SELF-FUNDING:
BASIC CONCEPTS
THROUGH
ADVANCED STRATEGIES

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April 7, 2016
Kearney, Nebraska

Ground rules

- Questions
- Industry acronyms
- Evaluations

Agenda ~The fundamentals

Section	Section name
1	The who, what and why of self-funding
2	Self-funded models (TPA/ASO)
3	Specific stop loss
4	Stop Loss Lasers
5	Aggregate stop loss
6	Stop loss contract types
7	Underwriting and market review

Agenda ~ Plug and play services

Section	Section name
8	Provider networks
9	Pharmacy benefit manager
10	Data integration and warehousing
11	Domestic and international medical travel
12	Lifestyle/wellness strategy
13	Telephonic/Facetime medicine
14	Disease and care management
15	TPA/ASO Audit

Agenda ~ Emerging trends

Section	Section name
16	ACA Impact to self-funding
17	Small group self-funding and level funded
18	Transplant, specialty Rx and dialysis carve out
19	Final Exam
20	Summary and Q&A

Dispel the myths

- ❑Self-funding is only for groups that are over 500 lives.
- ❑Self-funding is 10x the amount of work as a fully-insured plan.
- ❑There are no administrative costs if a group is fully-insured.
- ❑Self-funded plans avoid all of the PPACA health care reform.

What is self-funding?

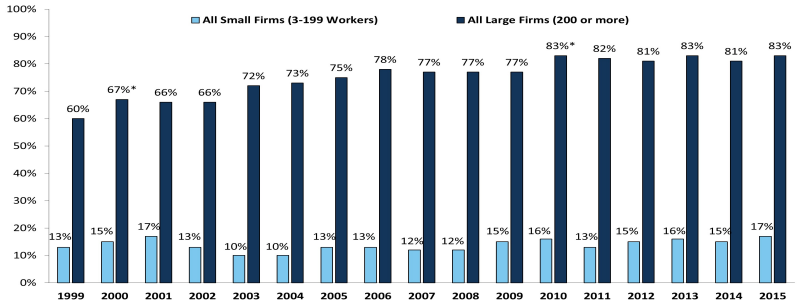
- Employer sets up fund to pay claims (usually through the services of a TPA or ASO vendor)
- Employer designs its own benefits plan
- Stop-loss protection for abnormal risks
- Partial/true self-funding

Growth of self-funding

- Started with Taft Hartley Act of 1947 for union groups
- In 1967, there were 2,500 self-funded plans
- Employee Retirement Income Security Act: 1974
  - Placed regulation with federal government
  - Self-funded plans under ERISA escape state regulations, including insurance regulation

Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999-2014

Exhibit 10.2
Percentage of Covered Workers in Partially or Completely Self-Funded Plans, by Firm Size, 1999-2015



* Estimate is statistically different from estimate for the previous year shown (p<.05).

NOTE: Sixty-three percent of covered workers are in a partially or completely self-funded plan in 2015. Due to a change in the survey questionnaire, funding status was not asked of firms with conventional plans in 2006. Therefore, conventional plan funding status is not included in the averages in this exhibit for 2006. For definitions of Self-Funded and Fully Insured plans, see the introduction to Section 10.

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2015.

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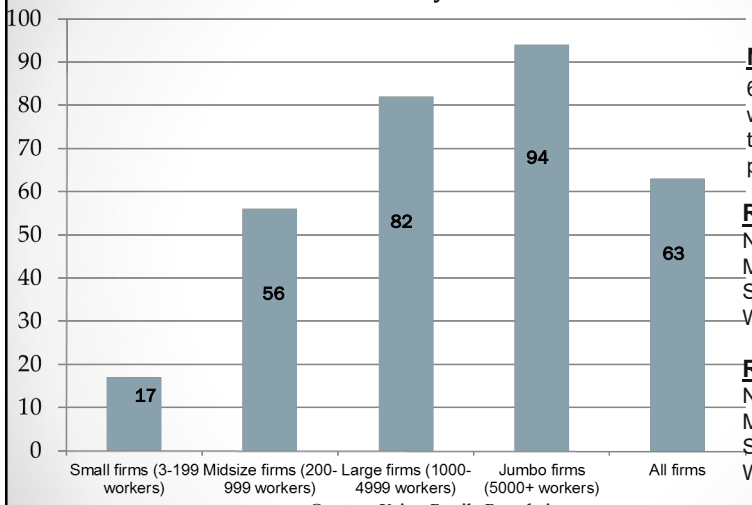
Self-funding trend: 2015

Percentage of Covered Workers In Self-funded Plans by Firm Size



Courtesy Kaiser Family Foundation

Nationally

63% of covered workers were in a plan that was completely or partially self-funded.

