advance medical directive) for these reasons:

- To protect plan assets from invasion by a health care facility that gives needless medical care to those patients unable to direct their own medical care because of physical or mental incompetency
- To provide a lifetime maximum of $1 million or even more for those participants who legitimately need extraordinary and expensive care.
- To give utilization review vendors an additional tool by which medical care may be most prudently managed.

To use the presence of the advance medical directive as a condition of providing a higher lifetime maximum, or vice versa, is acceptable as long as it is supported by a certification of actuarial or underwriting parity. Typical parity is (a) high-limit lifetime maximum with a directive or (b) reduced lifetime maximum without a directive.

Employers may wish to offer their employees (and spouses) the opportunity to execute such directives as a fringe benefit similar to on-site flu shots. Many personnel vendors will view this fringe benefit as an addition to their product/service line.

Plan Amendment

Effective ____________________, the Individual Lifetime Maximum Benefit of the Health Care Plan of ______________________________, for Participants and their Covered Dependent Spouses, will be:

Group	Description	Individual Lifetime Maximum Benefit
1	Those who have on file with the plan administrator A legally-valid advance medical directive (living will)	$
2	Others	$

This amendment does not apply to covered dependent children. This amendment will be applicable only if the plan administrator has on file an actuarial certification, of reasonable currency, which attests to the actuarial and underwriting equivalence (or parity) between the estimated (a) cost savings to the plan and (b) reduction in benefit value, and which meets the so-called anti-subterfuge provision of the Americans with Disabilities Act § 501(c) and relative EEOC regulations.

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The purpose of this amendment is to (a) extend lifetime maximum benefits as high as possible for those who are medically needful while (b) protecting plan assets from being imprudently used to provide unnecessary care to those who have lost mental competency to make their own medical decisions.

Actuarial Certification

I certify that the plan amendment for the health care plan of ________________________ effective _____________________ meets the anti-subterfuge provisions of Section 501(c) of the Americans with Disabilities Act and related EEOC regulations.

That is, the economic value, as measured by acceptable actuarial and underwriting practices and standards of the following two plan benefits are equal:

- Lifetime maximum of $ _______________ with an advance medical directive.
- Lifetime maximum of $ _______________ without an advance medical directive.

This certification presumes that the subject plan uses a utilization firm for purposes of hospital certification and large case management. My logic assumptions and methodology are described in the pages that follow.

Actuarial signature follows.

Logic, Data and Assumptions Methodology

LOGIC
This subject amendment is cost neutral as to total plan costs. The reason is two-fold:

Actuarial
The additional plan claims resulting from increasing the lifetime maximum from $150,000 to $1 million are offset, to a great extent, by reduced claims because of savings from the medical directive on claims below such a maximum.

Underwriting
It has been demonstrated that those with a medical directive are more prudent (or less costly) health care purchasers (at least for facility-related care) than those without such directive. In underwriting terms, the presence of a medical directive equates to a better risk and vice versa. Treated as an underwriting consideration is the fact that the utilization review function will be more cost effective where there is a medical directive than otherwise. This belief is supported by strong anecdotal evidence.

DATA AND ASSUMPTIONS

Some of the experiential data used in this actuarial analysis are as follows:

- The IRS-promulgated uniform one-year term premiums, probability of death of a plan participant is .003. See Treas. Reg. § 1.79 –3(d)(2).
- Of a population of patients under physician-care, with a lingering or terminal health condition, 8% will be classed as mentally incompetent and unable to direct their medical care. See *Annals of Internal Medicine,* Vol. 132, No. 6, 451-459.

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- Among Medicare beneficiaries, 5-6% will die in any year, and such final illness will comprise 25% of the program's cost. See www.nap.edu/readingroom/books/approaching (6.html).
- Medical facility costs for those terminally-ill with a medical directive are approximately 30% of those without such a directive. See *Archives of Internal Medicine*, March 14, 1994, 541-547; JAMA, June 26, 1996, 1907-1914.
- Savings from presence of medical directives determined to be some 25% for over-65 patients and presumed to grade upward for those under 65. See *Long Term Care Interface*, July/Aug 2000, 41 *et. seq*.
- Anecdotal evidence abounds, primarily from TPAs and utilization review firms, that the presence of such directives would have been very useful in combating imprudent care in medical facilities.
- One medically-controlled study showed those patients with a medical directive used less medical care, at least for terminal illness, than those without such a directive. See *Archives of Internal Medicine*, Sept. 26, 1994, 2077-2083.

