# Benefits

# 101

MAY 2025

LOCKTON®

# Lockton introductions

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# Agenda

Medical Plans Review

Funding Structures

Strategic Planning

Questions

# Medical Plan Review

# Medical Coverage

## Most common networks/plans

| | Health Maintenance Organization (HMO) | Exclusive Provider Organization (EPO) | High Deductible Health Plan (HDHP) | Preferred Provider Organization (PPO) |
|---|---|---|---|---|
| Network Size | Limited | Broad | Broad | Broad |
| Provider Access: IN network | Yes | Yes | Yes | Yes |
| Provider Access: OUT of network | Emergency only | Emergency only | Yes | Yes |
| Required: Primary Care Physician (PCP) | Yes | No | No | No |
| Required: Referrals | Yes | No | No | No |
| Funding Type | Typically insured, but self-funding is available | Insured or self-funded | Insured or self-funded | Insured or self-funded |
| Saving Account | FSA/HSA (HDHP) | FSA/HSA (HDHP) | LFSA/HSA | FSA/HSA (HDHP) |
| Benefit Considerations | Frequently, richer benefits than other plans<br><br>Copay- and deductible-driven plans | Similar benefits to PPO but limited to IN network providers<br><br>Copays, deductibles, and coinsurance | Requires higher deductibles: $1,650/$3,300 in 2025<br><br>NO copays; deductible must be met before the plan pays – this applies to prescription costs | Wide variety of options in both design and richness<br><br>Copays, deductibles, and coinsurance |

# Types of Medical Spending Accounts

| | Eligibility | Contribution Limits (2024) | Contribution Source | Rollover | Portability | Tax Benefits | Investment Options | Qualified Expenses | Account Ownership |
|---|---|---|---|---|---|---|---|---|---|
| **Health Savings Account (HSA)** | Must be enrolled in a High-Deductible Health Plan (HDHP) | $3,850 individual / $7,750 family | Employee and/or employer | Funds roll over year to year | Portable, stays with you even if you change jobs | Triple tax advantage: pre-tax contributions, tax-free growth & withdrawals | Can be invested in stocks, bonds, mutual funds | Medical, dental, vision, prescription drugs, and more | Owned by the individual |
| **Flexible Spending Account (FSA)-Health Care** | Available to employees with employer-sponsored plans | $3,050 per year | Employee (pre-tax) | Use it or lose it | Non-portable, tied to employer | Pre-tax contributions, tax-free withdrawals for qualified expenses | No investment options | Medical, dental, vision, prescription drugs, and more | Owned by the employer |
| **Health Reimbursement Arrangement (HRA)** | Employer-sponsored, no specific health plan required | Determined by employer | Employer only | Funds roll over year to year | Non-portable, tied to employer | Employer contributions are tax-deductible | No investment options | Medical, dental, vision, prescription drugs, and more | Owned by the employer |

# Funding Options

# Common Financing Methods

| Fully Insured | |
|---|---|
| Premium | • Fixed monthly premium paid by client to carrier |
| Administration | • Under a traditional fully-insured plan, the carrier will handle all eligibility and claims administration for a specified premium payment.<br>• Administratively, a fully insured plan may be an easier option for those clients that do not have an extensive human resources or payroll department or smaller clients who do not have a claims history available that can accurately predict future claims costs. |
| Claim Payment | • Carrier pays claims whether over or under premiums |
| Advantage | • Ease of admin for the client; low risk, claims admin dictated by contract |
| Disadvantage | • May be paying higher costs, no refund if plan performs lower than expected; restricted plan design<br>• Minimal data access |

| Level-Funded | |
|---|---|
| Premium | • Fixed monthly premium paid by client to carrier |
| Administration | • Similar to Fully Insured |
| Claim Payment | • Carrier pays claims whether over or under premiums |
| Advantage | • Cost components are broken (Admin, Claims, Stop Loss)<br>• Ability to receive surplus refund if claims perform under expected |
| Disadvantage | • Funding rates above expected claims costs<br>• Restricted plan programs (Rx, disease management, etc.) |

