OVATION HEALTH
THE FUTURE OF HEALTHCARE

TAKE CONTROL WITH SELF-FUNDING

An educational guide for employers ready to break free from the high cost of employee benefit plans.

CHALLENGES FACING SMALL BUSINESSES

Biggest Health Plan Challenges for Small Businesses

- Rising premiums with little or no negotiating power.
- Limited plan options and provider networks.
- Administrative headaches and compliance demands.
- Unpredictable renewal increases.
- Difficulty attracting and retaining talent.
- Cash flow strain from high benefit costs.

💡 **Many small businesses are exploring new solutions—like self-funding—and taking back control over benefit decisions and medical costs.**

THE COST BURDEN ON SMALL BUSINESS EMPLOYEES

Healthcare costs continue to rise year after year, putting added pressure on employers to balance affordability and quality of coverage.

Small businesses often struggle to find competitive health plan options because they have less negotiating power, fewer HR resources, and higher administrative costs per employee than larger companies.

While all businesses face rising premiums, small businesses generally are less able to absorb these rising costs.

As a result, their employees pay higher premiums and have plans with higher deductibles than employees from larger businesses, creating undo financial stress.

💡 **With a self-funded plan—you can retain top talent and deliver affordable quality care.**

SELF-FUNDING: CONTROL COSTS, GAIN FLEXIBILITY

For many small businesses, the rising cost of traditional health insurance has become a serious challenge. Self-funding offers a smarter alternative. With a self-funded health plan, employers pay for claims directly or through a Third-Party Administrator (TPA) instead of paying a fixed premium to an insurance carrier. In other words, the employer retains control of their money when claims are paid.

- **Cost Control:** Employers gain transparency into where healthcare dollars are going and can take steps to manage spending more effectively.
- **Flexibility:** Plans can be tailored to fit the needs of the employees, rather than having one-size-fits-all coverage.
- **Savings Potential:** By avoiding the high margins and overhead of traditional insurers, small businesses can often save up to 20%-40% compared to fully insured plans.
- **Protection from Risk:** Adding stop-loss insurance means that even in the event of a high-cost claim the employer's financial risk is capped.

Self-funding is no longer just for large corporations. Today, with innovative plan designs and strong support from third-party administrators, small businesses can take advantage of the same strategies to lower costs, improve benefits, and remain competitive in attracting talent.

63% of Americans have already made the shift are in a self-funded health plan.

4 REASONS TO SWITCH TO SELF-FUNDING

1. **Reduced insurance costs**
   Insurance companies tack on what's known as a risk charge for their policies that amounts to approximately 2-4% a year. Depending on the size of your workforce, this charge can range from thousands of dollars to potentially millions. A self-insured company never has to pay this cost.

2. **Reduced state premium taxes**
   Self-insured programs, unlike insured policies, are not subject to state premium taxes. The premium tax savings is about 2-3% of the premium dollar value. Again, we're talking about potentially saving many thousands of dollars annually, if not more.

3. **Full control over healthcare spend**
   Self-funded plans are subject only to the Employee Retirement Income Security Act (ERISA), so they can choose the benefits that best fit the needs of their employee group; and that meet the federal government's "essential health benefits" minimums.

4. **Improved cash flow**
   Self-insured employers do not have to prepay for coverage (the premium paid to an insurer), and claims are paid only as they become due. In low-claim years, this can result in significant savings.

Unlock Big Savings with Self-Funding

More employers are switching to self-funded health plans than ever before for good reason.

Self-funding, means never again having to blindly pay monthly premiums — instead, you control your health plan design and costs.

This results in more transparency and lower costs for your business.

It's a 'cut-out-the-middle man' approach that is helping companies regain control of runaway healthcare spending, while improving healthcare outcomes for their employees.

THE ROLE OF THIRD-PARTY ADMINISTRATORS

A Third-Party Administrator (TPA), is a services provider and does most of the work for self-insured health plans.

