

Health Care Reform: Annual and Lifetime Limits and Leveraging Stop-Loss Coverage

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Agenda

- The Removal of Limits and the Cost Implications
- Essential Benefits
- Waivers
- Tough Choices Regarding Insured vs. Self-Insured
- Stop-Loss Pros and Cons
- Upcoming Issues Affecting Health Plans

Changes Health Care Reform Requires



- Plan sponsor exposure to high-dollar claims will increase due to:
 - Elimination of Lifetime Maximums (2011)
 - Elimination of Annual Maximums (2014)
 - Mental Health Parity (now or in subsequent years)
 - Dependent eligibility rules (no pre-existing conditions and to age 26)
- Health Funds that offer coverage no longer able to provide limited dollar benefits
 - Revisit part-time plans
 - Waivers available for annual dollar limits
- Insurance reforms change funding option dynamics for health plan sponsors
 - New Medical Loss Ratio Requirements
 - New underwriting rules
 - New taxes
 - Changes to cost-savings equation between fully insured and self-funding arrangements
 - New viability of stop-loss coverage for many self-insured plans

**Health Care Reform increases
fund financial exposure**

Polling Question

Does your plan currently have lifetime dollar limits?

➤ Yes

➤ No

Removing Lifetime and Annual Dollar Maximums

- No lifetime dollar maximums on essential benefits effective for the first plan year after September 23, 2010
 - Annual limits on the dollar value of benefits that are essential health benefits may not be less than the following amounts for plan years beginning before January 1, 2014:
 - \$750,000 for plan years beginning on or after September 23, 2010,
 - \$1.25 million for plan years beginning on or after September 23, 2011, and
 - \$2 million for plan years beginning on or after September 23, 2012
- **37188 Federal Register** / Vol. 75, No. 123
/ Monday, June 28, 2010



Range of Potential Cost Increases for Health Funds

Expanding dependent children eligibility to age 26	+1% to 4%
Remove lifetime limits (e.g., \$1 million)	+0.25% to 0.50%
New taxes on insurers and medical device companies passed on to plans	+1% to 2% on insured plans
New research fees (2013)	+\$2 per covered life/year (\$1 initial year)
Increased administrative costs <ul style="list-style-type: none"> • Communications expenses (documents, enrollment costs) • Added professional fees • W-2 production (if required) 	Vary by plan
Provider cost shifting to group health plans from expanded Medicaid and Medicare enrollment	Unknown
New plan expenses <ul style="list-style-type: none"> • 100% Preventive services (for non-grandfathered plans) • Clinical trial procedure expenses (2014) 	+1% to 3%

Essential Health Benefits

- Plan sponsor may make a reasonable judgment about what is or is not an “essential health benefit”
- Agencies have said they will not challenge that determination, assuming it is reasonable and applied consistently in the plan
- Guidance on “essential health benefit” definition will not be out until HHS makes rules on what benefits must be covered in the Exchanges



Essential Health Benefits *continued*

- Section 1302(b) of the ACA defines essential health benefits to include at least the following general categories and the items and services covered within the categories:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health and substance use disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care

Government Waivers: Available Yet Temporary

- Waivers on annual limits are temporary
 - Must apply each year for waivers
 - Most plans are getting approval
 - By 2014 all annual limits on essential benefits must be eliminated
- Waiver application process relatively straightforward
 - Data requirements
 - Timing
 - Demonstrate removal of limits will create significant cost increase or significant decrease in access to benefits
- Plan cost increases for removing annual limits under \$200,000 can be dramatic for Funds