| Self-Funded | |
|---|---|
| Premium | • Client may purchase stop loss through the claim's administrator (if also an insurance carrier) or through a third-party specialty carrier.<br>• Client pays claims with additional funds as they are incurred |
| Administration | • Under a self-funded plan, the carrier or a third-party administrator will process claims for an administration fee and will pay those claims with additional funds deposited by the client.<br>• There may be additional fees for additional services or programs (disease management, clinical review, etc.) |
| Claim Payment | • Employer pays claims as they occur<br>• Your claims will be different each month and it's important to understand the ebbs and flows associated with them. |
| Advantage | • Lower cost; pay as you go-better cash management; more flexible claims admin, no state taxes paid on premium (not really insurance)<br>• Extensive data access |
| Disadvantage | • Requires internal admin, report enrollment to carrier; increased financial risk; may pay claims outside of contract and therefore not planned |

**Think:** Bundled Model

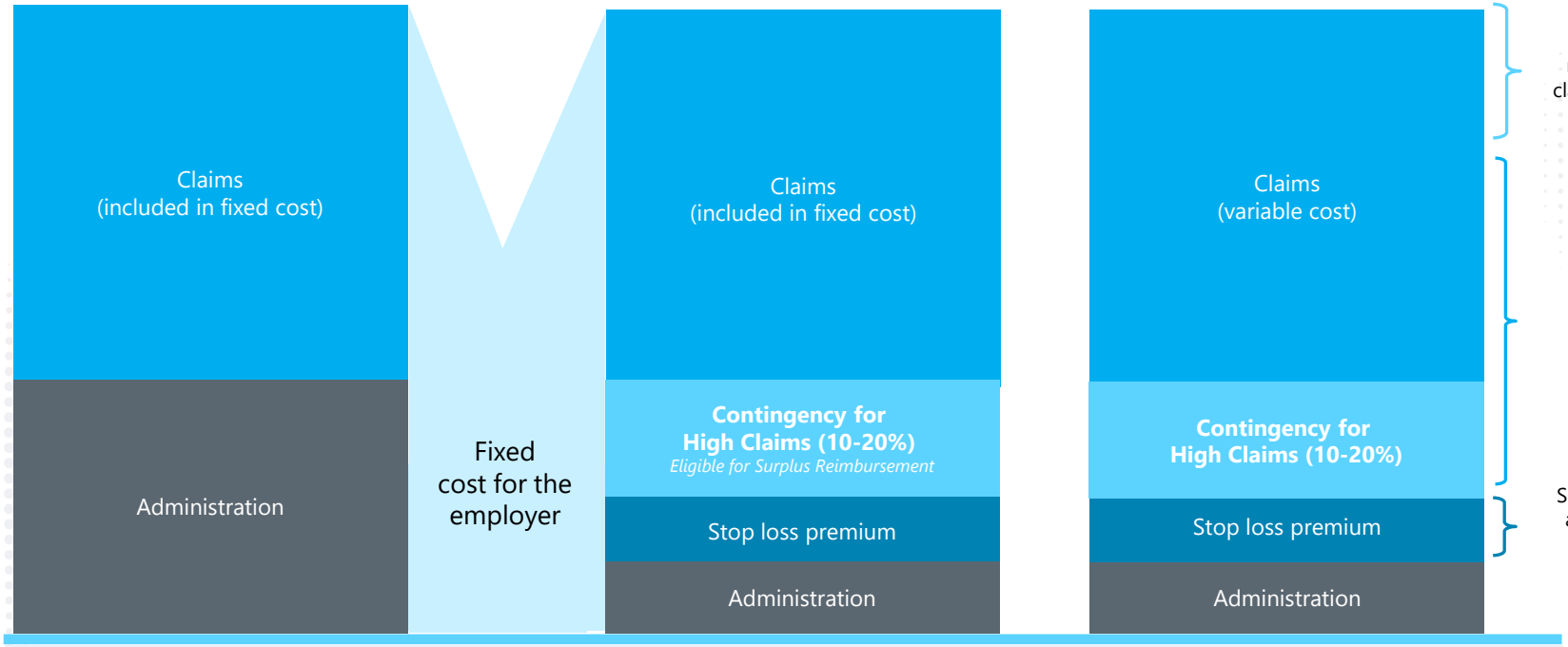
**Think:** Unbundled Model

# Funding Strategies

**Carrier assumes liability, fixed for the employer:**
Pay premiums to the carrier; they set the rates and take the risk

**Carrier assumes liability fixed for the employer:**
Ability to break out admin and stoploss, Rx rebates, more transparency. Minimal control over claims.