Regionally 2014

Northeast	61%
Midwest	65%
South	64%
West	47%

Regionally 2015

Northeast	70%
Midwest	64%
South	68%
West	48%

The Fundamentals

The advantage

- Cash flow benefit
- Lower operation cost
- Reduced carrier profit margin
- Risk charges
- Plan control and flexibility
- Stability
- Managed care services
- Network configuration

The advantage

- ROI on reserves
- Effective claim management
- Elimination of most state premium tax
- Plug and play services
- State mandated benefits avoided

State mandated benefits

Most mandated benefits		Least mandated benefits	
Rhode Island	70	Idaho	13
Virginia	70	Alabama	19
Maryland	67	Michigan	23
Minnesota	65	Hawaii	24
Connecticut	63	Utah	26

Most popular mandates		Least popular mandates	
Mammography Screening	50	Breast Implant Removal	1
Maternity Minimum Stay	50	Cardiovascular Disease Screening	1
Breast Reconstruction	49	Circumcision	1
Mental Health Parity	48	Gastric Electrical Stimulation	1
Alcohol & Substance Abuse	46	Organ Transplant Donor Coverage	1

Courtesy of Council of Affordable Health Insurance

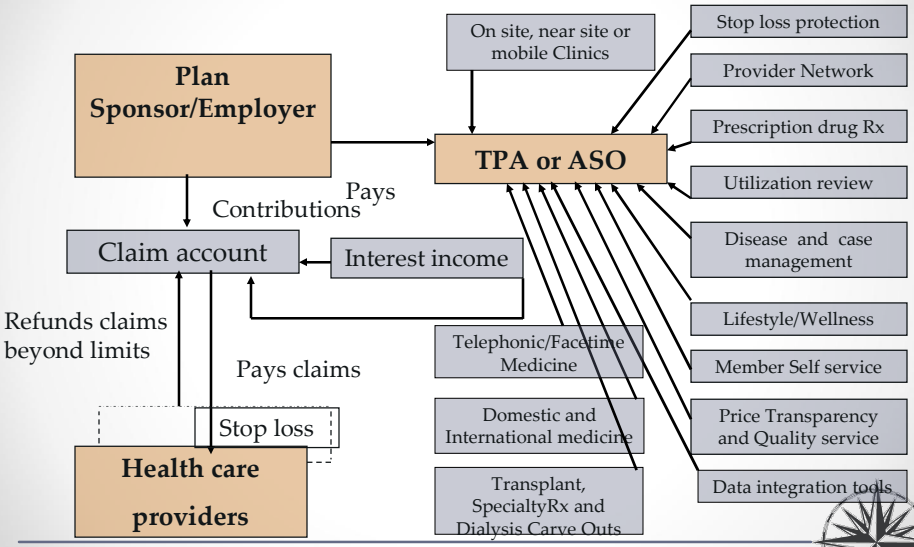
The disadvantages

- Claims experience
- Budgeting for claim costs
- Plan termination
- Fiduciary and legal responsibility
- Employer involvement
- Lasering of large claims
- Timeline to lock final rates

Types of self-funded models

- Proprietary model
  - Administrative Services Only (ASO)
- Unbundled model
  - Third Party Administrator (TPA)

Typical self-funded model



What is stop loss?

Specific coverage

- Insures the employer against a catastrophic loss incurred by **one individual** over a certain dollar limit.
- **Example:** transplants, leukemia, premature birth

Aggregate coverage

- Insures the employer against unusually high overall claim levels for the **entire covered group**, due to high frequency or an unexpected number of large, catastrophic claims
- Aggregate generally consists of ordinary claims – well care, colds, flu, prescription drugs, vision, etc. Only claims below the specific deductible on covered individuals are eligible.

Employer protection

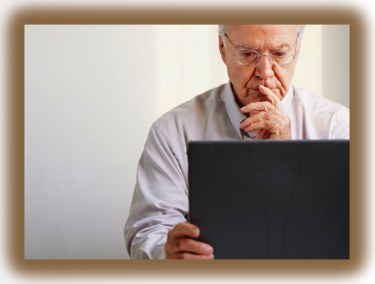
Specific	Aggregate
Medical	Medical
Prescription drugs	Prescription drugs
	Dental*
	Vision*
	Short-term disability*

* optional

Specific stop loss topics

Sub-section	Specific stop loss topics
1	Role
2	Guidelines
3	Variations

Specific stop loss role



- Represents the employer's risk assumption
- Generally represents the individual plan participant's cost to the plan
- Defines the liability level of the stop loss arrangement
- Set at a level to provide appropriate protection for the employer, while allowing the employer to participate in the risk of the plan
- Must be set at a level to provide adequate protection for the aggregate attachment point

Specific stop loss role

Coverage on the individual claim

- All eligible claims in excess of the individual stop loss level are reimbursed by the carrier
- All eligible claims below the individual stop loss level are the responsibility of the employer

Lifetime maximum: Unlimited on plan date after 9/23/10

Carrier liability

Employer liability

$20,000 to $2,000,000

Specific stop loss level

Specific stop loss guidelines

Number of covered employees	Minimum per person	Maximum per person
25-100	$20,000	$50,000
101-150	$30,000	$75,000
151-250	$50,000	$125,000
251-500	$100,000	$200,000
501-1000	$150,000	$250,000
1000+	$200,000	$2,000,000

Specific stop loss variations

Traditional

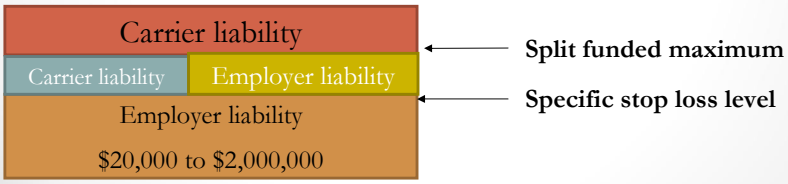
Split-funded

Aggregating specific

Split funded specific stop loss

- All eligible claims in excess of the split funded maximum are reimbursed by the carrier
- All eligible claims over the specific stop loss level are shared 50/50, 60/40 or 75/25 between employer and carrier
- All eligible claims below the individual stop loss level are the responsibility of the employer

