Self-Funded Plans in a Post-Reform World
OUR SPEAKERS

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Agenda

• Overview

• Self-Funded Plans Under the ACA
  – Essential Health Benefits

• HRAs Under the ACA

• Nondiscrimination Rules

• ACA Reporting for Self-Insured Plans
Overview

- Considerations when contemplating self-funding:
  - Cash flow
  - Appetite for risk
  - Administrative costs
Overview

• Benefits of self-funding:
  – No premium taxes (except on stop-loss insurance), but need an administrator
  – Self-funded ERISA plans do not need to comply with state mandated benefit laws, which leads to:
    - consistency in benefit design when operating in multiple states;
    - greater freedom to determine eligibility;
    - greater freedom to determine covered benefits; and
    - greater flexibility to exclude or limit coverage for certain types of claims
  – Potential for better coordination with wellness programs
Overview

• Other considerations:
  – Greater responsibility for claims decisions
  – Ability to tailor plan documentation
  – HIPAA compliance
Self-Funded Group Health Plans Under the ACA

- Most of the ACA’s group health plan mandates apply equally to self-funded and fully insured group health plans, including:
  - Coverage of preventive health services
  - Extension of coverage to adult children (age 26)
  - Prohibitions on lifetime dollar limits, rescissions
  - Elimination of preexisting condition exclusions
  - Patient Protections (PCP designations, ER parity)
Self-Funded Group Health Plans Under the ACA

- Some mandates apply only to fully insured plans:
  - Deductible limits (REPEALED)
  - Modified community rating rules
    - Applicable to non-grandfathered individual and small group plans
    - Carriers may vary premiums based only on age (3:1), tobacco use (1.5:1), family size, and geography
Self-Funded Group Health Plans Under the ACA

- Some mandates apply only to fully insured plans:
  - Medical loss ratio rebates
  - Nondiscrimination rules (DELAYED)
    - Already apply to self-funded plans
  - Health insurance industry tax
    - Could lead to more plans self-funding
    - Applies to medical, dental and vision
  - Guaranteed availability and renewability
    - Could ease transition back into fully insured market
    - Could lead to adverse selection in insured market
Self-Funded Group Health Plans Under the ACA

• PCORI fee applies to self-funded and fully insured plans
  – Fee is $2.08 fee per member per year for plan years ending on or after October 1, 2014, and before October 1, 2015
    - Paid by insurers if insured plan
    - Paid by plan sponsor if self-funded plan (Form 720)
    - Fee supposed to sunset after 2019
  – Applies on a per-covered employee basis for HRAs
  – Applies on a per-member basis for major medical
    - Examples of due dates:
      - 07/01/13 – 06/30/14 – due by 7/31/15
      - 01/01/14 – 12/31/14 – due by 7/31/15
      - 07/01/14 – 06/30/15 – due by 7/31/16
Self-Funded Group Health Plans Under the ACA

• Transitional Reinsurance Fee (2014-2016 calendar years)
  – Intended to stabilize premiums in the individual markets
• Assessment on carriers and self-funded plans
• Fee is $44 PMPY ($3.67 PMPM) for 2015
  – $27 PMPY ($2.25 PMPM) in 2016
• Generally applies to all group health plans – no exceptions for non-ERISA plans (e.g., governmental or church plans)
• Does not apply to HIPAA-excepted benefits, expatriate plans, post-65 retiree plans, “integrated” HRAs and non-minimum value plans
• Pay via Pay.Gov
Cadillac Tax Applies starting in 2018

- 40% nondeductible tax on excess over threshold
  - $10,200 Single, $27,500 Family
  - Based on total cost of coverage (employer plus employee), plus any contributions to HRA/FSA/HSA
- Tax is paid by insurer or administrator, not by participant
- Increased by $1,650 Single, $3,450 Family:
  - For retirees age 55 or older and not eligible for Medicare, or
  - If majority of employees covered by the plan are engaged in a high-risk profession (listed in statute)
- Excludes HIPAA-excepted dental and vision plans
Essential Health Benefits

- Plans **not required** to cover Essential Health Benefits
  - Self-insured plans
  - Insured large group plans
  - Grandfathered plans
  - If these plans cover EHBs, they cannot impose annual or lifetime limits on the dollar value of EHBs