**Employer assumes liability, plan for variability:**
Pay claims from bank account; stop loss premium and admin paid to vendors



# Components of Premium: Fully Insured vs. Self-Funded

| Component | Description | % of premium fully insured | % of premium level-funded | % of premium self-funded |
|---|---|---|---|---|
| Claims | • Costs from a healthcare provider or facility for services provided (represents the largest component of premium). | 60%-65% | 65%-70% | 70%-75% |
| Reserves | • Funds set aside to cover liability for claims incurred but not yet reported (IBNR).<br>• Estimate of 1.5 months of expected paid claims.<br>• Fully insured will charge for reserve administration and risk. | 12% | 10%-12% | 10%-12% |
| Pooling charge/ stop loss | • A provision that limits the dollar amount a plan will have to pay for any individual claimant to a predetermined level during the policy year.<br>• May include aggregate stop loss insurance that provides financial protection when the total of all claims under the specific deductible is higher than expected. | 10%-12% | 8-10% | 10%-12% |
| Administration | • Includes claims and eligibility administration, network, risk charges, profits, broker compensation. | 8%-10% | 6%-8% | 6%-8% |
| Taxes | • State and ACA taxes. | 3%-5% | 1-1.5% | 1%-1.5% |
| Margin | • Fund established to protect a plan against unexpected claims fluctuations. | 5%-9% | 2-5% | 2%-5% |

# Individual & aggregate stop loss

**Self-funded groups can purchase two types of stop loss coverage:**

1. **Individual stop loss (ISL)** is excess risk coverage (specific) that covers expenses of an individual who exceeds an established yearly deductible for the policy year.
   - Claims for individual excess risk are reimbursed on an ongoing basis throughout the plan year.
   - Protects the plan.
   - Potential of "Lasers" or a carrier may place a higher deductible on certain high risk individuals or even exclude them from coverage.
2. **Aggregate stop loss (ASL)** is excess risk coverage that covers expenses for an entire group that exceeds an established attachment point for the policy year.
   - Claims for aggregate excess risk are reimbursed at year-end after a full 12 months of claims have been paid and audited.
   - Protects the plan.

# Strategic Planning

# Strategic planning timeline

## 01 ALIGN & ANALYZE

- Alignment of priorities
- Prior year financial performance and stewardship
- Discuss market and innovation trends
- Client utilization metrics
- Programming — current offering
- Discuss strategic needs

## 02 ANALYZE & OPTIMIZE

- Financial update
- Data-driven analysis
- Benchmarking and survey data
- Vendor partner analysis
- Narrowing of strategy: insights into action

## 03 OPTIMIZE & EXECUTE

- Financial forecasting for next year
- "Plug and play" budget modeling
- Marketing results
- Executive presentation assistance
- Carrier implementations (as necessary)

## 04 EXECUTE & ENGAGE

- Final decisions
- Plan for/launch open enrollment
- Communication support
- Carrier implementations (as necessary)
- Notify carriers of plan changes

**NEW PLAN YEAR**

# Questions to Ask During a Renewal

- **How did our previous year's costs, usage, and scope of coverage perform?**
  - Reviewing past performance helps identify areas for improvement
- **What feedback have we received from employees regarding their benefit needs and interests?**
  - Conducting surveys or focus groups can provide valuable insights to design competitive benefits packages
- **What are the current market trends and how do our plans compare?**
  - Evaluating other plans and carriers ensures your offerings remain competitive
- **What is the rationale behind any proposed rate increases beyond demographic changes?**
  - This helps determine if rate hikes are based on real risk changes or other factors
- **How does the paid loss ratio for health and dental compare to the insurer's target loss ratio?**
  - This provides insight into whether your plan's claim usage is fair compared to insurer targets
- **How much have you negotiated from the insurance company's original proposed renewal rate adjustments?**
  - This reveals the effectiveness of your consultant's negotiation strategy

