MARTIN INSURANCE GROUP, LLP

CLIENT NEWS & ADVISORY

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Level Funding: The Best of Both Worlds?

Hello Everyone,

This topic is going to be especially relevant to those of you who employ between 2-99 employees, but it still has relevance and use to those with over 100 employees. The topic is level funded health plans. Where this subject might not be new to some, it could be to others, and there are some facts that every employer should be educated on when using these plan structures.

"What is level funding?"

When **the ACA came out, medical carriers were told that they could no longer underwrite based on gender, previous claims and pre-existing conditions**. This was great for those employers who had a sick and aging population, but terrible for those employers who had a semi-young and healthy population. Under ACA, all employer groups are thrown into "risk pools" (*also known as a **Community Rated system***) with other employers to share the cost of premiums and claims.

The solution the market came up for this was **"Level Funding," a rating system like previous systems that underwrites based off demographic and risks on a specific group of people**. Even though these plans are not fully ACA regulated and are considered self-insured, they meet the main ACA requirements such as providing Essential Health Benefits and filing requirements like Form 1094-B and Form 1095-B. In the early years, Texas had 1 carrier bring this idea to the market, but since then, almost every major carrier offers this underwriting system to employer groups.

"How does it work?"

A level-funded health plan is a hybrid between traditional fully insured plans and self-funded coverage. It gives employers predictable monthly costs (*the "level" part*), while offering potential refunds if claims are lower than expected.

Every dollar in premium is dispersed into three "buckets":

1. **Claims funding –** Designed to pay for everyday claims.
   i.e. office visits, prescription, labs, minor surgeries and scans.
2. **Administrative costs –** Reimburses the carrier for their network, claims system, billing system, ID cards, etc.
3. **Stop-loss insurance** – This protects both the employer and employee from large claims that exceed the claims fund.

At the end of the plan year, if your company's claims are lower than expected, you may receive a refund of unused claims dollars. This is known as a "surplus" refund.

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Not all Surplus Refunds are Created Equal -

Always make sure your broker/consultant explains the different Level Funded contracts to you. Here are some common contractual agreements to look out for:

Surplus Refund – One carrier might say you will get "100%" of your claims fund back, while another says, "you split it 50/50 with us."

Incurred But Not Reported (IBNR) – IBNR exists because of the natural lag between when an employee incurs a claim, vs when the insurance carrier gets it from the provider and process it. Extra funds are set aside in case the claim shows up weeks, months or even years later. Some carriers will have the IBNR calculated based off known claims at the end of the contract – while others have a flat percentage. How a carrier calculates IBNR can change any surplus amount.

Reimbursement Timelines/Caveats – Again, different from carrier to carrier. Some carriers will say "we will send you the surplus refund on month 15 (*3 months after the 12-month policy contract ends*)." While others might say 6 months or even a year later. Also, some carriers say that you FORFEIT your refund altogether if you do not renew your contract with that carrier.

Friendly Precautions and Reminders

- **Claim "Run Out" Clauses:** Run out is the window of time for a provider to submit a claim, that occurred during an active policy year, to an insurer, after said insured group has ended their policy with that insurer. For example, most fully insured plans allow a run out claim submission between 90-180 days after the employer decided to not renew/cancel the health plan with that carrier.
  - With level funded contracts, you need to specifically ask what this timeline is. Some might be up to 12 months later (*AKA a 12/24 contract*), while others do NOT honor any claims submitted after the contract ends (*AKA a 12/12 contract*).
- **No State Continuation:** For those **employers with less than 20 employees**- many Level Funded plans are NOT recognized by State Continuation in TX. Meaning, unless you voluntarily subject your company to Federal COBRA rules and regulations, your employees will not be able to continue their group health plan after they are terminated or fall under full time hours. *(COBRA still applies to companies with 20 or more employees.)*
- **Still subject to Federal Compliance:** PCORI fees, Medicare Part D notices, 1095s, and more. Having a Level Funded plan does not excuse you from these compliant pieces. In fact, it may even require more of your interaction and less of the insurance carrier's.

Who is Level Funding right for?

While Level Funding is not a one size fits all solution, it can yield savings over fully insured contracts and has the potential to save a lot more to those companies, with less than 50 employees, that are currently on a community rated plan "IF"-

- **Generally, experience moderate to low claims.**
- **Company employee population of 5-150.**
- **A HR/CFO/Owner who doesn't mind a little extra engagement to obtain less premiums.**
- **Employers interested in having more control and info on how their policies are running.**
- **Employers that have an educated broker who will spend the time negotiating your premiums and contracts with your insurer every year.**

If you would like to find it if Level Funding would be a good fit for your company's Employee Benefits Program, please contact Taylor Martin – Email: TaylorMartin@miglp.com | Phone: (210) 236-9821

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