Tough Choices Ahead for Limited Benefit Plans

➤ Groups that sponsor limited benefit plans need to consider options

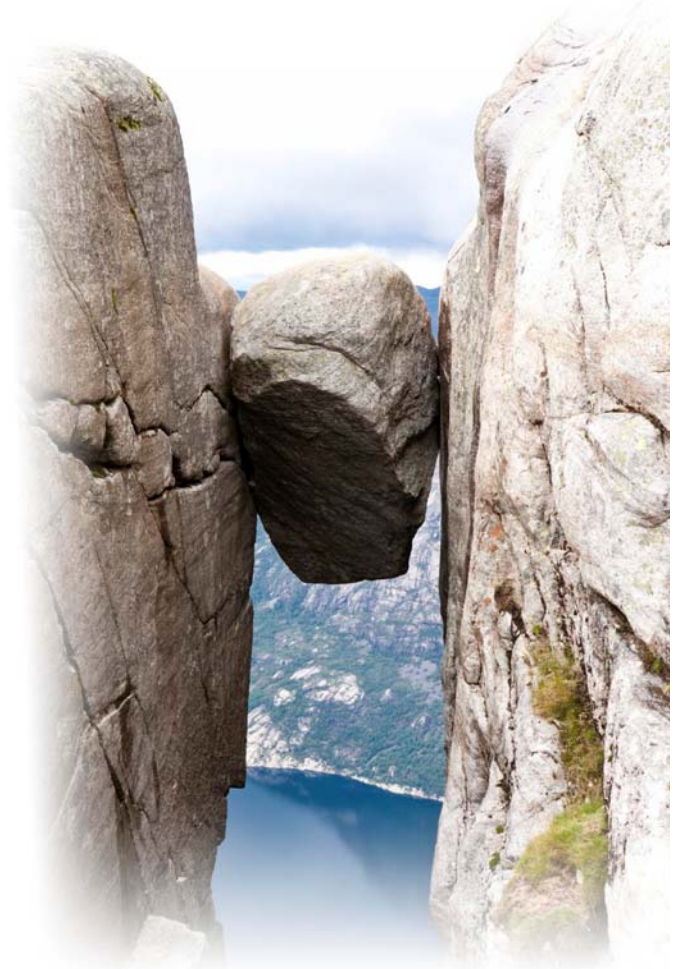
- Bargain for greater contributions (income)
- Modify plans to remove limits
- Eliminate ancillary coverage
- Offer ancillary coverage only and eliminate core medical plans
- Self-pay employee contributions

➤ Remove limits and replace with new unlimited plans, offset cost by:

- Increased front-end deductibles
- Higher copays or member coinsurance
- Deeply discounted HMO restricted panels

➤ Grandfathered status may need to be forfeited to offset cost to remove limits

- Preventive services
- External appeals



HOW BEST TO HELP MITIGATE COST AND RISK INCREASES?



Insurance vs. Self Funding Health Benefits

- The costs to stay fully insured may become more expensive
 - New federal taxes add to state taxes
 - Restrictions in underwriting tend to raise rates for most groups
- Value of self funding
 - Avoids premium taxes (to be increased by health reform)
 - Avoids insurer underwriting or risk charges
 - Provides positive cash flow when actual case claim experience is lower than insurer-forecasted trends that are passed on in higher premiums
 - Avoids some state mandates that can reduce flexibility
- Self funding the liability is potentially still too risky for some groups
 - Not enough reserve cushion
 - Cash-flow constraints
 - Unsettled workforce

**The funding choice
calculus has changed.**

$$\begin{aligned} 5x - 40 + 2x + 10 &= 180 \\ 7x - 30 &= 180 \\ +30 &+20 \\ \hline 7x &= 210 \\ /7 & \\ x &= 30 \end{aligned}$$



Value of Stop Loss

- Provides a protective layer of coverage to those plan sponsors looking to reduce costs through self funding
- Stop loss protects reserves and plan assets
- Stop-loss coverage can soften the strains of volatile claim fluctuation in any given period



Health funds should evaluate risk from both underwriting and cash-flow perspectives.

Polling Question

Which plans in the audience already have Stop Loss Coverage, who does not and who is actively considering it?