METHODOLOGY

Several simple models were created using Monte Carlo simulations that attempted to factor in the modicum of available published experience. A considerable amount of anecdotal experience was accumulated. Also, the writer's past experience in health care plan underwriting and pricing was relied upon. Any analysis is believed to be actuarially proper; however, because we are so *far right* on the lognormal curve, any margin of error must be of concern.

Treat Early Retirees as COBRAs

Suggestion

The employer *may* amend its health care plan document to redefine a participant, with early retirement benefits, to be a COBRA. Such amendment would, e.g., extend COBRA to cover the period from (a) early retirement age plus 18 months to (b) age 65.

- ERISA gives the employer the right to so amend.
- Congress crafted COBRA to be a minimum benefit.
- A COBRA and an early retiree are two significantly different types of plan participants and require different treatment.

The significance of the decision for the employer is that the FAS 106 requires a buildup or accrual of liabilities of such early employer-provided retiree costs during the participant's working lifetime. Such accrual is *not* required for COBRAs.

The writer asserts that every employer, as an ERISA-demanded act of prudency, should make a conscious and deliberate plan design decision to *amend or not to amend* where early retirees with contributory benefits are involved. Consequences of such a decision are reviewed in the next section.

This suggestion applies *only* to early retiree benefits, which are funded, in part, by participant contributions. Treatment of over-65 retiree benefits is unchanged.

Consequences

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Legal

The writer understands such decision to *amend or not to amend* is a legal *non-issue*:

- The redefinition amendment must not diminish any promised benefits to such retirees; nor significantly discriminate (either to help the prohibited group or to harm the protected group).
- Existence of any related labor or employment contracts must be considered and honored.

The different legal and funding (actuarial) status of such early retirees and COBRAs must be recognized:

- A COBRA for purposes of plan funding is an *active participant*; an early retiree is an *inactive participant*. With COBRA, we have one fund. With early retirees, we have two funds.
- The COBRA may, prior to the end of such COBRA extension period, return to work and be treated as having *unbroken* service. Such is usually not the case with an early retiree.
- Each COBRA beneficiary has claimable rights regardless of having employee or dependency status. This is normally not the case with an early retiree.
- COBRA benefits are considerably more secure because of the *similarly situated* requirement of COBRA. This is normally not the case with retiree benefits. The reader should note the plethora of litigation involving retiree benefits.
- COBRA premiums are actuarially determined while those for early retirees are employer-determined. This may be a great significance to the participant.
- COBRA has secondary events benefits (spouse continuing coverage after a legal separation, e.g.) that are normally not found with early retiree benefits.
- Early retirees with employer-pay-all benefits may be redefined to be COBRA, but fail to be treated as COBRAs for FAS 106 purposes. This is because the element of election, precert with COBRA is absent where the benefits are employer-pay-all.

Financial

It is absolutely certain plan administrative costs will decrease because the FAS 106 maintenance costs will disappear. Such cost decrease may be significant. Employers who seek high reserves (for tax-deferral purposes, e.g.) have the *right* to treat such participants as early retirees. Those who seek low reserves have the *right* to treat such participants as COBRAs. Benefit costs from such redefining will not be affected measurably. COBRA benefits are a bit more expansive because of the secondary event requirements of COBRA.

With such amendment, the so-called FAS 106 accrued liability drops to $0. This would, where material, be treated as a change in accounting practice. Where the employer pays any portion of the retiree costs, FAS 112 would apply *when* the COBRA event occurs. That is, the present value of the *employer's cost* of the COBRA premiums is a FAS 112 liability. With early retirees, the plan has two funds (a) actives/COBRAs and (b)early retirees. Where such early retirees have been amended to COBRAs, the plan has but a single fund. Depending on many factors, the *bottom line* cost effect for the COBRAs, early retirees and employer cannot be predicted.