Lifetime maximum: Unlimited on plan date after 9/23/10



Aggregating specific

Assumptions

- $75,000 specific deductible
- $60,000 aggregating specific deductible

Aggregating specific deductible

MEETING WITH SEVERAL CLAIMS

Three claims, each with totals over the specific deductible

- Subtract the specific deductible from each bill, apply the remainder to the aggregating deductible until it is satisfied (up to $60,000 in this example)

Medical claimant	Claim amount	Specific stop level	Applies to aggregating specific
Bob	$80,000	$75,000	$5,000
Sue	$100,000	$75,000	$25,000
Tom	$120,000	$75,000	$45,000
Total			**$75,000**

Result: Since the aggregating specific deductible is only $60,000, carrier pays $15,000 of Tom's bill. Since the aggregating specific deductible is met, carrier payments begin on all new claims as soon as the specific deductible ($75,000) is satisfied.

Stop loss lasers

- Carve out specific risks within the stop loss contract
- Increase employers liability on specific risks
- Reduce carriers liability on specific risks
- Common to place lasers on new business
- Routinely used on renewal

Deductible laser

Ongoing condition estimate	$120,000
Specific deductible	$50,000
Added carrier exposure	$70,000
Laser amount	$70,000*
New specific deductible	$120,000

*Does not go toward aggregate

Is a $10,000,000 claim possible?

ACA Provision on Lifetime maximums

- Allowable renewal on
- Lifetime max or after
- $750,000 9/23/2010
- $1,250,000 9/23/2011
- $2,000,000 9/23/2012
- Unlimited 9/23/2013

- Self-funded employer plan
- Dependent child
- Hospitalized 6 months per year
- After 9/23/13 stop loss carrier lasered at $4,000,000
- Aged out at 26 a year later
- Enrolled in Federally Facilitated Exchange

With or without laser features?

- Laser less stop loss contracts
  - 5% to 7% load
  - With first renewal rate cap
- Laser less stop loss contracts (new)
  - 2 to 3 year rate cap
  - Perpetual offer

Other laser styles

Medical conditions

Contract type laser

Aggregate stop loss topics

Section	Name
1	Role
2	Guidelines
3	Aggregate Projection

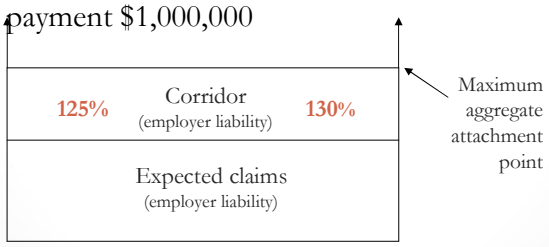
Aggregate stop loss role

- Protects the employer from significant variation in the claims experience
- Aggregate coverage protects against utilization risk
- Specific coverage protects against catastrophic risk
- Specific claims not included

Aggregate stop loss

Cap on claims liability for whole group

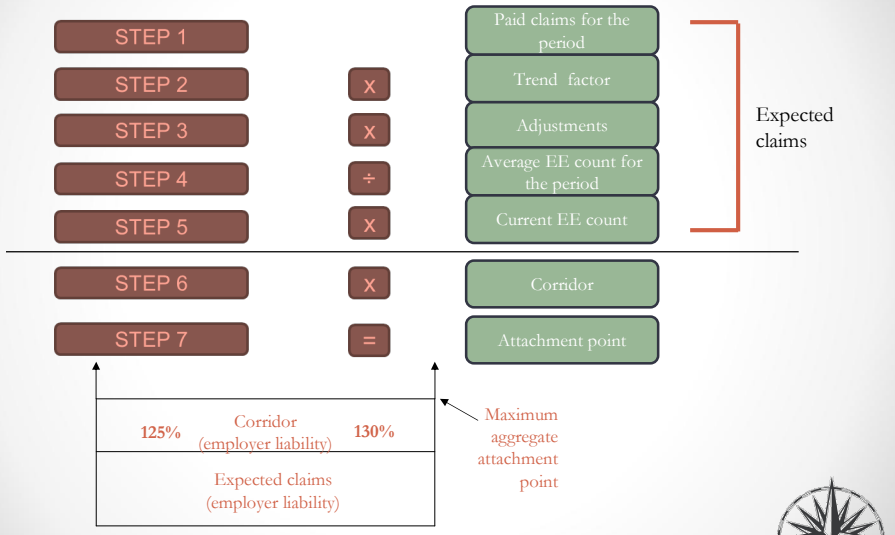
- Expected claim cost is established
- Aggregate is a percentage of expected claim cost
- Eligible claims exceeding aggregate stop loss level are reimbursed by carrier
- Maximum payment $1,000,000



What is Corridor?

The difference between expected claims and the aggregate deductible; this is the risk the employer is accepting in its self-funded plan.