- We are fully insured (stop loss not relevant)
- We have stop loss coverage and may consider changes
- We have stop loss coverage now and are not considering changes
- We do not have stop loss coverage and are not considering adding it now
- We do not have stop loss coverage now but we are actively considering it

Which Plans Should Consider Stop-Loss Insurance?



1

Plans now dealing with unlimited liabilities for first time

2

Plans trying to maintain self-funded status

3

Insured plans looking to self funding as a way to avoid additional or escalating insured costs

Stop-Loss Policies Mitigate Some Self-Funding Risk



- Stop-loss coverage can absorb some of a plan sponsor's exposure to high-dollar claims due to elimination of annual and lifetime maximums
- Stop-loss coverage can absorb some of the excess expenses due to new medical technology and growth of intense medical treatments with high price tags
 - \$200,000 per specialty medications
 - Increased frequency and cost of premature neonatal birth rates (e.g., \$500,000 cost for extremely premature twins)
 - \$300,000 dialysis
 - Increased long-term survival rates of cancer patients (also increase chance of large claims)

Stop-Loss Funding Policy Variations

➤ Conventional stop-loss policies include:

- **Specific or Individual Stop-Loss Coverage**—After a per-individual deductible level is reached in any plan year, the insurer reimburses the plan for paid claims above the individual deductible. This coverage protects a plan against the adverse economic losses of multiple high-cost claimants.
- **Aggregate Stop-Loss Coverage**—Provides reimbursement for claims above an overall plan cost target. Typically, 125% of expected annual paid claims. Caps a plan's overall spending risk. Corridors of 125% still expose plans to substantial excess expenses.



Stop-Loss Funding Policy Variations

- Several variations of traditional coverage arrangements have emerged in recent years that are worth consideration:
 - **Aggregating Specific**—In addition to the specific coverage, a plan would need to reach an overall aggregate plan deductible before excess claims are reimbursed.
 - For example, a plan has \$100,000 specific with \$200,000 aggregate deductible—no reimbursement occurs until in aggregate \$200,000 of reimbursable expenses is reached
 - **Split Funded Aggregate**—
Allows plan sponsors to purchase lower aggregate stop-loss thresholds
 - For example, 110% of total plan cost estimates but only reimburses up to 50% of the excess liability



What Clients are Doing

- Those without stop loss currently considering it and weighing their options
- Increased bid activity with those that currently have stop loss
- Requesting renewals early, to assess the need to bid
- Reviewing current protection levels for adequacy



Stop-Loss Contracting

- It's not just about price
- Stop-loss insurers can be like PBMs, look for complex exclusions and terms that change the value of competing policies
- Plan sponsors should require:
 - Greater transparency and consistency of underwriting process
 - Higher aggregate limits
 - Competitive premium rates
 - Custom terms that best meet needs
- Understand disclosure and audit requirements
- Other Issues that need to be addressed:
 - Insurer “lasering” individual claimants from coverage (exclude from future coverage)
 - Annual payout limits on stop-loss coverage that are too low to protect assets
 - For example, stop loss policy with a \$1 million annual payment limit on a \$100 million per year health plan