Contributory Versus Noncontributory Issue

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In the analysis of these suggestions, three different early retirement funding situations should be examined:

- **<u>One: Participant-Pay-All</u>**
  The redefinition suggestion should be fully accepted by the accountants. Funding commonality with early retirees and COBRAs exists.
- **<u>Two: Participant and Employer Shared Cost</u>**
  The redefinition suggestion should be reviewed by the accountant and accepted or denied on a case-by-case basis. Sufficient funding commonality between early retirees and COBRAs may or may not exist.
- **<u>Three: Employer-Pay-All</u>**
  The redefinition suggestion should not be accepted and FAS 106 should be applied. Funding commonality between early retirees and COBRAs does not exist.

Government Entity Plans

No accounting pronouncement similar to FAS 106 has been finalized for government plans but are being readied for use. Where such entities choose to recognize accrued liabilities on a voluntary basis (fiscal strategy, bonding ratings, e.g.), such suggestion is not appropriate because reduced reserves are not a goal. When the Government Accounting Standards Board does, in the future, *require* accrued liabilities (as does FAS 106), the suggestion of *amend or not to amend* will be most appropriate at such time.

Publicly-Traded Employers

Consider two competitive publicly-traded employers, A and B, which have similar balance sheets, market size, etc. Employer A extended COBRA (thereby redefining early retirees) while Employer B was not advised of its option to do so. Such difference in practice will give Employer A a financial *one-up* on Employer B. The writer's concern is that Employer A and B have a level playing field in regard to knowing their options.

Responses of Affected Persons

The writer's experience with this suggestion goes back at least 15 years and is summarized as follows:

Affected Person	**Response**
Participants	Favorable; they prefer being COBRAs.
Employers	Very favorable; they appreciate having the freedom to choose.
Attorneys	Neutral – it's an accounting and not a legal issue.
Accountants	Initial response is usually silent, negative or skeptical. However, accountants will normally honor the plan document language when confronted directly therewith and where the plan is contributory.
Actuaries	Response unknown.
Regulators	No formal response has been sought.
TPAs	Favorable
Consultants	Favorable
Risk Managers	Favorable

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Bankruptcy of Employer

When the participant is provided coverage, after active service, prior to age 65, either as (a) a COBRA or (b) a retiree, the effect of the employer's bankruptcy on the security of such benefit is essentially the same. Consider the following:

1. Neither COBRA nor retiree benefits have any statutory protection from a Chapter 7 bankruptcy.
2. Both COBRA and retiree benefits gain significant statutory protection in a Chapter 11 bankruptcy.

   a. **COBRA**
      - ERISA specifies retirees shall be afforded rights as COBRAs in certain instances:
      - Loss of coverage is due to a Chapter 11 bankruptcy.
      - Such loss occurred between the period of one year prior to one year after such bankruptcy filing.
      - COBRA rights extend to family members.
      - COBRA continuation period is extended to a lifetime.

   b. **Retiree**
      Chapter 11 of the Bankruptcy Code provides that retiree health benefits shall be afforded preferential treatment regardless of the funding method (insured v. self-funding, e.g.) of such benefits.

Commentary

This suggestion is not new, but is not widely known and it should be. It does not force anything on anyone, but does offer the employer an ERISA funding option within a small benefit area. What will we do if Congress forces COBRA to be extended to cover the so-called *gap period*? Will not this issue need to be examined at such a time: Will this suggestion lesson the likelihood of a *forced* COBRA benefit expansion by Congress? A few states have adopted the extended continuation for early retirees at the present time. In dealing with such plans, should we not be both logical and prudent? With small plans, the maintenance costs of FAS 106 are usually excessive when measured against the benefits.

Accounting disciplines must be honored. The final decision as to whether such redefinition will, or will not, be honored always is with the accountant. However, early retiree and COBRAs are significantly different and must be treated. If the accountants believe this suggestion violates sound accounting principles, FAS 106 should be amended so as to clearly distinguish between two classes of COBRAs:

- Class A – COBRAs who should be treated as actives.
- Class B – COBRAs who should be treated as inactives.

Accessibility to Providers or Benefits

Introduction

Anytime there is an easy access to either health care providers or benefits, there will be either overuse or abuse of benefits (or both). Examples:

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Accessibility to Health Care Providers

Easy accessibility to providers is one, but by no means the only reason why health care plans of health care workers have high costs.

