SEAC 2013 Fall Meeting

TRENDS IN THE LARGE EMPLOYER GROUP SPACE

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ACA

Note:

The information provided herein is not intended to provide legal and/or accounting advice and should not be relied upon as such.

2014 ACA Provisions (51+ groups, size definition can vary by State)

- No annual / lifetime dollar limits on essential benefits [1;2]
- Adult dependents up to age 26 must be offered coverage [1;2]
- Elimination of any pre-existing condition periods [1;2]
- Waiting periods cannot exceed 90 days from date of hire [1;2]
- Fee collection starts: reinsurance fee, PCORI, health insurer premium tax. [1;2]
- Max Out of Pocket (MOOP): $6,350 Single & $12,700 family for all Fully Insured and Self-Funded NG plans [2]

1 Grandfathered

2 Non-Grandfathered

2015 ACA Provisions (51+ groups)

- Employers with 50 full-time equivalent employees must offer health coverage or be assessed a penalty. Part-time or seasonal employees can add up to more than 50 full-time employees.
- Max Out of Pocket for Self Funded groups must include Rx copays not to exceed the IRS limits. $6,350 Single & $12,700 Family (2014 limits – indexed in future years)

2018 ACA Provisions (100+ groups)

- Excise tax on high-cost group plans: tax imposed on value of "excess" coverage starts January 2018

TBD ACA Provisions

- Large plan auto enrollment requirement: plans must automatically enroll all new full-time employees and continue enrollment of current employees
- Nondiscrimination rules apply to insured plans
- Quality of care reporting requirement to Department of Health and Human Services and enrollees; annual report on whether plan fulfills quality requirements

Will rates go up because of ACA changes?

- Rates are expected to rise, given that all plans are affected by ACA guidelines in some way, including new fees that apply to Fully Insured and Self Insured groups, it is expected that insurance rates will be affected. Each groups situation will be unique.

Will rates go up because of ACA changes?

Fully Insured:

- Affordable Care Act Assessment taxes and fees started March 2013
- Reinsurance fee, PCORI fee, Health Insurance Providers Fees
- Fees prorated in 2013
- Full impact starts in 2014

Will my rates go up because of ACA changes?

Self Insured:

- Most carriers will not handle collecting fees and taxes requiring employers to pay directly to the Government
- Affordable Care Act Assessment taxes and fees started March 2013
- Reinsurance fee, PCORI fee
- ACA insurer fee does not apply to Self Insured plans
- Full impact starts in 2014

2014 ACA Provisions

Maximum Out of Pocket Provisions : MOOP

- Non-Grandfathered plans only
- $6,350 Single (2014 MOOP, indexed thereafter)
- $12,700 Family (2014 MOOP, indexed thereafter)
- Insured : Deductible, Co-Insurance, Copays to include Rx copays starting 2014
- Self-Insured: Deductible, Co-Insurance, Copays. Rx copays may be delayed until 2015.
- No limit on the Deductible and Co-Insurance for out-of-network benefits.

2014 ACA Provisions

MOOP?

•Regardless of the size or funding type, MOOP's apply to all Non-Grandfathered plans

•This means no non-grandfathered plans can have a MOOP in excess of $6,350 Single and $12,700 Family starting in 2014

•This includes all HSA, HRA and other CDHP type plans regardless of final financial impact to the member.

•GAP coverage and other third party type plans that traditionally would pick up the difference in the members cost are not considered payable by the carrier are not included in the MOOP

ACA Pay or Play

- Pay or Play rules have been delayed until 2015
- Must offer FT employees affordable coverage that meets minimum value or potentially pay penalties
- Some movement to having part-time employees work less than 30 hours per week so as not to be counted as full-time
- Some companies will need to increase benefits and/or contributions for employee classes

Challenges of ACA in 2014

- Dramatic change to each market
- Massive infrastructure changes
- Communications
- Resources
- Extremely short implementation timeframes for issuers, employers, brokers/agents and providers
- Still awaiting numerous final rules
- Still awaiting proposed rules