Stop-Loss Contracting

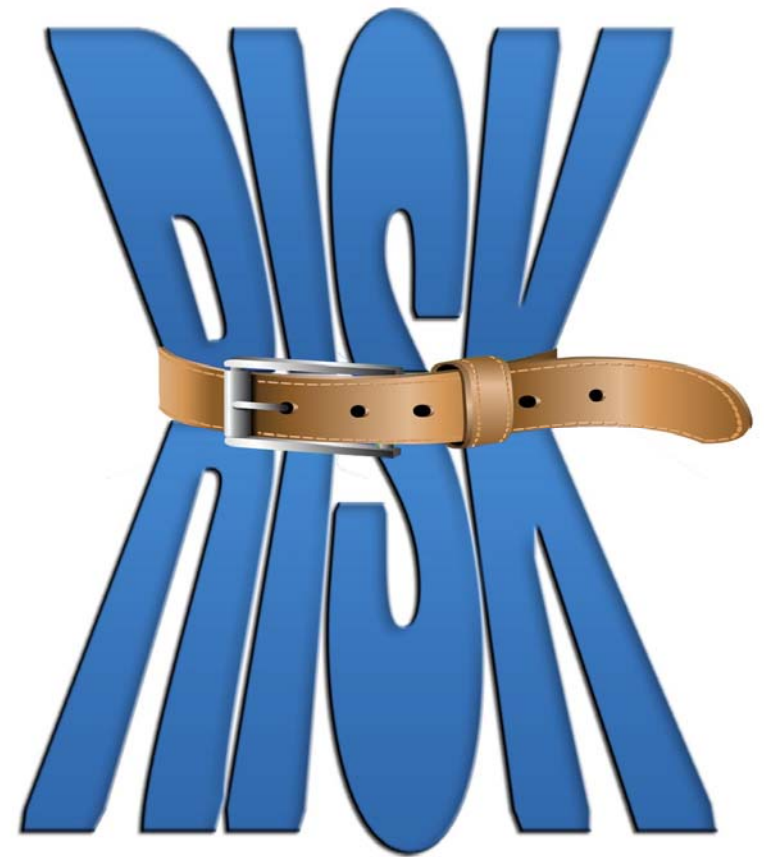
➤ What to look out for:

- Stop-loss carriers replacing lifetime maximums with annual maximums, even if not requested, and even if the underlying plan does not include an annual maximum
- Increased diligence in collecting disclosure information both at new business and renewal
- Actively at work and pre-ex conditions may be enforced if no disclosure information
- Mismatch of medical necessity and experimental procedure definitions between the policy and the underlying plan
- More frequent lasering than before



Focus on Reducing Risk of High-Cost Claims

- Invest in prevention and population health improvement
- Contract with national centers of excellence and large-case management programs to improve claim experience
 - Deep discount, high-quality cardiac and cancer facilities
 - Dialysis centers
 - National specialty pharmacy deals



Upcoming Issues Facing Health Plan Sponsors

- Plan soon to avoid the 40% excise tax on high-cost plans
- State exchanges, free-choice vouchers and subsidized premiums
- Mental Health Parity
- Economic uncertainty will likely continue
- Political uncertainty will likely continue

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Health Care Reform Guide

After discussing, debating and analyzing for over a year, Congress passed health care reform legislation in March 2010. Throughout the process, Segal has provided timely updates on the latest developments and guidance on how health care reform will affect your health plan.

Below, we have gathered the resources that we are producing to help you as you move forward in making your plan compliant with the new law.

Health Care Reform Timeline for Calendar-Year Group Health Plans

Segal Publications

- September 8, 2010 *Capital Checkup*, "Guidance on Annual Limit Waivers Released"
- August 2010 *Bulletin*, "Agencies Release Regulations on Preventive Care under the Affordable Care Act"
- July 2010 *Bulletin*, "Latest Agency Regulations Address the Affordable Care Act's Rules for Group Health Plans"
- June 2010 *Bulletin*, "Regulations on 'Grandfathering' under the Affordable Care Act"
- June 2010 *Health Care Reform Insights*, "Rules on Coverage for Children Clarified"
- May 2010 *Health Care Reform Insights*, "Retiree Reinsurance Program: Implementation Details"
- May 2010 *Bulletin*, "Regulations on Group Health Plan Coverage of Adult Children Released"

Articles and Podcasts by Segal Consultants

- Talking Points: First Steps of Health Care Reform Podcast with Dean Hatfield on PLANSPONSOR.com

Webinar Recordings and Slides

- Health Care Reform: Understanding Grandfathering and Other Recent Regulations [Webinar Recording](#) | [Slides](#) July 15, 2010
- Health Care Reform: Practical Implications for Multiemployer Plans [Webinar Recording](#) | [Slides](#) April 13 and 14, 2010
- Health Care Reform: Practical Implications for Public Sector Plans [Webinar Recording](#) | [Slides](#) April 13-14, 2010

Announcements

Segal is pleased to announce that **Jessica R. Bernanke** has joined our National Health Compliance Staff as a Senior Compliance Specialist, located in our Washington, DC office.