With a TPA you can lower overhead costs, lower claims management costs and achieve better claims outcomes.

TPAs charge a fixed per employee per month capitated fee for their services, which is usually 5-15% of the total annual cost of a self-funded health plan.

- TPAs protect employers from conflict with benefit denials, based on plan documents.
- TPAs take on administrative burdens including eligibility, customer service for members, insurance claims processing and payment, reporting, and record-keeping.
- TPAs also provide support coordinating services from vendors such as actuaries, claims adjusters, claims analysis firms, or legal counsel, when necessary.

💡 **We are a licensed TPA with fixed rates for services that have not increased in the past 8 years.**

COMMONLY USED TOOLS FOR SELF-FUNDED PLANS

1. STOP-LOSS COVERAGE FOR ADDED SECURITY
2. OPEN ACCESS AND DIRECT CONTRACTING
3. A CARE TEAM WITH PATIENT ADVOCACY
4. REFERENCED-BASED PRICING STRATEGY
5. PRIORITIZING DIRECT PRIMARY CARE
6. UTILIZING TRANSPARENT PHARMACY BENEFIT MANAGERS
7. UTILIZATION REVIEWS TO MANAGE CARE AND COSTS

Our Ovation Health self-funded plans include all of these tools and more.

1. STOP-LOSS COVERAGE: SECURITY FOR EMPLOYERS

It’s the scenario employers worry about most… An employee enrolled in their self-funded plan falls seriously ill, incurring hundreds of thousands of dollars in medical bills.

So, what’s the employer’s liability? How much of the expense will the company have to shoulder?

The reality is the actual risk exposure is limited, thanks to stop-loss insurance.

- This form of reinsurance coverage is a built-in safeguard that reimburses companies for medical claims when they exceed a specified amount.
- In addition to stop-loss, aggregate coverage can be added to reduce claims liability to as low as $10k.

💡 **Through Ovation Health, this built-in safeguard reimburses when medical claims exceed $50k.**

2. OPEN ACCESS AND DIRECT CONTRACTING

A self-funded plan allows for direct contracting which enables open access to facilities and physicians. Just like those that work with insurers, networks include primary care physicians, specialty physicians, hospitals, urgent care clinics, labs, x-ray facilities, home healthcare companies, hospice, medical equipment providers, infusion centers, chiropractors, podiatrists, and same-day surgery centers.

These direct contracting arrangements provide new opportunities to collaborate on efforts to control costs and to address the specific health needs of the employer and its workforce.

- Direct contracting arrangements offer self-insured employers the chance to gain control over the quality of the health care benefits that their employees receive.
- Working directly with providers, self-funded employers can develop tailored care options to meet the specific needs of the employee group.
- Employers and employees pay less when contracting directly with providers.

3. ADVANTAGES OF A CARE TEAM WITH PATIENT ADVOCACY

CASE MANAGEMENT

Case management occurs *before* and *during* a patient's admission, procedure or treatment.

The Care Team reviews services to ensure they are medically necessary, in an appropriate care setting, and are at or above quality standards.

This is why it is essential for members to coordinate their care with a Care Team expert.

In this way, we can improve the quality of care and prevent unnecessary costs and claims denials.

PATIENT ADVOCACY

Patient Advocates negotiate on behalf of members to obtain fair rates for medical services and treatments.

Sometimes this is through a cash pay arrangement, with same-day payment. In these cases, hospitals and providers are willing to accept a reduced fee for an immediate cash payment, which allows them to bypass time-consuming paperwork, collections and insurer adjustments.

In this way, we are able to save between 20% and 65% on healthcare costs.

4. CUTTING COSTS WITH REFERENCED-BASED PRICING

Reference-Based Pricing (RBP) is a pricing strategy that works by setting a cap on how much the plan will pay for medical procedures. **Medicare is used as the "reference" point for agreed upon pricing.**

Medicare is able to set relatively low prices because of its buying power and access to hospital cost data. It is the industry accepted base line. Using this strategy, negotiated rates are often equal to Medicare rates.

