SELF FUNDED

Stay the course

MANDATE DELAY SHOULDN'T ALTER SELF-FUNDED PLAN DESIGN

Michael Austin / thelspot.com

Many of us in the industry are evaluating our positions and client recommendations after the recent announcement on the delay of PPACA's employer mandate penalty.

How does this affect the drive forward for the self-funded world and the small employers that are fully insured with plans to move to self-funded in 2014? The plan should be to stay on course.

There seems to be a lack of knowledge in the broker world regarding self-funding, and now we have another year to adjust the learning curve. Many brokers ask why they would—and should—recommend self-funding employee benefit plans to their clients.

Among other reasons:

- Self-insured plans are not tied to community rating for determining premiums as are fully insured arrangements.
- Self-funded plans are more adept at allowing employers to determine what its true costs of coverage are. With this data, employers can address high-cost services more directly.
- Self-funded plans are likely to be in a better position to manage future uncertainty because they escape greater regulation that the health insurance industry faces.
- Review of premium increases by the Department of Health and Human Services under PPACA doesn't apply to self-funded plans. Premium

increases are most often based on claims experience.

- Self-funded plans avoid the adverse selection insured plans frequently encounter.
- Self-funded health plans, for most employers, are governed by the Employee Retirement Income Security Act of 1974. ERISA preempts state insurance regulations, meaning employers with self-funded medical benefits are not required to comply with state insurance laws that apply to medical benefit plan administrators. On the other hand, insured plans must comply with some of ERISA's requirements.
- Self-funded plans avoid the essential health benefits mandates of PPACA. One large insurance company in 2012 estimated that the services mandated for fully insured plans by PPACA will increase premiums from 7.5 percent to as much as 15 percent.

Because of the differences in the rules governing self-funded plans versus those governing fully insured plans, some employers who've not previously thought self-funding was a better approach to providing health care benefits are now revisiting the issue.

SIZE MATTERS

The recommended minimum size for self-funding is usually 50 lives but we're able to quote groups smaller than 50 lives due to the change in the stop loss market. The best size is 50-plus. Some carriers have minimum numbers for certain plans.

There any minimum employee participation requirements for a small employer to be offered stop-loss insurance. The employer plans with low participation rates (below 75 percent) are not generally considered candidates for stop-loss coverage. Some stop-loss insurers have slightly higher or slightly lower participation thresholds, but on average, anything below 80 percent will typically not receive a stop-loss quote. If the employer is willing to complete a statement of health form or better yet, contribute to the employee only cost the participation numbers are usually met.

Self-funded plans are likely to be in a better position to manage future uncertainty because they escape greater regulation that the health insurance industry faces.

The stop loss amount or individual specific is generally based on the size of the employer and how much risk they are willing to take.

STOP-LOSS CONSIDERATIONS

Aggregate stop-loss insurance protects the employer against high total claims for the health care plan. Any amounts paid by a specific stop-loss policy for the same plan would not count toward the aggregate attachment point.

As employers' enrollments have remained flat or have been reduced due to the current economic environment, there hasn't been a material change in the common attachment points desired by employer for both small and larger plans. The proportional use of stop-loss among various group sizes has remained consistent. In terms of overall growth, as the use of self-insurance has grown over the past two decades, the market for stop-loss insurance has expanded proportionally.

PPO networks are used for self-funded clients to control cost. The network that is the best fit for the client is usually based on geography. Most TPAs are able to work with many local and national networks.

In certain cases the carrier will quote both a "laser" and a "no-laser" option and let the client chose which they prefer. A laser is a higher specific on one individual than all other employees. An attempt is made to provide as much medical information as possible to the carrier to avoid lasers. If the group can provide complete two to three years of claims experience, including large and potential claimants, the carrier could possibly accept a standard disclosure form.

LaRea Albert is CEO of Lone Star TPA in Tyler, Texas. She can be reached at LAlbert@lonestartpa.com.