Ms. Bernanke's work focuses on regulatory issues related to health care reform under the Affordable Care Act, ERISA, HIPAA, COBRA and other health and welfare plan matters.

Related Content

- 2011 Segal Health Plan Cost Trend Survey
- Guidance on Annual Limit Waivers Released
- Health Care Reform: Understanding Grandfathering and Other Recent Regulations
- Kaye Pestaina to Assist with Implementation of ACA

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Health Reform Resources

➤ Health Care Reform Timeline

	Provisions Directly Affecting Existing Group Health Plans	Medicare Reforms	Other Health Reforms
2010	<ul style="list-style-type: none"> Retiree reinsurance program Fee-free coverage for children through end of year child turns 26 Small business tax credits 	<ul style="list-style-type: none"> \$20 reimbursement in Part D coverage gap ("doughnut hole") 	<ul style="list-style-type: none"> Temporary high-risk pool DOL to require Multiple Employer Welfare Arrangements (MEWAs) to register with DOL
2011	<ul style="list-style-type: none"> No lifetime dollar limits on essential benefits Only permitted annual dollar limits Extension of coverage for adult children until age 26 No preexisting condition exclusion for children under 18 Ban on rescinding coverage Prohibit Spending Arrangements/Health Reimbursement Arrangements/Health Savings Accounts from the monthly contribution deductible only with prescription 	<ul style="list-style-type: none"> Additional Prescription Drug Plan (PDP)/Medicare Advantage plan with prescription drug coverage (MA-PD) discounts for blind and severely disabled PDP/MA-PD may waive copayments for first 60 days of generic Medicare Advantage payments frozen at 2010 levels Medicare Part D premiums increased for high-income beneficiaries New Medicare wellness benefits 	<ul style="list-style-type: none"> Higher penalty for Health Savings Account withdrawals for non-qualified expenses Medical loss ratio requirements for insurers (85% for large groups) CLASS program (voluntary public long term care program) Annual fee on pharmaceutical manufacturers and importers
2012	<ul style="list-style-type: none"> Employer W-2 reporting on 2011 coverage Standardized information disclosure (with notice of modification 90 days in advance) Comparative effectiveness research fee paid by insurers and self-insured plans beginning plan year ending after September 30, 2012 (\$2 per covered life, \$1 in first year) 	<ul style="list-style-type: none"> Medicare Advantage payments decreased 	
2013	<ul style="list-style-type: none"> FSA contributions capped at \$1,200 (pre-tax) 	<ul style="list-style-type: none"> Corporate health plans lose tax deduction for Part D Retiree Drug Subsidy enhancements 	<ul style="list-style-type: none"> Increases in Medicare Hospital Insurance fee for high-income individuals Annual fee on medical device manufacturers and importers
March 1	<ul style="list-style-type: none"> Employer notice to employees about the Health Insurance Exchange 		
December 31	<ul style="list-style-type: none"> Plans to certify compliance with certain Health Insurance Portability and Accountability Act (HIPAA) Electronic Data Interchange (EDI) standards 		

* Most of the provisions in this table are effective for the calendar year 2010. Some provisions are effective for the calendar year 2011, and some are effective for the calendar year 2012. For example, for a plan with a 1-year plan year, all of the provisions listed in the table are effective for the first plan year for 2011, and for the second plan year for 2012.

➤ Issue Briefs

➤ STAT!

➤ Bulletins

➤ NewsLetters

➤ Webinar recordings and slides

www.segalco.com/health-care-reform/

Questions

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