# Considerations when evaluating a partner

## Strategic Planning

- How will they engage with your leadership team, including the CMO?
- What kind of benchmarking do they provide?
- How can they help your team better understand what really matters to employees? What if this doesn't align with leadership views?
- *Avoid partners that already have a plan or a playbook – paint in color, but not by numbers.*

## Cost Management

- What is their market leverage and how do they wield it?
- What is their approach to negotiating contracts and ensuring best-in-class terms throughout the duration of your time with a given vendor?
- What specific steps are they taking to help manage your large claims risk? How will they keep you ahead of the pharmacy wave?
- *Less than 1% of your people are driving roughly 35% of your costs – the opportunity for savings is not on the edges, it's in the trenches.*

## Compliance

- What tools, resources, and training do they make available to keep you up to date and compliant with legislation, and regulations? Do they have in-house ERISA counsel?
- How do they evaluate new, or emerging, compliance concerns such as proposed legislation and relevant court cases?
- *Legislative arrows are being released daily – make sure you have a shield.*

## Employee Communications

- What is their approach to communicating change? How does this affect open enrollment communications?
- What tools do they have to reach employees that aren't in front of computer all day?
- What digital solutions do they deploy, or have access to? Are those included in their services or a separate cost?
- *You're communicating to teenagers and grandparents, accountants and landscapers, police and engineers – expect, and embrace, new approaches.*

# Questions?

# Appendix

# Key Terms

**Aggregate Deductible**

Each covered individual is not required to meet the individual deductible. Meaning the Employee + 1 and Employee + Family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan.

**Balance Billing**

When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

**Benefit Percentage & Maximum**

The benefit amount is limited by a percentage of payroll, or Benefit Percentage, and the length of time the benefit will be paid.

- Short-Term: Based on weekly benefit, max to correspond with LTD if applicable
- Long-Term: % and age max established to prevent disability from being more profitable than work

**Coinsurance**

Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

**Consumer-Driven Health Plan (CDHP)**

A plan option that provides choice, flexibility, and control over healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

**Copay**

The fixed amount you pay for healthcare services received, as determined by your insurance plan.

**Disability**

Any occupation: Unable to perform the material duties of any occupation he/she is qualified for based on experience, education, skills, and training.

Specialty: Unable to perform the material duties of the area of specialization within the occupation.

**Deductible**

The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

# Key Terms

### Earnings Test Definition of Disability

Insured must suffer a "substantial loss of income" (contract will specify the percentage of income that must be lost to qualify.) This is important with occupations that rely on commission or billable hours.

### Elimination Period

Begins the day the insured "goes out" or is unable to work

- Short-Term: Accident, Sickness, Maternity;
  0 – 15 days
- Long-Term: 90 – 180 days

### Explanation of Benefits (EOB)

A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

### Embedded Deductible

The individual deductible amount must be satisfied by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be satisfied for the remainder of that calendar year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. (No member may contribute more than the individual out-of-pocket maximum amount to the "per family" out-of-pocket maximum amount."

### Flexible Spending Accounts (FSAs)

A special taxfree account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

### Healthcare Cost Transparency

Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

### Health Reimbursement Account (HRA)

A personal healthcare account funded by your employer that you can use to pay for qualified medical expenses.

# Key Terms

**Health Savings Account (HSA)**

A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a CDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

**Minimum Essential Coverage Plan**

Covers 100% of the cost of certain preventive services, when delivered by a network provider. Helps cover the costs of certain medical expenses incurred due to an accident or sickness at a specified benefit amount for a limited number of days per year.

**Network**

A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

**Open Enrollment**

The period set by the employer during which employees and dependents may enroll for coverage.

**Out-of-Pocket Maximum**

The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

**Reasonable and Customary Allowance (R&C)**

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

**Summary of Benefits and Coverage (SBC)**

Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

**Summary Plan Description (SPD)**

The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

**Preexisting Condition Limitation**

Coverage may be limited for any sickness or injury for which the insured has sought treatment prior to the plan effective date.

**Offsets**

The benefit the insured is to receive from the carrier may be reduced by funds the insured is receiving from other eligible sources.

*Independence changes everything.*

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