It's not just about the price

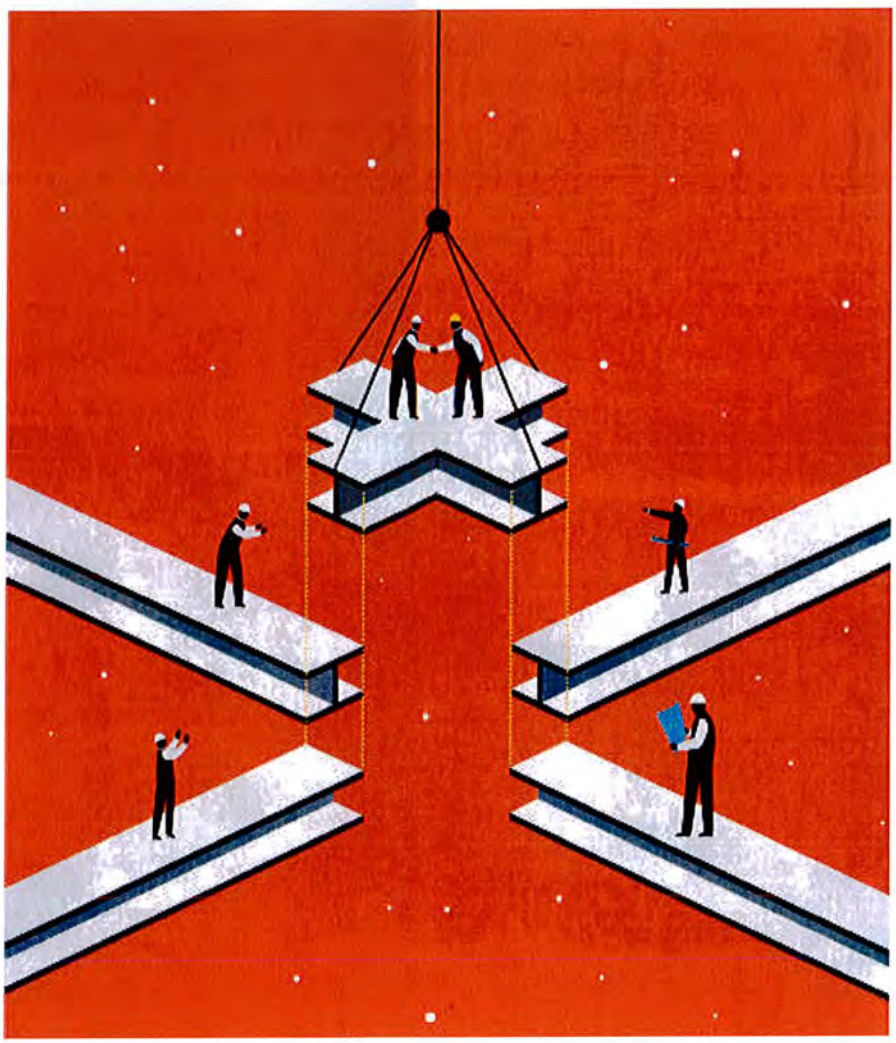
STOP-LOSS FOR SMALL EMPLOYERS

As brokers and consultants have been developing strategies for their small- and medium-sized employers to prepare for the full implementation of the Patient Protection and Affordable Care Act in 2014, there's been a growing interest in moving these clients to self-funded health plans. While there has always been advantages to self-funding, PPACA has added to the attraction of self-funding through opportunities for greater cost efficiencies and benefit plan design flexibility.

While self-funding is an increasingly attractive option for small and medium, it's almost always only a viable option if accompanied by the purchase of appropriate stop-loss coverage. Under a self-funded health plan, the employer is taking full financial responsibility for funding that health plan, with unlimited liability for large claims beginning in 2014. Most small and medium employers cannot reasonably assume such risk without specific stop-loss to protect against individual catastrophic claims and aggregate stop-loss to protect against an unexpected amount of total claims in the year.

It might be tempting simply to send out requests for quotes to a number of stop-loss insurance carriers, line the quotes up on a spreadsheet and choose the lowest price. The process might even move beyond the pure commodity approach to evaluation and consider other factors such as experience of the stop-loss carrier, reputation for customer service and claims paying, cost containment support and financial strength.

But stop-loss insurance is a unique product that requires greater care in choosing the appropriate product and carrier. Careful consideration needs to be given to policy features designed to better protect the financial health of small and medium-sized employers and their benefit plans.