Accessibility to Health Care Benefits

Examples include in-network physician visits paid at 100% and Rx with a small copay. Such benefit not only encourage overuse and abuse, but worse yet, they may serve as an unwanted attraction to those prospective participants seeking opportunities to use, overuse and abuse. Plan should be drafted to accomplish both of the following:

- Design the plan benefits so as to minimize the opportunity for overuse and abuse; that is, no 100% coverage.
- Design the plan benefits so the employer will not be attractive to those prospective employees with health problems who are seeking benefits more than work opportunity.

Medical Errors

The plan should be amended to prevent any provider-assignee from profiting when there has been a medical error.

Medical Error. An error must be reported as such, and be a matter of public information.

Example of Not Profiting. The provider A makes a medical error during a procedure, the cost of which was $1,000; provider B makes the corrective procedure, the cost of which was $1,000. The plan will recover $1,000 from A but pays $2,000 to B.

The plan does not have to do anything, more or less, than act on public information; matters of harm, liability, etc. are of no concern to the plan in its recovery. It must be stressed that public disclosure of medical errors is not in place at the present time. While plans with such reporting may be mandated in the future, the goals of such reporting will be to improve patient care and not to blame faulty providers.

Attained Age Funding

Legal Background

Funding by attained age is permitted by the ADEA as long as such is not a subterfuge to age discrimination. A prima facie case against subterfuge would exist where the cost slope is within an actuarially-defendable morbidity claim cost slope.

Why Age is a Proper Funding Factor

Having established that a reasonable sloping of claim costs by age is legal, we examine whether it is prudent. Actuarially, it is prudent otherwise why would individual medical insurance rates at age 100 be over 5 times those rates at age 25, on average. Viewing a self-funded plan as a miniature insurance

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company, the logic, from a risk management standpoint, that applies to an insurer should also apply to a self-funder.

Administratively, the use of age as a funding variable will cause some, but minimal disruption. The variable is stored in most systems but not used in the preparation of most reports. Where age is used as a funding variable, the age factor will appear frequently in the reports: examples include COBRA premiums, census and claim costs. A plan document and an SPD amendment are also required to accommodate the use of age.

Proper Age Factors

Basing such factors on individual major medical insurance. The sloping by age 1 at 25 to 5.5 at age 60 is reasonable. For employer-sponsored plans, a sloping of 1.0 at age 25 to 3.5 at age 60 is reasonable. To err on the side of caution, a recommended slope is 1 at 25 and 2.5 at age 60. The goal of this sloping is two-fold:

1. Clearly designate age as a variable that affects plan costs.
2. Treat the variable so as to remain well within both the letter and spirit of ADEA.

These are relative cost factors:

Attained Age	Individual	Participant and Spouse	Participant and Child	Family
Child	60	NA	NA	NA
To 34	70	70	80	80
35-44	100	100	110	110
45-54	140	140	140	140
55-64	180	180	170	170
Over 65	230	230	200	200

Plan Amendment

The funding method of this plan is hereby amended to recognize age of the covered persons as a factor. Such factors are made part of the COBRA premium computation, which are actuarially determined and made a part hereof by reference. Age will also be deemed a variable in the recordkeeping and reporting plan functions as well as the determination of the participant contributions, if any.

Miscellaneous

Preauthorized Health Care Expenses

With potentially troublesome items, such as durable medical equipment, it is prudent for the plan to expect that the parties have an agreement prior to expenditure. Planning ahead is always a good idea.

Probationary Benefits

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The concept of probation has been a feature of employee benefits from the beginning. So it should be with health care plans and newly covered participants. HIPAA rules relative to discrimination by health status will not be violated if all new plan participants, within the first six months of plan tenure, have a $200,000 maximum, e.g., as opposed to a $1 million maximum.

Retirees and Independent Contractors

It is prudent to leave no doubt that such persons are not eligible for benefits. Exceptions would be where such person is specifically named as being covered in the document.

Subrogation

To be as up-to-date as possible, the subrogation clause should accomplish the following:

- Permit the ERISA plan, in its settlement, to concede some of its recovery to the attorneys of the covered person on the *common fund* theory found in common law.
- Make clear that a structured settlement, drafted by the attorney of the covered person, will not thwart the plan from recovery. This is the so-called make-whole problem.
- Recognize that after the *Great-West v. Knudson* Supreme Court decision, the plan's interest will not be thwarted by the *made whole rule*; nor should the plan expect to get full recovery unless specifically provided in the plan document.
- The clause should be drafted so as to permit recovery even if there is no tortfeasor. An example would be *disgorgement* payments from an Rx litigation settlement.