Because prices are capped in advance, both the employer and the member patient are better able to estimate their expenses.

💡 **With Reference-Based Pricing we can cut claims costs by 25%-40%.**

Example of Referenced-Based Pricing

An echocardiogram may be regularly billed at $1,500, and a PPO will negotiate a discounted rate of possibly $900.

However, a Reference-Based Pricing plan, would pay just $425 because its "allowable" rate is based on how much Medicare will reimburse healthcare providers for their services.

Direct Primary Care (DPC) can improve patient outcomes and lowers costs by removing insurance complexities, fostering a strong physician-patient relationship, and emphasizing preventative care through personalized, longer visits and same-day access.

BETTER OUTCOMES

- **Enhanced Physician-Patient Relationship**
  DPC eliminates insurance intermediaries, freeing physicians from administrative burdens to focus on in-depth patient care with longer, more personal consultations.
- **Focus on Prevention and Early Detection**
  DPC providers offer consistent, proactive care, facilitating early detection of health issues when they are more easily and cost-effectively treated.
- **Improved Access to Care**
  DPC ensures same-day or next-day appointments and provides 24/7 access via text, email, or telemedicine, allowing for prompt attention to health concerns.
- **Personalized Care Plans**
  DPC enables the development of tailored preventative care and chronic disease management plans, resulting in better control of conditions such as diabetes.

LOWER HEALTHCARE COSTS

- **Reduced Administrative Overhead**
  By avoiding complex billing and insurance claims, DPC practices lower their administrative costs.
- **Fewer Expensive Services**
  As the focus is on prevention and accessible primary care, there is a substantial decrease in costly ER visits and hospitalizations.
- **Lower Out-of-Pocket Expenses**
  The fixed monthly fee of DPC eliminates copays, deductibles, and hidden costs.
- **Employer Benefits**
  Employers who offer DPC may have reduced healthcare claims and lower costs.

6. CONTROLLING RISING DRUG COSTS WITH PBMs

Pharmacy Benefit Managers (PBMs) help employers manage prescription drug costs by negotiating discounts with pharmacies, managing formularies, and implementing cost-saving programs. By leveraging their expertise and industry relationships, PBMs can lower overall drug spending, improve access to necessary medications, and provide transparency into prescription costs. For employers, partnering with a transparent PBM is a practical way to control healthcare expenses while maintaining quality care for employees.

By negotiating rebates with drug manufacturers and discounts from large pharmacy companies, PBMs have had a significant impact in slowing down runaway drug costs.

The Benefits of PBMs

- They offer home delivery of medications and select networks of more affordable pharmacies.
- They encourage the use of generics and more affordable brand medications.
- They have better management of high-cost specialty medications.

7. UTILIZATION REVIEWS TO MANAGE CARE AND COSTS

How Utilization Reviews Help Manage Care and Costs

Utilization review is the process used by some insurers and employers to evaluate healthcare after it's been administered to determine if it was appropriate, necessary, cost effective, and quality care.

This goal is to identify the things that are going well and look for the opportunities to enhance plan performance. In this way, medical costs can be better managed, and you can better adapt to any changes that may arise to keep your costs down.

Our quarterly "Group Performance Review" includes plan performance data and the group's level of participation and collaboration with the Care Team and providers to mitigate risk, increase quality of care, and manage healthcare costs. Within our report you will have access to:

- Enrollment Detail
- Medical Claims summary and savings
- Rx Claims
- Rx Claims Comparison (to the national average)
- Rx Information (top Rx and highest cost Rx)
- High Claims Details
- Claims Spend
- Coordinated Care Assessment
- Performance Summary

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This publication was produced by Ovation Health.

Ovation Health offers comprehensive group health insurance for small to mid-size employers.

For health plan information or a quote, please contact us at **866-549-4199** or **sales@ovation-health.com**

www.ovation.health