Michael Austin / thelspot.com

CONTRACT PERIODS

The stop-loss contract provides financial protection to the employer sponsor of the self-funded health plan and has great flexibility to respond to plan costs based on dates of service (incurred dates) and when medical claims are actually paid (paid dates). The stop-loss policy is often referred to as being on an XX/YY contract, where XX refers to the number of covered incurred months and YY the number of covered paid months.

For employers moving from fully insured to self-funding, the stop-loss policy typically covers incurred dates during the 12 months of the plan year as

the fully insured carrier is responsible for claims incurred prior to this. Very often, these stop-loss policies are quoted on a basis that also only covers claims paid during those same 12 months, often called a 12/12 contract. This contract certainly produces an attractively low first-year cost.

The downside is that the employer is potentially exposed to a renewal rate shock as the stop-loss contract is renewed on a full paid (24/12) basis. More importantly, the employer is potentially exposed to unprotected liability.

For example, an employer may have incurred a plan liability for a hospitalization occurring toward the end of a plan year.

However, the claims resulting from that hospitalization may not be paid for weeks, or perhaps months. If the stop-loss policy was purchased on a 12/12 basis, that claim may not be covered if it's paid after the 12-month paid period under the contract. To better protect against that exposure, consideration should be given to a contract basis providing three months (12/15 contract) or six months (12/18 contract) run-out protection.

Stop-loss insurance is a unique product that requires greater care in choosing the appropriate product and carrier.

TERMINAL LIABILITY OPTION

TLO provides an alternative to purchasing a policy with an extended payment period (however, it doesn't address the potentially high increase at first renewal). This option provides that the payment period under the stop-loss contract may be extended for an additional period, typically three months, following termination of the stop-loss contract. This option must be elected at the beginning of the policy period and may be used for both specific and aggregate coverage.

ADVANCE FUNDING

Stop-loss policies are designed to be reimbursement policies and as such, require the plan to pay, and the employer to fund, claims before the stop-loss carrier pays. This requirement may be financially impossible for SMEs faced with a catastrophic claim involving hundreds of thousands of dollars or more. A stop-loss policy with an advance-funding feature overcomes this problem. The stop-loss carrier will advance that portion of an eligible claim that would be reimbursable under the stop-loss policy.

MONTHLY AGGREGATE ACCOMMODATION

Stop-loss aggregate coverage operates on a plan-year basis. If total claims at the end of the plan year exceed the aggregate deductible, the stop-loss carrier reimburses those excess claims.

However, there's no protection for volatility from month to month. small and medium-sized employers concerned about monthly cash flow might consider the option of monthly aggregate accommodation. For policies with this feature, at the end of each month, if cumulative claims exceed the cumulative aggregate deductible, the stop-loss policy will advance the difference. This feature gives greater cash flow protection to those employers.

ELIMINATION OF LASERS

One of the primary concerns regarding stop-loss for small and medium-sized employers is the annual nature of the contract. Each account is re-underwritten at renewal and groups with poor experience might receive very high renewal increases.

Also, a group with an ongoing catastrophic claim may be subject to a higher specific deductible for that claimant (a laser). Either of these scenarios can lead to significant financial exposure to small and medium-sized employers seeking to renew its stop-loss coverage. To avoid this risk, that employer should determine if its stop-loss carrier provides an EOL option. For a modest risk charge, the carrier will agree not to impose any new lasers at renewal and will limit renewal increases to a stated amount.

While price is certainly an important consideration, it's important for brokers to advise their small and medium-sized clients of stop-loss policy features and options that will better serve to protect the financial viability of their self-funded plan. With the right policy features, most SME clients can become comfortable with the liability associated with self-funding their employee benefit plan and have all the advantages that this financial model provides.

Michael Kemp is senior vice president at Independence Holding Company. He can be reached at mkemp@ihcrisksolutions.com.

Self-funded plans and PPACA:

PPACA MAY CAUSE EMPLOYERS TO GRAVITATE TOWARD SELF-FUNDED PLANS

Michael Austin / thelspot.com

In the wake of the upcoming (though slightly delayed) employer shared responsibility (or "play or pay") requirements of the Patient Protection and Affordable Care Act, there's been increased interest in self-funded health plans, particularly among those employers who will be subject to the requirement. The benefits community will likely face many questions from current and potential customers about self-funding options and this overview will briefly touch on the basics of self-funded plans, the pay or play requirements, and a few reasons that PPACA may have caused increased interest in self-funding.