Liability of Employer

Introduction

Employer-sponsored health care plans, regardless of the manner of funding, have flourished because employers were confident of limited exposure to losses. That is, a claim may have to be paid, but no punitive, exemplary, etc., damages were possible because of ERISA.

Even though acting within the letter and spirit of the Federal HMO law, the public reaction to HMOs has been very negative because (a) insurer usurpation of the practice of medicine, (b) undisclosed, financial arrangements by which physicians profited by denying care, (c) bureaucratic red tape and (d) stories of human pain and suffering resulting from HMO practices.

It is likely that Congress, rather than repealing or amending the HMO law, will enact some type of legislation that will address any and all types of health plan influence on patient care. Congress may well throw the *baby out with the bath water*. We speak here of the much discussed *Patients' Bill of Rights Law*.

Lurking beneath these legislative efforts may be seen the efforts of those who believe our interests would be well served if employer-provided health care was replaced by a federal single payer system. Those wishing such a plan include (a) those who believe Washington, D.C. is the center of the universe and (b) the globalists and internationalists who want a single payer system in the United States because

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such a system would improve their competitive advantage. The logic, which should be in place prior to the possible passage of a *Patients' Bill of Rights Law*, is discussed below.

Employers React to the Proposed Patients' Bill of Rights Law

As a basic principle, let it be well understood that employers will be plan sponsors only with a zero tolerance to liability. Talk of (a) shifting the liability, (b) limiting the liability or (c) insurance against the liability will prove to be idle. There must not be *any* liability.

Further, the logic that employers cannot be self-funders because of the resultant liability but may limit or avoid such liability by funding fully insured is fallacious. With *Pilot Life v. Dedeaux* in mind, the employer has the same amount of liability with a self-funded plan as with a fully insured plan. If a participant is upset, the litigation will be directed at both the plan supervisor and employer in a self-funded plan. The shift of liability to the insurer will not be effective. There are too many legal theories by which the employer can and will be drawn into the litigation with a fully insured plan. Notwithstanding the problems, these are the employers' options:

1. **Total Elimination of Liability**
   a. Drop the plan.
   b. Adopt a defined contribution plan.
   c. **Shift Liability to Another Entity**
      - Plan supervisor is made plan administrator.
      - Plan sponsor becomes a VEBA.

   The problem with (i) and (ii) is funding and keeping any person(s) willing to become plan fiduciaries.
2. **Significant Reduction in Risk**
   a. Adopt a micro-managed plan.
   b. Use a UR firm for all questionable medical decisions.
   c. Have the TPA be the claims adjudicator and recordkeeper of last resort.
3. **Other**
   a. Employer-purchased liability insurance.

TPA Anti-Fraud Programs

Examples of Fraud

A listing of examples of fraud, which are frequently found with self-funded plans, is as follows:

- **Laboratories**
  Physician-owned (financial bias); code gaming; needless or fake tests (rolling labs).
- **Rx**
  Physician prescribes expensive Rx to an accomplice who then markets such on the black market.
- **Durable Medical Equipment**
  Overpriced or unneeded items are sold, usually by telemarketers.
- **Home Health Care**
  Price gouging with the old, ill or dying of such services as home infusion.

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- **<u>Copayment Waivers</u>**
  This is comparable to offering free services to the patient and is illegal.
- **<u>Quackery</u>**
  List is very long.
- **<u>Physician Code Gaming</u>**
  Upcoding, double-coding, miscoding, etc.
- **<u>White Collar Type of Crime</u>**
  Embezzlement, cybercrime, etc.
- **<u>Vendor to Vendor Fraud</u>**
  Not all vendors to self-funded plans are to be trusted. Due diligence will avoid abuse from marketers, MGUs etc.

An underlying impetus to fraud in self-funded plans comes from illegal drugs, drug users and organized crime.

Programs to Avoid or Control Fraud

The TPA should have in place an anti-fraud procedure guide. Potential danger areas that should be included are as follows:

- Foreign claims
- Disability
- Provider fraud
- Cyber fraud
- Organized crime/cartel-related
- Vendor fraud.