Private Exchanges

- Initially established for Post Retirement Medical benefits in order to reduce the PRMB Obligation – set up as a defined contribution approach for retiree benefits
- Gaining in popularity for Large Groups partially due to public and private exchanges in the Individual and Small Group segments
- Interest in defined contribution and marketplace of choices
- Employees given a variety of benefit choices from several carriers
- Employer may be able to limit benefit choices and carrier choices depending on the exchange design
- Employer may have some flexibility in contributions to the various options
- Consumer friendly systems needed to help guide through the Myriad of choices (small/limited networks, varying degrees of managed care, Consumer driven products, etc…)

Private Exchanges

Issues with PIX design:

Fully-Insured:

Pros:

- Defined contribution – employer and employee contribution known in advance
- Menu of carriers/benefit plan options – Offers employees a lot of choice
- Options Carrier/Plan options can be customized to employer
- Can offer many coverage's – health, dental, vision, legal services, etc…

Cons:

- Ultimate slice business – very hard to price benefit options even if competitor prices known
- Consumers select plans in their best interest. Healthy risks usually opt for the lowest cost option – hence carrier competition for less rich benefit options is based on favorable selection not necessarily based on better provider networks or customer experience

Private Exchanges

Issues with PIX design:

Self-Funded:

Pros:

- Menu of carriers/benefit plan options – Offers employees a lot of choice
- Options Carrier/Plan options can be customized to employer

Cons:

- Not defined contribution
- Consumers select plans in their best interest. Healthy risks usually opt for the lowest cost option – hence

  Carrier competition for less rich benefit options is based on favorable selection not necessarily based on better provider networks or customer experience
- Carriers don't have insured risk – hard to establish discount guarantees
- How are prices set between carriers?

Self-Funded Discounts

- Due to rising popularity of small/limited networks and ACO and other managed care strategies, large consulting firms are developing PMPM models to better evaluate competitors
- Discounts are OK when all competitors have the same network, little variation in managed care arrangements with providers and similar claim system edits

Self-fund

- Smaller groups becoming self-funded
- Small group definition will be 1 to 100 FT Equivalent in 2016
- 3 to 1 rating restriction in small group market creates incentive for "younger" groups to self-insure
- Actual to Expected annual claim variation for smaller groups is significant – lower specific and/or aggregate stop loss thresholds are needed to help stabilize a groups losses (makes budgeting for health care expenses difficult)
- The health insurance premium tax/fee will ultimately be more than an additional 3%, this is not paid by self-insured groups
- Premium tax is also avoided

Small Group/Large Group Definition

- Definition of small group for employer mandate:
  For 2015 , large employer is defined as an employer who employed an average of at least 50 full-time equivalent (FTE) employees on business days during the preceding calendar year. For 2015, the preceding calendar year is 2014.
- Size is determined monthly by adding the number of full-time employees to the number of FTE employees.
- Full-time employees are individuals who have worked an average of 130 or more monthly hours (30 hours per week).
- Part-time and seasonal employees' hours will be converted into FTE employees for determination of employer size.

Small Group/Large Group Definition

- In 2016, Small group market definition increases to businesses with up to 100 average FTE employees in the preceding calendar year to the effective date of coverage, making more businesses subject to the essential health benefits package and all other insurance market reforms.

Other Trends

- Large Claims
  - Due to the removal of annual and lifetime maximums, very large claims are expected to increase in frequency (not just a large group issue)
  - Reinsurance needed to cover the removal of limits – this can mean specific coverage, but there is also a need for "lifetime" coverage. (lasering may become an issue as reinsurers try to determine how to meet the need and have risk mitigation techniques in place)
- Health Cost Trends
  - Historically low trends in recent years
  - Hospitals losing DSH revenue (driver) offset by increase in revenue from previously uninsured
  - Uninsured subsidized on Public exchanges and in some states Medicaid expansion – could lead to provider capacity issues (lower utilization trends for group business)
- MV/SBC – providing minimum values to fully insured groups to meet federal reporting requirements

Fun Facts (for Actuaries)

- If an employer provides $1 in an HRA to an early retiree, the early retiree does not qualify for any premium or benefit subsidies on the Exchange
- A 60 year old will pay less (unless both are $0) than a 25 year old on the Exchange if they have the same income and are subsidized and buy down to the Bronze level of coverage (since subsidy is at second Silver)
- A non-grandfathered 2014 compliant benefit of $6,350 deductible and 100% thereafter meets minimum value, but there are other NGF 2014 compliant benefits that don't meet minimum value