Aggregate stop loss: expected claim calculation



Cost defined

- Fixed costs
  - Specific premium
  - Aggregate premium
  - ASO/TPA fee
- Variable costs
  - Expected claims
- Total costs
  - Fixed
  - Variable
- Maximum costs
  - Fixed
  - Attachment point

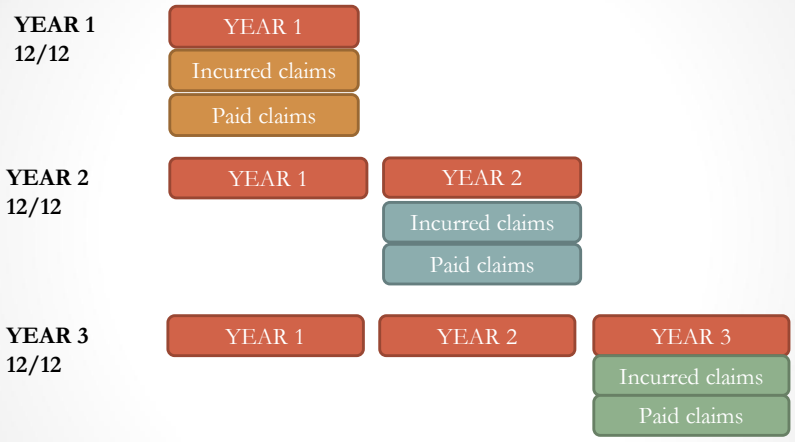
Specific and aggregate: Stop loss contract variations

- Traditional
- Level funded
- Paid
- True paid
- Gapless
- Mezzanine
- Family stop loss

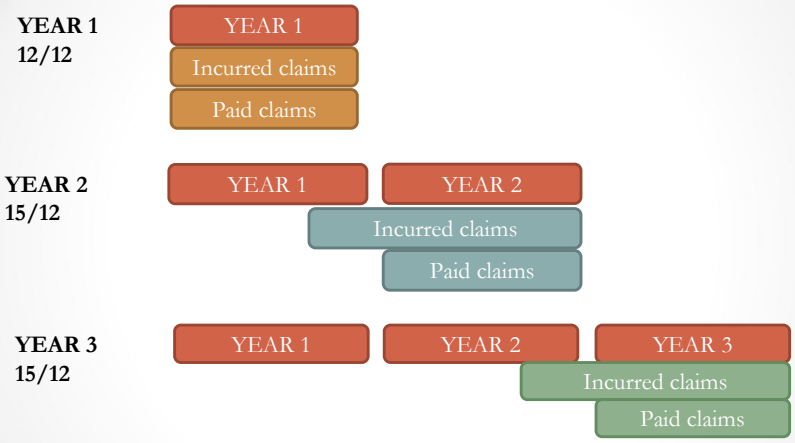
Specific/Aggregate stop loss contract basis

Contract terms	Description
12/12	Incurred in 12; paid in 12
12/15	Incurred in 12; paid in 15
15/12	Incurred in 15; paid in 12
24/15	Incurred in 24; paid in 15
12/21	Incurred in 12; paid in 21
15/18	Incurred in 15; paid in 18
12/24	Incurred in 12; paid in 24