Also, the TPA should be integrated in and become part of the numerous national programs aimed at identifying and eliminating fraud on health care plans.

Saving the Small Groups

The Problem

In the early days of self-funding, small groups were handled with considerable ease and practicality.

- Specifics of $2,500 were often used and the acquisitions thereof were from a soft market.
- Medical inflation was a problem, but not ruinous.
- Regulatory intrusion into stop-loss terms had not yet appeared.
- MEWAs were abundant, but hardly flourishing.

With the changing of these factors, self-funding of small plans has become more difficult. The small group market, once the *bread and butter* of many TPAs, is gravitating back to fully insured. The inability of the self-funding concept to work with small groups might constitute a *black eye* to self-funding.

The Solution

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The most practical way of keeping small groups under self-funding is for the TPA to establish a MEWA-look alike with these important distinctions:

- Each employer plan is a freestanding ERISA plan and the experience of the small employer does not help or hurt any of the small employers in the group. That is, it is not a MEWA.
- The small group pool gains bring only cheaper-by-the-dozen advantages.
- The packaged plan is replete with risk management disciplines (attained age funding, e.g.).
- Stop-loss is specific-only with low specifics available:

Group Size	Standard Specific	Stop-Loss Carrier	Reciprocal Banking Type Trust
25-39	$4,000	$7,500	$3,500
40-64	7,500	7,500	0
65-99	10,000	10,000	0

Emerging Employer Attitudes and Practices

Monitoring Total Nonpayroll Costs

The logic is simple; workers with high health care costs usually have high time lost costs and low productivity. Less correlated, but a factor to be considered none the less, is the cost of the worker's work-related accidents and illnesses.

Plan Inducing the Wrong Type of Workers

Where the plan is more liberal in benefits than is typical for the trading area, or where the requisite participant contributions are less burdensome, the plan will be a lightening rod to employees with health problems.

Participant Contributions

The contributions must be high enough to (a) make the plan economically feasible and (b) foster participant appreciation. Also, they must be low enough to encourage employee participation. An important aspect of employee participant contributions is that the employer has an obligation to see that the self-funded plan is run prudently. This means the plan's benefit or risk management disciplines could be challenged by the plan's beneficiaries as a violation of ERISA fiduciary standards.

Multiple Vendors

It's the writer's first hand knowledge gained as an expert witness in health care plan litigation that often, if not usually, the disputes occur because vendors were doing *their own thing* in an uncoordinated and unregulated manner. That is, multi-stop service is a risk if not controlled. Similar logic would apply to the homeowner who permits the tradesmen to practice without direction and order from a general contractor.

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New Employer Economic Paradigm

Understanding the Paradigms

The old paradigm treated the health care plans as a fringe benefit with its primary purpose to help the human resource staff acquire and maintain an effective group of employees. The new paradigm treats the health care plan for what it is, a major corporate expense. At the current prices thereof, it should no longer be deemed a tool to help the human resource staff. The plan has gotten too costly to do that. We are on a collision path. Either the plan costs must be scaled back to agree with the old paradigm or there must be a new purpose set forth to justify the high costs of the health care plan.

Reasons for a New Paradigm

The principal reasons for needing a new paradigm are as follows:

1. When family COBRA premiums, with some regularity, are exceeding $2,000 per month, the economic reality should be setting in. These costs are not sustainable. Space does not permit us to explore the economics of free trade, global markets, necessity to avoid world wide inflation, etc. Let us conclude that something has to give.
2. Within the past decade, many changes have occurred, each of which in its own way has, or should have, an impact on the paradigm:
   - Nation's changing population, politics and ethos
   - Inability of both the first and second generation of cost containment to control health care costs
   - Increasingly aggressive federal mandates
   - New provider force – the Rx companies
   - Growth of the role of the independent contractor and changes in IRC § 162(e) permitting full deduction of self-employer health care expenses.
   - Growing popularity of the defined contribution options, suggesting a future change pattern similar to that of the pension to IRC § 401(k) pattern.
3. On the horizon are two major challenges to the old paradigm:
   - Possible Patients' Bill of Rights law
   - HIPAA-required claims and privacy regulations.

