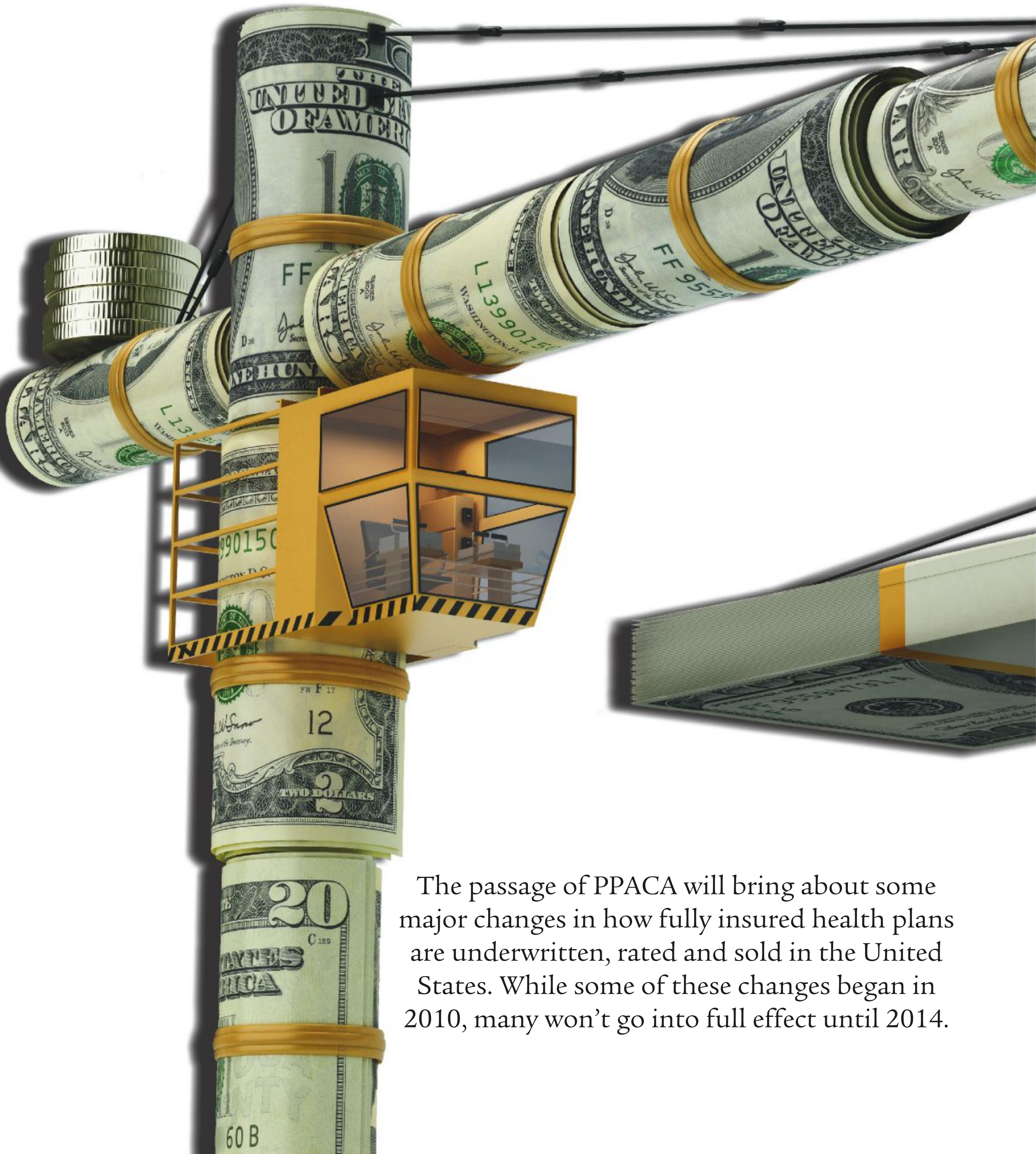
The PPACA Train Has Left the Station:



The passage of PPACA will bring about some major changes in how fully insured health plans are underwritten, rated and sold in the United States. While some of these changes began in 2010, many won't go into full effect until 2014.

by David L. Fear, Sr. RHU
Vice President and CFO
Shepler & Fear General Agency
Roseville, CA
davefear@sheplerfear.com

Why Self-Funding May Make Sense

For employers with less than 100 employees who continue to purchase fully insured coverage, two major things happen: First, they will be pooled into a new "community-rated" program. Fully insured rates will be allowed to vary by age, geographic regions and family size (i.e., employee only, employee and spouse, employee and children, employee and family).

The second thing that will happen in 2014 is that rates for fully insured plans for employers with less than 100 employees will no longer be "experience rated." In the current system, many states allow for a "risk adjustment factor" that can vary by employer size and experience. That will go away under PPACA in 2014. Employers with poor claims experience will be pooled with those with favorable experience, and they will each pay the same rate regardless of their experience.

Some of the PPACA rules will apply to self-funded plans (i.e., unlimited lifetime benefits, women's health benefits, preventive care, etc.). However, many other PPACA provisions will not apply to self-funded plans and these plans will still remain exempt from state insurance regulation and state benefit mandate requirements. They will continue to be subject to federal regulation under ERISA and avoid the payment of state premium taxes.

However, the most important thing is that self-funded plans will not be subject to the PPACA rating and underwriting requirements that will be imposed on fully insured plans for employers with fewer than 100 employees.

How Does Self-Funding Work?

Instead of paying premium to an insurance company or health plan, the employer places those dollars into a separate account. From this account, three expenses are paid: premium for stop-loss insurance, fees for administrative services and medical claims for plan participants.

ERISA requires that a Plan Document govern the plan and that all plan participants be given a Summary Plan Description of their benefits. Employer contributions to a qualified self-funded plan are fully tax deductible as long as they meet all of the rules imposed under ERISA.

Let's take a look in more detail at the cost components of a self-funded plan:

Stop-Loss Insurance. Typically, there are two types of stop-loss insurance that are packaged together to protect the plan. Specific stop-loss provides the plan protection from individual catastrophic claims. Aggregate stop-loss provides the plan protection from overall high claims utilization within the plan year.

Most specific stop-loss policies have a "retention" (or deductible) in which the plan must pay benefits before the stop-loss coverage kicks in. Specific stop-loss retention levels range from as low as $7,500 to as high as $250,000. The larger the plan, the greater the specific stop-loss retention level. (Most experts recommend that it be 10% of estimated annual claim payments.)

Aggregate stop-loss is like an umbrella policy that sets an attachment point so when the overall claims paid by the employer's fund exceed a certain level, the aggregate stop-loss coverage kicks in. Typically, the aggregate stop-loss attachment point is set at 115% or more of expected paid claims.

There are many other contractual features of stop-loss insurance coverage that will affect the cost, including provisions to cover claims runoff if the plan is terminated. It is important to note that both specific and aggregate stop-loss insurance are NOT health insurance and do not directly pay benefits to the plan participant. They are really more like a form of liability insurance for the employer's self-funded plan.

Because self-funded plans are not regulated by the states and not subject to state benefit mandates, they can extremely flexible in their plan designs.

Administrative Services. These services are typically provided by a licensed and bonded TPA or by an insurance company through an administrative services only arrangement (ASO). Some large employers have chosen to self-administer their self-funded plan but, for the most part, the overwhelming majority of employers that self-fund do so with the use of a contracted administrator.

The TPA or ASO arrangement will typically provide all of the services needed to operate and manage the plan. The employer enters into an administrative services agreement with the TPA or ASO insurer. That agreement will detail who does what, when and for how much. At the very least, the TPA/ASO will be handling eligibility maintenance (so healthcare providers can verify that a plan participant is covered), claims payment, filing for stop-loss insurance claims reimbursement, and providing regular financial and utilization reports related to the self-funded plan.