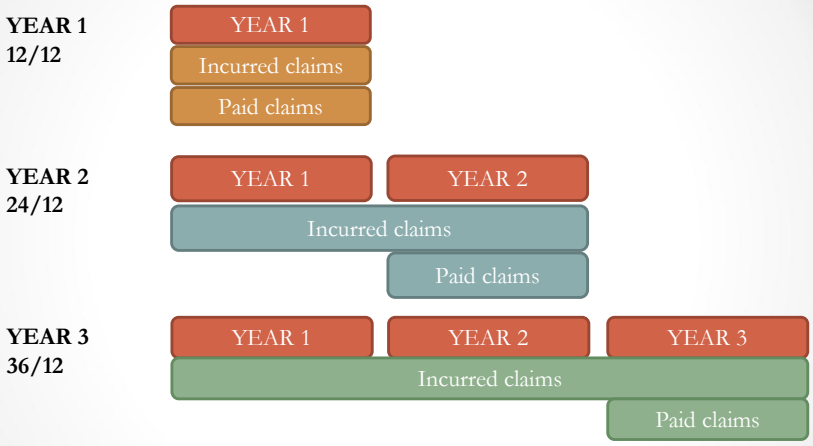
STOP LOSS contract illustration: RARE



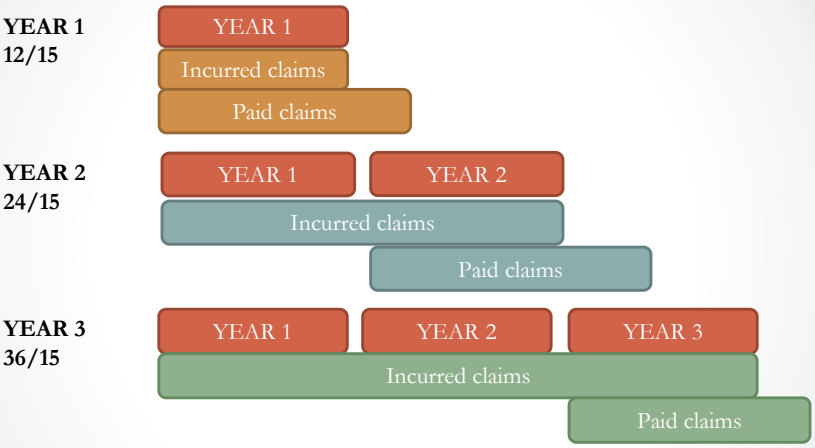
STOP LOSS Contract Illustration: COMMON



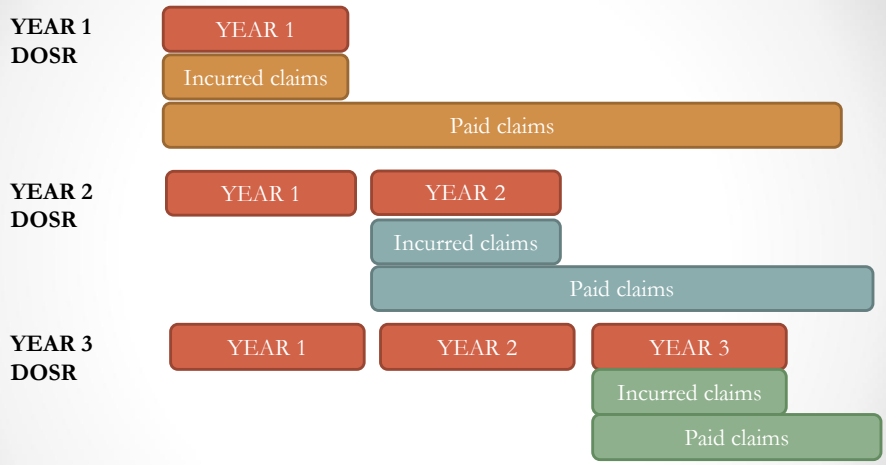
STOP LOSS Contract Illustration: BETTER



STOP LOSS Contract illustration: BEST



STOP LOSS Contract illustration: EVEN BETTER



DOSR = Date of service rendered or incurred

Medicare prime vs. secondary

If the individual is…	And this condition exists…	Then this program pays first…	And this program pays second…
Is age 65 or older and covered by a GHP through current employment of spouse's current employment	The employer has less than 20 employees	Medicare	GHP

Medicare prime vs. secondary

If the individual…	And this condition exists…	Then this program pays first…	And this program pays second…
Is age 65 or older, and covered by a GHP through current employment or spouse's current employment	The employer has 20 or more employees, or at least one employer is a multi-employer group that employees 20 or more individuals …	GHP	Medicare

Medicare prime vs. secondary

If the Individual…	And this condition exists…	Then this program pays first…	And this program pays second…
Has an employer retirement plan and his age 65 or older…	The individual is entitled to Medicare	Medicare	Retiree Coverage

Specific stop loss terminal liability option

- Provides 3 months of run-out coverage
- Offered with contract types:
  - 15/12
  - 24/12
  - 18/12
  - 36/12
- Covers all claims incurred during a policy period and paid during a 3 month run-out period
- Must be elected on the original effective date or beginning of contract period
- Plan sponsor must be returning to a fully-insured

Aggregate stop loss terminal liability option

- Provides 3 months of paid claims run-out protection for those claims incurred during the current policy period before termination
- Must be purchased up front
- Triggered automatically upon non-renewal
- Does not apply to mid-term cancellations

Underwriting requirements

- ❑Plan design
- ❑Plan change history
- ❑Exclusions/limitations
- ❑Actively at work
- ❑Retirees
- ❑Dependents
- ❑Disabled
- ❑Union employees
- ❑COBRA participants
- ❑Age/sex factors
- ❑Zip code

Underwriting requirements

- ❑Paid claims (aggregate only)
  - Two years paid claims by month
  - Two years employee counts by month
- ❑Large claims history (two years)
  - Diagnosis
  - Prognosis
- ❑Ongoing conditions
- ❑Manual rates

Stop loss underwriting

- Longer term relationships preferred
- No more than two carriers in five years
- May decline groups based on carrier history
- May load rates based on carrier history

Stop loss market review

- ASO/TPA preferred relationships
  - TPA size does matter
- Stop carrier direct
- Managing General Underwriters (MGU)
  - Preferred
  - Underwriting authority
  - Risk/Treaty share

It's renewal time

- ❑ Contract terms
- ❑ Renewal terms and conditions
- ❑ New TPA/ASO or carrier reporting
- ❑ Run-in limits
  - Specific
  - Aggregate
- ❑ Laser less renewals
- ❑ The fine print

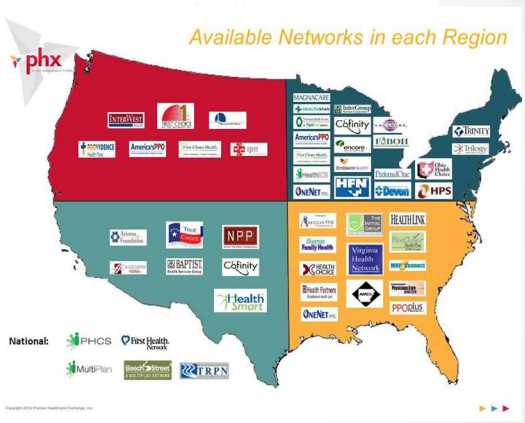
Agent, broker or consultant compensation

- ❑ Consulting arrangement
  - o All products are net
- ❑ Claims administration
  - o PEPM $1 to $?
- ❑ Stop loss premiums
  - o 10-15%

Plug and Play Services

Provider networks

- ❑ Geo access reports
  - Provider access
  - Network savings
  - Disruption
  - Performance guarantee
- ❑ Primary networks
  - Proprietary
    - Broad network
    - High Performance
  - Rental
- ❑ Secondary networks
  - Travel or backdoor