- Plans **required** to cover Essential Health Benefits
  - Non-grandfathered health insurance plans in the individual and small group markets both inside and outside of the Exchanges
  - Medicaid benchmark and benchmark-equivalent and Basic Health Programs
Essential Health Benefits

- Essential Health Benefits include:
  - Ambulatory patient services (doctor’s visits);
  - Emergency services;
  - Hospitalization;
  - Maternity and newborn care;
  - Mental health and substance use disorder services, including behavioral health treatment;
  - Prescription drugs;
  - Rehabilitative and habilitative services and devices;
  - Laboratory services;
  - Preventive and wellness services and chronic disease management; and
  - Pediatric services, including oral and vision care.
Essential Health Benefits

• Employers that sponsor self-insured plans should identify which benefits are EHB’s
• Under current guidance, a self-funded plan can adopt any HHS-approved EHB package for purposes of determining which benefits offered under the self-funded plan are EHBs
• Employers should consider how the election of a particular EHB package as a benchmark should be documented (e.g., plan document, SPD, administrative policy)
Out-of-Pocket Limits

- ACA imposes limits on out-of-pocket cost sharing for in-network EHBs
  - 2015 ACA limits: $6,600 / $13,200
  - 2016 ACA limits: $6,850 / $13,700
- Notice of Benefit and Payment Parameters for 2016
  - Preamble to final regulations “clarifies” the limits apply regardless of whether an individual is enrolled in single or family coverage
  - In other words, family plans must have an “embedded” individual deductible
  - Not entirely clear whether this applies to self-insured plans
Reference Pricing Under the ACA

• Addressed in Q/A-4 of DOL Technical Release XIX

• Plan has a reference-based pricing structure for a particular procedure (e.g., a knee replacement)

• Some providers accept the reference price as payment in full; others will not

• As long as the plan uses a reasonable method to ensure that it provides adequate access to quality providers, it may treat providers as out-of-network if they do not accept the reference price as payment in full

• ACA’s OOP limit rules do not apply to out-of-network providers
HRAs Under the ACA

• Use of HRAs To Reimburse Premiums In the Individual Market
  – IRS & DOL: Free Standing HRAs that reimburse premiums for individual policies do not meet ACA requirements regarding annual limits
    - Such arrangements are not “integrated”
Nondiscrimination Under Code Section 105(h)

• Under Code § 105(h) a self-funded plan cannot discriminate in favor of highly compensated individuals (HCEs) as to eligibility to participate or the benefits provided under the plan

• HCEs include the highest paid 25% of employees
  • HCEs assessed on a Controlled Group Basis
  • Look for subsidiaries, brother-sister controlled group, affiliated service groups—separate EIN meaningless
Nondiscrimination Under Code Section 105(h)

- These rules currently apply to self-funded plans
- Nondiscrimination rules for insured plans under ACA originally intended to apply in 2011 (or when a plan loses grandfathered status)
  - The ACA’s requirements have been indefinitely delayed until further regulatory guidance is released
- For insured plans, the penalty is $100/day with respect to each individual to whom the failure relates, not taxation of discriminatory benefit, which is the penalty for self-funded plans
2015 Employer Reporting Requirements

• Code Sections 6055 (insurers and self-insured plans) & 6056 (applicable large employers)
  • First mandatory reporting in 1Q 2016, representing CY 2015

• Complex reporting requirements

• Employers that self-insure have a reporting obligation under Section 6055 as well as 6056
  • Will generally use C-Series Forms 1094/1095 when reporting

• IRS expected to release additional FAQ guidance on reporting of COBRA participants
Self-Funded Plans – Employer Opportunities
Rick Kelly, FSA
Funding method for most prevalent plan, by employer size

- **50-499 employees**
  - Insured: 75%
  - Self-funded: 25%
  - Up 2% from last year

- **500-4,999 employees**
  - Insured: 70%
  - Self-funded: 30%
  - Up 1% from last year

- **5,000 or more employees**
  - Insured: 7%
  - Self-funded: 93%
  - Up 2% from last year

Sources:
- Mercer’s National Survey of Employer-Sponsored Health Plans
Why Consider Self Funding - Part I

+ Avoid premium tax

+ Can choose not to cover state mandated benefits

+ Do not pay carrier risk charge

Total savings to employer = 5-9%
Why Consider Self Funding - Part II

**FREEDOM & FLEXIBILITY**

- Flexibility on defining essential benefits within the Affordable Care Act
- Avoid Adjusted Community Rating
- Leverage access to data to only pay for your costs and directly improve your trend
Flexibility on Defining Essential Benefits

States define essential benefits differently even though the ACA is a federal law.