Governing the Plan

The Challenge

The writer has memories going back to at least 50 years of the bias with certain types of fully insured plans where the personnel committee wished for some benefit that the finance committee believed was too costly. This bias between these same forces continues today.

This bias in the governing of self-funded plan is an issue to be considered because of huge plan costs, complexities, options, multiple vendors, statutory/regulatory demands and relevant case law. Hundreds of court decisions deal with conflicts in the governing of ERISA plans.

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The problem is *not* that a self-funded has a bias in administration (human resources v. financial) a conflict but, rather any or all of the following:

- The bias is not understood or recognized by the plan sponsor.
- The bias may be exploited to the plan's financial harm by any of the decision-makers or vendors.

That is, the peril is not that the bias exists (which, of course it does), but more importantly, that it fails to be recognized and accepted as a factor in the plan's *purpose* and *funding*.

The Response

There should be a section in the plan document in which the governance of the plan is made clear to the plan sponsor. The options of the plan sponsor are these:

Plan Sponsor Retains Governance

____ Dominance by human resource staff.
____ Dominance by financial staff.

Governance Outsourced to Professional Management Firm (TPA, e.g.)

Professional management firm becomes the ERISA plan administrator. Several plan features are essential.

- Micromanaged plan document
- Intrusive managed care functions are not provided by the professional management firm but rather are subcontracted to an independent UR firm. Such firm must not be at risk for any decisions in which medical care may be an issue.

TPA – Arranged Aggregate Reinsurance

Introduction

There are five reasons for this risk management modification:

1. We should eliminate, as much as possible, the practice of using aggregate stop-loss as one of the primary arenas in which the employer and vendors choose to do *commodity-type* competition. To bring good repute to self-funding, vendors should show virtue and compete in measurable fees and service. Aggregate maximums have nothing to do with quality of service. Also, they are only marginal in measuring costs in that, as a rule, the lower the aggregate limit, the less attainable it will be, This is because of the many obstacles that will be offered by many of the carriers to an aggregate claim when it is presented.

2. *Claims gaming* for practical purposes makes aggregate stop-loss nearly an uninsurable risk. *Claims gaming* includes not only holding back or pushing forward of claims, but also includes the pervasive and questionable practice of failing to complete the disclosure statement in the manner and spirit intended.

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3. The driving up of the specific limit for competitive and regulatory reasons, makes the medium and smaller plans very difficult to manage risk-wise. A 30-life plan with a $10,000 specific and the same plan with a $2,500 specific are two entirely different creatures risk-wise.

4. There is a great need to bring uniformity to what is called aggregate stop-loss. The almost limitless variations in terms: paid *v.* unpaid, benefits covered, inside limits, manner of audits, etc., make it necessary to bring order out of chaos.

5. The stop-loss carriers, while doubtless unintentional, do offer self-funders numbers which, at times, may do mischief. Typically, the carrier shows an aggregate of, say, $500,000 with either a stated or implied corridor of 25%. The employer and its vendors take these numbers and believe its expected claims will be $400,000. It is the writer's assertion, based upon many and varied Monte Carlo simulations, the more realistic claims, are, say, $420,000 and the corridor is 19%. Two instances may be cited where the stop-loss carrier numbers have unintended and unfortunate consequences:

- Correct expected claims are needed (with COBRAs, e.g,).
- State laws or regulations often demand a 24% corridor; only 19% is the corridor in the instance cited above.
- The so-called *agg audit* has spawned an industry of *bounty hunters,* which practice has generally demeaned self-funding. *The agg audit* is needed regardless of whether there is or is not a claim, but only to test the overall worth of the vendors. We should judge the builder by the beauty, worth and utility of the edifice and not by the wasted nails found on the ground.

For these reasons, the TPA should make these changes:

- Convert its block to spec-only stop-loss at renewal for employers who agree to do so.
- Replace the aggregate stop-loss with TPA-managed, block treaty stop-loss or reinsurance coverage which is pooled and experienced rated.

Transition Steps

To move from the traditional stop-loss aggregate to the more workable block treaty reinsurance these steps are suggested.