Pharmacy benefit manager Rx

- ❑Two PBM models
  - Traditional
  - Pass through
- ❑Manages the drug aspects of the plan
- ❑Access to capitated rates/discounts on drugs
- ❑Often has cost management services available
  - Generic drivers
  - Safety checks
  - Mail order
  - Specialty pharmacy

Functions & Services of PBMs

- ❑Inclusive to more restricted networks
  - Narrow to exclude high cost pharmacies
- ❑Between 60,000+ pharmacies to less than 30,000 participating locations
- ❑Linked together for real-time eligibility
- ❑Discounts on brand and generic medications
- ❑Reduced dispensing fees
- ❑Concurrent drug utilization review
  - contraindications
  - drug interactions
  - age/sex edits
  - eligibility edits
  - benefit design management

Pricing models in the marketplace

Price Element	Traditional Model Contract	Transparent Model Contract
Retail Brand Discounts	Flat AWP discount applied to every claim Not necessarily what the pharmacy is paid PBM retains spread (if any) or absorbs loss	Pass –through of actual contracted rates No spread retained by PBM May vary by pharmacy Can have guaranteed discounts
Retail Generic Discounts	Guarantees for Non-MAC and MAC Not necessarily what the pharmacy is paid PBM retains spread (if any) or absorbs loss	Pass-through of actual contracted rates No spread retained by PBM May vary by pharmacy Can have guaranteed discounts
Dispensing Fees	Guaranteed amounts for every claim Not necessarily what the pharmacy is paid	Pass-through of actual contracted rates May vary by pharmacy
Mail Order Discounts & Dispensing Fees	Flat rates negotiated between PBM and plan sponsor	Same as Traditional pricing but market is ripe for acquisition charge plus pricing
Rebates	Flat guarantee per claim, or a percent of actual rebates Excess retained by PBM	Pass-through of actual realized rebates No retention by PBM
Other Pharma revenue (e.g., data fees)	Retained by PBM	PBM may retain depending on contract
Administrative Fees	Typically very low or zero Usually a per-claim fee	Typically much higher than traditional Contracted on a PMPM, PEPM or per claim basis

Data integration tools and warehousing

Types of DIT tools

- Internet portals
- Management dashboards
- Standard parameter driven reports
- OLAP cubes
- Ad hoc query
- Training and reference documentation
- Vendor management

Data integration and warehousing

Data enhancement

- ❑ Data groupers
  HCG, DRG, Episodes of Care
- ❑ Population groupers
  Person ID, risk scores, disease classification
- ❑ Benchmarking
- ❑ Reference table roll-up
  MCD, therapeutic class
- ❑ Evidence-based quality measures

❑Data sources

- Claims, pharmacy, enrollment, member, provider
- Financial adjustments, encounters, lab results, HRA
- FTE, call detail, patient registries, state lab and immunizations

❑Data elements

- Claims, CPT, DRG, ICD9, NDC, POS, TOB
- Provider; NPA, taxonomy, specialty network
- Business groupings: group ID, line of business, product types

Domestic medical travel

- ❑National access to providers and surgeons
- ❑Fixed case rate pricing
- ❑Care coordination
- ❑Plan enhancement to offset “out-of-pocket" costs
- ❑Member and family travel costs
- ❑Simple plan integration

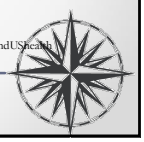
International medical travel

- Surgical procedures
  - Orthopedics
  - Spine surgeries
  - Cardiology
  - Weight loss
  - Transplants

- Estimated cost savings
  - 50% package medical savings
  - 90% pharmacy savings

Type of Procedure	US Retail Price Range ($000)	Average Overall Package Price India	Costa Rica
•Laparoscopic Gastric Bypass	$35 – 45	$17,800	$20,700
•Laparoscopic Sleeve Gastrectomy	$30 – 40	$15,500	$18,700
•Hip Replacement – Unilateral	$40 – 55	$17,000	$22,300
•Hip Replacement – Bilateral	$80 – 100	$25,000	$35,500
•Knee Replacement – Unilateral	$35 – 50	$16,000	$20,600
•Knee Replacement – Bilateral	$70 – 95	$23,000	$33,400
•Knee Arthroscopy+	$9 – 16	$8,900	$9,300
•ACL Repair	$25 – 35	$11,500	$11,800
•Shoulder Replacement	$35 – 45	$17,500	$19,400
•Shoulder Arthroscopy+	$10 – 18	$9,000	10,400
•Rotator Cuff Repair	$19 – 28	$15,000	$14,400
•Hysterectomy	$16 – 27	$14,700	$16,500
•Hernia Repair+	$10 – 20	$10,200	$12,400
•Spinal Fusion (1-level)	$90 – 120	$19,500	-
•Spinal Fusion (2-level)	$120 – 160	$24,500	-
•Spinal Fusion (3-level)	$150 – 200	$29,500	-
•Spinal Disc Replacement (1-level)	$160 – 380	$20,500	-
•Spinal Disc Replacement (2-level)		$25,500	-
•CABG	$120 – 170	$17,500	-
•Single Heart Valve Replacement	$150 – 200	$21,000	-
•Double Heart Valve Replacement	$170 – 240	$23,000	-

*NOTE: Package costs shown for these outpatient procedures do not include the companion travel benefit due to relatively low levels of cost savings.Courtesy of IndUSHealth