Most self-funded plans will also contract with additional service providers such as PPO and utilization review organizations in order to reduce the cost of paid claims, the third and largest expense of a self-funded plan.

Medical Claims. The majority of expenses paid out of the self-funded plan account are for the cost of healthcare services incurred by plan participants. Typically, a self-funded plan will provide benefits for medical expenses, but may also include dental, vision, prescription drug and disability expenses. The plan document will outline all of these items in terms of how they are paid (i.e., deductibles, coinsurance, copayments, etc.), for whom they are paid (eligible participants), when they are paid (incurred expenses and time deadlines for payment requests, and what is paid (covered benefits, limited benefits, excluded items). Most self-funded plans will incorporate elements of managed care, such as contracting with provider networks (PPO, EPO or indemnity), utilization review of non-emergency services, case management and discharge planning and, of course, negotiated fees for services rendered. An experienced TPA will process claims exactly as the plan document requires them to be handled.

Level Funding Arrangements

Level funding products have been recently introduced into the market by a number of carriers in order to provide smaller employer with the benefits of self-funding. These are packaged plans that include stop-loss insurance, administrative services and guaranteed maximum liability. They are also subject to ERISA pre-emption of state insurance rules and taxes. Level funding closely resembles a traditional fully insured plan yet provides the potential for a refund of surplus dollars at the end of the plan year (following a runoff period). It is available to small employers with more than 10 employees and generally requires a health screening process prior to implementation in order to determine a guaranteed aggregate stop-loss attachment point for the group.

Section 105/Partial Self-Funding

Some smaller employers now purchase fully insured high-deductible health plans and partially self-fund their benefits using a wraparound arrangement that reduces their fixed costs and generates savings the majority of the time. This arrangement takes advantage of favorable tax treatment under Section 105 of the Internal Revenue Code, allowing the employer to tax-deduct expenses as would be done under a traditional fully insured plan or under a fully self-funded plan. These arrangements are also referred to as Section 105/wrap plans or Health Reimbursement Arrangements.

Plan Design Flexibility

Because self-funded plans are not regulated by the states and not subject to state benefit mandates, they can extremely flexible in their plan designs. One of the keys to success in a self-funded program is designing the benefits to achieve certain results. For example, most self-funded plans include managed care features to reduce the cost of healthcare services that are paid for by the plan. They will contract with PPOs that feature lower costs for services. Additionally, they will contract with Utilization Review Organizations and Pharmacy Benefit Management providers to help reduce the cost of inpatient and other specialty services, including prescription drugs.

The most successful plans are implementing wellness incentives that move participants into a healthy action program that impacts claim costs and lowers plan utilization. PPACA contains provisions for expanding employer-sponsored wellness programs. The simplest wellness programs now include incentives for fitness and nutrition, health risk assessments and usage of healthy lifestyle tools. Benefit incentives may include lowering copayment or coverage contributions as well rewards for healthy actions. Also, the use of telemedicine has become a key ingredient of cost-containment in self-funded plans.

In conclusion, the PPACA train has left the station. Employers should not delay undertaking a thorough review of their plans. They should investigate funding and plan-design alternatives immediately. Employers have never had a better reason to implement cost-containment strategies that involve alternative funding and benefit-design features. Benefit advisors should be on top of the latest changes in the market, including the use of stop-loss insurance and wellness strategies. HIU

It's easier when you're
holding
ALL
the cards.

We offer
dental plans for **ALL** budgets
and needs. That's why we call it
Dental for Everyone!

No paperwork!

- *Online Enrollment*
- *Online Payment*
- *Online Fulfillment*

MWG
MARKETING

www.DFEinfo.com/HIU

Phone: 1-800-800-1397
Email: DFEinfo@morganwhite.com