In short, self-funding is the absence of health insurance provided by a third party. Self-funded health plans operate by paying claims from the plan sponsor's general assets, usually combined or offset by participant contributions, instead of purchasing insurance through an insurance company by paying premiums. In some cases, plan sponsors pay claims from a trust that is funded by plan sponsor contributions and participant contributions. Self-funding also is called "self-insurance," which indicates the plan sponsor's assumption of the responsibility to pay benefit claims and to accept the risk of those claims exceeding its expectations, thereby self-insuring the risk.

PPACA's play or pay rules require those employers with 50 or more full-time equivalents to provide health coverage under an employer-sponsored plan to all full-time employees, which are those who work an average of 30 hours per week or more. The plan generally must meet

Is this the new normal?

certain minimum value requirements and be affordable to the employee. If an employer does not comply with these requirements, it will face stiff penalties. The play or pay mandate was set to be effective Jan. 1, 2014, but it was announced recently by the Treasury Department that it is pushing the mandate's effective date to Jan. 1, 2015.

Many of the employers who will be subject to the requirements to offer health coverage to their full-time employees are now faced with the added cost of providing coverage to many more employees than currently eligible under their plans (or offering a plan at all where they never have before). Some may look to a self-funded plan to meet their needs and comply with the law. Interest has increased in self-funding in the wake of PPACA for a variety of reasons:

- New fees and mandates for insurers. Insurance companies are facing a variety of new fees under PPACA, which will likely increase expenses, which will be reflected in premium rates and passed on to policyholders. PPACA also imposes rating limitations, as well as guaranteed-renewability and guaranteed-availability rules on insurers that are anticipated to drive up costs (and as a result, premiums). Employers that complete a cost/benefit analysis comparing the rising cost of insurance premiums to the costs of self-funding may find that self-funding could generate savings.
- Less risk if employer decides to go back to insured plan. Under the guaranteed availability rule mentioned above, beginning in 2014, health insurance issuers in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. Because of this rule, employers who attempt self-funding and find it too costly may find it easier to move back to an insured product. This may encourage those employers who thought self-funding was too risky in the past to give it a try.
- Loss of availability of carve-out plans for management. A current benefit of sponsoring an insured plan instead of a self-funded arrangement is the avoidance of the nondiscrimination rules under the Internal Revenue Code's section 105(h), which currently apply to self-funded plans only. PPACA applies nondiscrimination rules similar to those of section 105(h) to insured plans, which may cause problems for employers who continue to sponsor carve-outs for management or other highly-compensated employees. While the effective date of this provision of PPACA is currently unknown, those employers who maintained an insured arrangement because of this particular benefit may soon be less inclined to do so.
- Easier integration of wellness programs. A major focus of PPACA has been to emphasize preventive care and wellness programs in the workplace in order to keep people healthier and reduce health care costs down the road as people age. In particular, PPACA has increased the permissible differential in the cost of coverage that employer plans may charge depending on whether an employee participates in a wellness or disease management program (particularly targeting tobacco use). Employers wishing to implement wellness or disease management programs may find that integration of these programs is easier in a self-funded arrangement, because communication and access to claims data may be easier with a third-party administrator rather than an insurance company. Self-funded plans may also be able to better tailor wellness programs to the needs of their employees because they will not be limited to the products available from insurance companies. Finally, some self-funded plan sponsors may realize savings from their wellness or disease management programs much more quickly than insured plan sponsors, who have to wait for the savings to trickle through the experience rating in future insurance premiums.

Employers that complete a cost/benefit analysis comparing the rising cost of insurance premiums to the costs of self-funding may find that self-funding could generate savings.

These are just a few aspects of PPACA that may affect an employer's decision to self-insure their health plan, whether because employers are now forced to comply with play or pay, or simply because they are attempting to navigate the changing waters of the post-PPACA health insurance world.

Joshua Sutin is the department leader and Jillie Gordon is an attorney in San Antonio, Texas-based Cox Smith's Employee Benefits/ERISA practice. They are members of the firm's PPACA team. Joshua can be reached at jasutin@coxsmith.com, and Jillie at jgordon@coxsmith.com.