Employer lifestyle/wellness strategy

Employer 3-year strategy

- Leadership acceptance
- Employer participation incentives
- Wellness committee
- Health risk assessment
- Biometric profiles
- Digital, telephonic or onsite coaching
- Lunch n' learns
- Employee premium contribution incentives

Telemedicine ~ Telephonic/FaceTime

Goal: Decrease Urgent Care and low-complexity office visits

- Telephonic/Facetime service – advanced version of call-a-nurse service
- Staffed by nurse practitioners who can diagnose and implement treatment including prescribing medications
- Available to plan members weekdays, weekends and off-hours
- Improve patient and member convenience – parents and patients can use service and not have to visit UC or physician office
- Deliver clinical quality care while reducing overall plan costs

Integrated health management

Independent integration service will help the member to:

- Benefit design
- Patient education
- Branded communication
- Health needs assessment
- Wellness education and programing
- Primary care coordination
- Disease management
- Acute care coordination
- Data mining and performance analysis

Cost transparency and quality

Independent membership portal for

- Pharmacy advisor for cost and effectiveness
- Local, Regional and national price and quality measures for hospitals
- Lifestyle/wellness library
- Employee health self service
- Video library
- Healthcare basics

Health Plan Payer Audit

- Effectiveness of the vendors policies, procedures and internal controls
- Participant and dependent eligibility
- Claims paid in accordance with the plan documents
- Accuracy of COB Procedures
- Validity of covered diagnoses
- Incidents and dollar volume of duplicate payments
- Test benefit calculations, network discounts, deductible, copayments and plan limits
- Timeliness of claim payments
- Procedures regarding pended claims
- Effectiveness of utilization review protocols
- Effectiveness of large case management
- High cost claims, financial coding accuracy and coordination with case management programs.

Emerging Trends

ACA impact to small group Self-funding

Self-funded plans are exempt:

- ❑ Primarily from:
  - o Paying the HHS-calculated annual tax to which health insurers are subject starting in 2014. This amount will vary between insurer and is based on the prior years health insurance premiums received.
    - 1% to 2.5% in 2014
    - 1.5% to 3.5% in 2015
    - 1.5% to 3.5% in 2016
    - TBD thru 2017
- ❑ Anecdotally small groups who self-fund are exempt from:
  - o Participation in modified community rating risk-adjustment system
  - o Requirement To meet medical loss ratio requirements
  - o To have premium/cost increases reviewed and potentially disapproved by state and/or federal government agencies
  - o Any exchange fees or costs that may be incurred by insurers who are participating on the Federally Facilitate Exchange or ACA related fees.

ACA impact to self-funding

Self-funded Plan Sponsors plans will pay

- ❑ Reinsurance contributions to fund the Transitional or Temporary Reinsurance Program
  - o 2014 $5.25 PMPM
  - o 2015 estimated $3.50 PMPM
  - o 2016 estimated $2.19 PMPM (Ends at the end of 2016)
- ❑ PCORI (Patient Centered Outcome Research Institute (2014-2019)
  - ❑ $2 PMPY
- ❑ Excise Tax 2018 (The Cadillac or Maserati Tax)
  - o 40% excise tax on amount above threshold
  - o Individual $10,200, Family $27,500, Indexed to CPI after 2018
  - o Affects all plans, union, non-profit, government, corporations
  - o Insured or Self-funded
  - o Postponed to 2020

ACA impact to small group self-funding

Small group insured plans under 50

- Low compensation subsidy eligible may disband
- High compensation
  - Retain fully insured
  - Self funded or Level Funded

Small group self-funded options

- ❑Controlled aggregate
  - Aggregate with monthly cap
- ❑Traditional aggregate/specific
  - Restricted plan document with insured carve out products
- ❑Level funded with or without surplus
  - Annual aggregate funding cap
  - Risk Share on excess aggregate
  - Various Surplus return scenarios
    - 50%
    - 66-2/3%
  - Monthly fixed costs

Small group level-funded options

Stop Loss Limits	Plan A	Plan B	Plan C
Specific	$50,000	$50,000	$40,000
Annual Aggregate	$51,323.00	$64,032.00	$38,383.00
Billed Monthly			
Employee	$315.22	$362.88	$241.84
Employee + spouse	$803.11	$921.02	$614.34
Employee + child	$615.11	$704.33	$471.59
Family	$1,040.01	$1,194.32	$799.45
Stop Loss Premium	$4,565.21	$4,902.99	$3,630.90
Admin Expense	$2,716.94	$3,119.33	$2,085.90
Claim prefunding	$4,276.91	$5,336.00	$3,198.58
Total	$11,559.06	$13,358.32	$8,915.38

Small group self-funding

Advantages

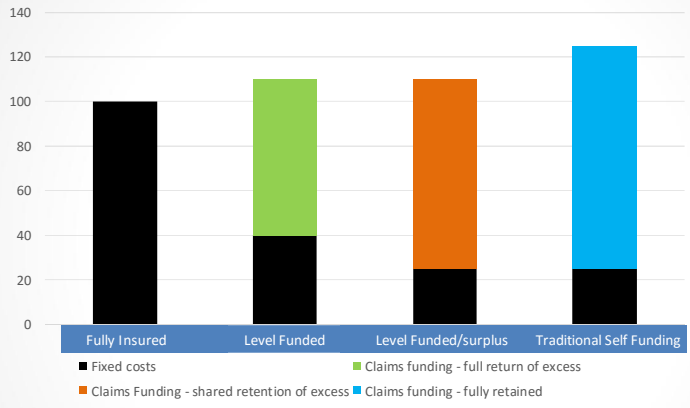
- Claims data not required needed to quote
- Access to utilization reports
- Some Flexibility of plan design
- Escape some state premium tax
- Avoid some state mandates
- Level cash flow
- Possible surplus refund
- Some ACA exemptions

