LARGE...

but Not Necessarily "In Charge"

by Grant Matthies

The definition of a large employer under the myriad of federal and state requirements is unclear to say the least. For more than a decade, as health insurance reforms swept across the nation at the state level, having 50 or more employees was the standard threshold used to qualify large employers. Fortunately, the recent passage of the Patient Protection and Affordable Care Act (PPACA) in March 2010 created some clarity in the definition of what constitutes a large employer; therefore, for purposes of this article, we will use 100 or more employees as the basic definition of a large employer.

Healthcare reform poses unique compliance challenges for large employers and the manner in which future decisions will be made in preparation for full-scale implementation of PPACA in 2014. Mandated changes are expected to affect all health plans with renewal dates starting October 1, 2010. Furthermore, additional changes will be required should a plan lose its "grandfathered status." This article summarizes key items to consider as we embark on the path towards compliance.

Mandated changes

Key changes required for all health plans with renewal dates starting October 1, 2010 include the following:

1. No lifetime limits on essential benefits.
    a. Restricted annual limits on essential benefits are allowed.
    b. It appears that most health plans will have no limits.
2. No rescissions except for fraud or misrepresentation.
3. Insurance carriers must provide dividends or rebates if minimum loss ratio requirements are not met.
    a. This applies to fully insured plans only; the loss ratio for large employers is 85%.
    b. Further clarification of factors affecting this calculation is forthcoming.
4. No preexisting exclusions for individuals under age 19.
5. Coverage must be provided to adult children up to age 26.
    a. Until 2014, grandfathered plans are not required to provide coverage if the child is eligible for another employer-sponsored health plan, specifically at their place of employment.
    b. Coverage for spouse and/or children is not required.

The impact of the mandated changes on healthcare costs could range from 1–4% of total plan costs, depending on the current benefit structure.

Grandfathered status

Employers will have to make important annual health plan decisions, including the level of benefits to provide and the cost to employees, as well as evaluation of which insurance carrier or claim administrator to use. President Obama has said on several occasions during the healthcare reform debate that "if you like the insurance plan you have, you can keep it." A practical interpretation of this comment might mean that if an employer makes no changes (or only minor ones) to its current program, then the plan may not have to comply with some of the PPACA provisions because it will have grandfathered status. However, this scenario seems fairly unrealistic, considering that we have not seen a reduction in utilization patterns or in the unit cost of healthcare services, thus resulting in annual claim trend increases between 11–14%.

Employers will need to make decisions that continue to meet their financial objectives, even if such decisions result in the loss of their plan's grandfathered status. Adjusting certain benefits such as deductibles, co-payments and coinsurance, changing employee contributions and/or moving to an alternative funding arrangement all have the potential to cause a health plan to lose its grandfathered status. An interesting rule to keep in mind: a self-insured plan that changes claim administrators will not lose grandfathered status, but switching plans from insured to self-insured (or vice versa) will.

For large group health plans, the loss of grandfathered status results in the following new rules:

1. No cost-sharing for preventive health services, which means that there cannot be a co-pay, coinsurance, deductible or maximum benefit.
2. No discrimination in favor of highly compensated individuals.
    a. This is restricted today under self-insured plans, so the likely impact is small.
    b. One area to review is whether or not an executive medical reimbursement program is in place and to make sure that it does not accidentally cause a change in status.
3. Direct access to OB-GYNs and pediatricians without referral.
    a. Unless a plan has a managed care option with a gatekeeper feature such as a Health Maintenance Organization (HMO) or certain Point of Service (POS) plans, members of the plan already have this option.
4. Coverage for emergency services must be paid the same, whether provided in-network (PPO) or out-of-network (non-PPO).
5. Mandatory compliance with a new internal and external claims and appeals process.
6. Coverage must be provided for clinical trials.
7. New annual quality reporting requirements will apply.

The impact of losing grandfathered status is estimated to be an additional cost of 0.5-2.5% of total plan costs, depending on the current benefit structure. However, if a health plan receives a double-digit increase in costs at renewal, it will still be necessary to review all options in order to meet cost objectives. Ultimately, losing grandfathered status may not result in a significant change, and most experts agree that within the next 2 or 3 years there will likely be few large employers who are able to maintain grandfathered status.

Adding a new plan

Many employers may want to know how their grandfathered status would be affected if they not only kept their current plan(s) in place, but decided to add a new one. For example, many employers have evaluated high deductible health plans that can be paired up with a health savings account as an option for employees to choose from during open enrollment. Although a new health plan is not grandfathered, an employer could have some plans grandfathered and others that are not, as long as the insurance carrier or claims administrator is willing to allow both types in their current system platforms.

If the addition of a new plan is being considered, it would be prudent to ascertain the long-term effects of such an addition.

Reinsurance

Self-insured health plans generally utilize reinsurance to cover catastrophic claim costs on both an individual and group level. A common misperception is that the reinsurance is part of the health plan, when, in fact, it is a financial arrangement. Therefore, the structure of the plan could potentially be different from what would be considered an eligible claim under the reinsurance program. This is important because all medical plans will likely move to an unlimited lifetime maximum. Reinsurance contracts historically have annual or lifetime maximums in the contract, and a self-insured employer will want to review the contract at renewal to make sure that they are comfortable with the amount of risk being assumed by the health plan.

Should the funding arrangement change?

There are benefits and risks associated with being fully insured or self-insured. The actual benefits under a plan do not dictate funding, such as the deductible, out-of-pocket expenses and coinsurance. The size of the health plan and an employer's tolerance for fluctuating costs associated with the assumed risks have a much more significant impact on funding.

Self-insured plans are typically exempt from compliance with state insurance mandates, but are required to follow federal mandates. Therefore, many of the requirements under PPACA that impact benefits will apply to all employers, regardless of the funding arrangement. There are some key cost changes for insured plans, such as a minimum loss ratio requirement as previously discussed, as well as an insurer tax that will be applicable in 2014 that could create more incentive to be self-insured. Self-insured plans will also have a per participant fee assessed starting at $1 in 2012 and increasing to $2 from 2013 through 2018. The bottom line is that employers should talk to their benefits consultant to determine what funding arrangement is best based on overall circumstances rather than relying on the new PPACA regulations to sway them one way or another.

Final thought

Fortunately, large employers *do* seem to have more choice and flexibility when it comes to compliance with PPACA. Upcoming elections in 2010 and 2012 may further alter the compliance landscape, as well as the expected barrage of impending regulations. We urge everyone to continue to stay abreast of what is happening and rely on your benefit experts to make sure appropriate decisions are being made.