Examples

► Infertility Treatment
► Bariatric Surgery

The impact on cost?

► Depending on benefit mix, typically 1-3%
Why Consider Self Funding - Part II

Beginning in 2016, groups with 100 employees or less will be subject to ACR

• Currently applies to groups below 50 employees

• Carriers cannot underwrite groups anymore
  – Rates vary only based on average age, not gender or health status

• Groups with average risk or better will see large premium increases
  – These increases can be greater than 100%!
Leveraging Data

When self-funding you are taking the on the risk of your employee population; it is critical to have access to your health care data and understand how to use it effectively.

BENEFITS

► Cost structure on medical claims
► Cost structure on pharmacy claims
► Protect organization from catastrophic risk
► Assess drivers of cost & develop strategies to address
► Increase consumerism of employees
► Multiyear planning vs reacting to each year’s renewal
Leveraging Data
Cost of Medical Claims

Data to your advantage

Important to measure the cost of different TPAs, not simply their discount level

► It’s how much you spend, not save off billed charges

To properly assess this cost need to utilize the nationally recognized Uniform Data Standards and have credentialed actuaries who participate on this workgroup perform the analysis

► Service and Risk Adjusted

► Value Based Reimbursements as well as FFS
Leveraging Data
Cost of Pharmacy Claims

More data to your advantage

PBMs do a great job at building profit margin in their contracts

► Analyze on a per channel, per drug basis

► Negotiate contract language to uphold the financial integrity of the terms negotiated

► True either for a carve-in or carve-out contract
Stop loss provides protection against very large claims preventing cash flow issues and increasing predictability

- Analysis of employee count, claim data, risk tolerance and financial capital determines appropriate deductible
- Contract language on stop loss will determine whether you are protected or exposed for years to come

Leverage available data on high cost claimants and clinical resources (eg MDs) to negotiate better stop loss terms
Leveraging Data

ID: 220098763  
Name: Blinded, Blinded  
Status: Current / Spouse  
Age/Gender: 52/F  
RJ/CGI: 47/7

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**Clinical Event Chart**

- Admissions:  
- ER Visits:  
- Office Visits:  
- Prescriptions:  
- Episodes:

**Selected Cycle**

2012 - 2013

**Date:** 2013-10-23  
**Diagnosis:** Diabetes With Neurological Manifestations Type II or Unspecified Type Not Stated As Uncontrolled  
**Provider:** SITARZ, KELLY MD  
**Cost:** $389.48
Leveraging Data
Increase consumerism of employees

Data available to self funded employers provides them an opportunity to make their employees better consumers.

✔ Understand drivers on the medical claims to
  + adjust plan design to change behavior
  + target appropriate wellness initiatives

✔ Utilize pharmacy smart phone apps independent of the PBM to create point of script discussions between employees and doctors

✔ Increase success through well thought out employee communication campaigns
Leveraging Data
Multiyear planning vs reacting to each year’s renewal

• Self funded employers have the ability to model out multi-year projections through leveraging data
  – Using actuarial and clinical resources for predictive modeling and to build out projections for 3-5 years

• Can then develop strategies to close any funding gap between future budget constraints and projections
  – Also helps assess Cadillac tax exposure now while there is time to phase in changes to mitigate
Forecast Analysis Drives Future Strategies

MMA underwriting team will load our Strategic Forecast Model with current plan values, contributions, expected trends and various cost management strategies that could be leveraged by the client.

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### Status Quo

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MARSH & McLENNAN AGENCY LLC
COMPLIANCE RESOURCE AND PARTNER: PROSKAUER
Cost Management Options

MMA and the customer hold work sessions to review the cost management options and the economic impact.

Strategic changes can be built for 3, 4 or 5 year periods.

Each cost management strategy category has multiple options and associated cost impact data pre-loaded.
QUESTIONS & DISCUSSION
Program ID: ORG-PROGRAM-227881

Title: Self-Insured Plans Under the ACA
Start Date: 3/19/2015
End Date: 3/19/2015
Recertification Credit Hours Awarded: 1.0
Specified Credit Hours: General