Step	**Activity**
1	TPA should obtain a general agent's license.
2	The TPA, as general agent, should negotiate a reinsurance contract with these features:

a. The risk to be reinsured would be the amount of paid claims under a self-funded health care plan (insurer) that exceed a formula amount for the risk year.

b. The TPA has authority to determine both the risk, the premiums and the claims but in strict accordance with reinsurer-provided guidelines.

i. **The Risk**

Risk factors (i.e., aggregate funding factors) are computed by the TPA, but using computer programs, work sheets, parameters, etc., all provided by the reinsurer.

ii. **The Premiums**

Tables of Premiums, applicable to the reinsurance and used by the TPA, are furnished by the reinsurer.

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iii. **The Claims**

When an employer (insurer) has a claim, the TPA may process it, but only by the reinsurer's rules. These would include usually a reinsurer-paid audit report.

c. The TPA would be required to make two critical representations (if not warranties).

i. The TPA must not engage in claims gaming or any other act that is discriminatory or in bad faith. Excess loss common shall be followed carefully by the TPA as well as the reinsurer.

ii. The TPA must agree to abide by both the letter and spirit of the reinsurer-provided rules.

iii. The TPA must agree to present the reinsurance option in its proposal spread sheet to be clear, fair and, as much as possible, remove the aggregate issue from being a competitive issue. Further, the reinsurer must approve the proposal format before it is used.

d. All of the employer self-funders of the TPA will participate in the reinsurance treaty except those employers specifically as opting out and cited to by amendment to the reinsurance treaty.

e. The TPA (GA) shares in the full profit or loss of the pool, not to exceed 25% (plus or minus) of the premiums. The profits or losses are reinsurer-determined. As discussed in the following paragraph, the TPA will assign any profit bonus to the employer pool and collect any loss payback from the employers.

3 The first renewal is made following the TPA-reinsurance agreement. The proposal of the TPA may show firm reinsurance costs, using 11 months of data with no caveats. Those caveats, which are specific risk related (APS, lasering, etc.) will continue to be used.

a. The TPA uses the forms, methodology premiums, factors, etc., provided by the reinsurer.

b. The TPA will take pains to see that claims gaming is eliminated and neutralized. Fair dealing must be basic to the TPA-reinsurer relationship.

c. Traditional reinsurance tracking reports will continue to be used. Specific risk-related reports (50% notice and large claim reports) are not needed with reinsurance, but are needed for the specific risk.

d. Operational audits by the reinsurer of the TPA are expected.

e. The reinsurer will, of course, have the opportunity to do whatever audit it deems appropriate if there is a real or potential, reinsurance claim.

Stop-Loss Changes

There are several ways to change the present practices of stop-loss that the writer believes will enhance the value and image of self-funding.

Expand Certain Agreement Provisions

Since there is no body of statutory or case law applicable to stop-loss, the stop-loss agreement should have expanded and/or clarifying language added to make up for the absence of such law. Areas where expanded language is needed include the following:

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- Broadened definition of clerical or ministerial errors.
- Greater specificity as to how the 50% and shocker notices are to be submitted.

Role of the TPA

The TPA should not have mere ministerial duties in filing and reporting, but rather should be under a joint contractual obligation to both the stop-loss carrier and the employer. The stop-loss agreement should be explicit in requiring all the parties thereto to give the highest level of good faith and fair dealing to each other.

Disclosure Statement

The stop-loss agreement should make the disclosure statement part of such agreement and set forth in considerable detail how errors therein will affect the coverage. Both the TPA and the employer are jointly bound to give the carrier what it requests in a fair and good faith manner.

Micro-Managed Plan Document

The stop-loss carriers should encourage self-funded plans to show in great detail what will and what will not be covered; also, to make the administrative, claims and privacy practices part of the plan document by attachment or exhibits.

Due Diligence

The employer or TPA should routinely ask for and the stop-loss carrier should routinely provide these two types of information:

1. **Administration**
   Which of the many stop-loss administrative services are provided directly by the stop-loss carrier and which are outsourced.

2. **Retroceding the Risk**
   a. What percentage of the risk is retained by the carrier?
   b. The risk, which is not retained by the carrier, is assumed by the MGU or reinsurers as follows:

   MGU
   - Risk held by MGU directly under its license with the state
   - Risk held by insurer owned in whole, or in part, by the MGU.

   Reinsurer
   - Domestic reinsurer
   - Offshore
   - Lloyds
   - Other

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