Small group self-funding

Disadvantages

- Full funding requirement
- Higher fixed cost component
- May not have hard run out
- Banking requirements may be cumbersome

Small group level funded Options

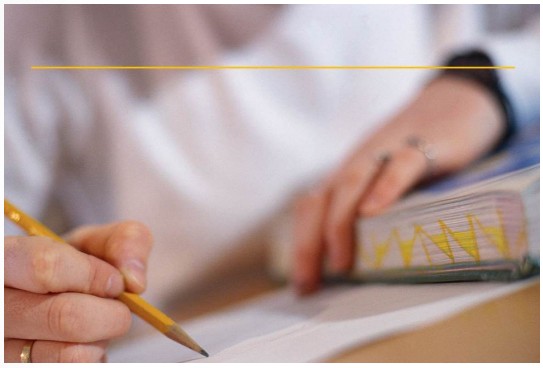


Graphs are a general representation and are not meant to show exact relationships between products. Other underwriting factors are important, including industry and specific level requested.

High cost carve out

- Organ transplant
- Kidney dialysis
  - Fully Insured
  - Direct Contract
  - 120% of Medicare
- Specialty pharmacy

Final exam and case studies



Scenario 1

12/15 contract type

- An employer renews a 12/15 contract with an effective date of 1/1/2014
- Two claims are submitted with service dates of 12/30/2014
- Claim A was paid by the TPA/ASO on 3/30/2015
- Claim B was paid by the TPA/ASO on 4/1/2015

Question:

How would the claims be adjudicated?

Scenario 2

12/12 contract type renews to a 24/12

- An employer renews with a stop loss carrier on 1/1/2013 and purchases a 24/12 contract
- The original effective date of the coverage is 1/1/2012 (12/12 contract)
- Two claims in excess of the specific are submitted for payment
- Claim A has a service date of 9/1/2013
- Claim B has a service date of 12/1/2011

Question:

How are these claims adjudicated?

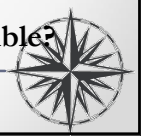
Scenario 3

24/15 contract type

- A large group who has a sizable population of active full time population of post 65 employees covered on their plan
- They changed stop loss carriers 1/1/14 and purchased a 12/15 stop loss contract choosing a specific stop loss level of $100,000
- The policy renewed on 1/1/15 to a 24/15 at $100,000
- Medicare informed the employer on 2/1/16 that they inadvertently paid a a claim as primary on claim that exceeded $250,000. That claim was incurred on 11/1/13.

Question:

How would the claim be adjudicated and who is responsible?



Scenario 4

48/12 contract type

- A large group had been self funded for four (4) years, staying with same stop loss carrier with a specific stop loss level of $250,000
- At each renewal, the stop loss carrier went from the original 12/12, then 24/12 then 36/12 with a 48/12 in place for 2015
- On 1/1/16 a local HMO offered an very competitive fully insured offer that the consultant and employer found very attractive
- They canceled the stop loss arrangement and moved to fully insured.
- On 1/23/16 the fully insured carrier received an eligible accident claim, not work related, that was incurred 12/24/15 that exceeded $375,000 and was still hospitalized and the prognosis is not good

Question:

Who is responsible for this claim and how would the claims be adjudicated?

THE WALL STREET JOURNAL.

WSJ

WEEKEND

SATURDAY/SUNDAY, JUNE 6 - 7, 2015

NEW FRONTIER: HEAD TRANSPLANTS

A Chinese surgeon has fused hundreds of mouse heads and bodies; next in his laboratory, monkeys

By Shirley S. Wang

HARBIN, China—Xiaoping Ren stood up after 10 hours hunched over an operating table and looked proudly at his patient, a small black mouse with a new brown head.

When he took a ventilator off the tiny creature's throat, the head began breathing spontaneously with its new body. An hour later, the body twitched, and, a few hours after that, the mouse opened its eyes, Dr. Ren recalls.

Since the July 2013 operation, he and his team at Harbin Medical University have done operations on nearly 1,000 more mice, testing various ways to help them survive longer than their record so far of one day after the surgery. A peer-reviewed international journal, CNS Neuroscience & Therapeutics, published the team's work in December.

Head transplants, at the extreme frontier of medicine, are inching toward reality. Dr. Ren plans to turn his surgical skills to monkeys this summer, hoping to create the first head-transplanted primate that can live and breathe on its own, at least for a little while.

If a breakthrough in this futuristic work comes, China might be where it happens. Since the mid-1990s, the Chinese government has been pouring money into scientific research, especially projects that are potentially high-impact or groundbreaking. China's investment in science and technology rose to 18% of the world's total research-and-development spending last year, from 10% in 2009, according to the Battelle Memorial Institute.

"China right now, they want to go to the top," said Dr. Ren. "If you think there's a

Please see SCIENCE page A8

Summary and Questions

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