MARSH & McLENNAN AGENCY

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EMPLOYEE BENEFITS STRATEGY FOR 2015

UNDERSTANDING PLAN DESIGN OPTIONS UNDER THE ACA

CONTENT:

AS REFORMS TAKE EFFECT, NOW IS THE TIME TO PLAN

For all the aggravations and confusion created by health care reform, the basic equation of health benefits remains the same for employers: to attract and retain the best talent, a good health plan is an essential part of any benefits package.

And with the ongoing changes brought about by the Affordable Care Act (ACA) it's never been more important to have a clear understanding of the options available to your company, as you consider the latest regulations, industry trends, and innovations.

By the time open enrollment begins for 2015, many of the major ACA reforms will be place. But ongoing delays and modifications to the law require employers to pay close attention when planning for the future. What steps can you take now to prepare for tomorrow's status quo? It's never too early to lay the foundation for a strategy that will position your company to be a leader in the health benefits world, as opposed to still struggling to catch up.

"A fully-insured company lets their insurance carrier take most of the burden."

PLAN DESIGN: WHICH OF THE FOUR MAIN OPTIONS ARE THE BEST FIT FOR YOU?

So let's look at some of the pros and cons of the health benefit options available for employers. For the purposes of this article, we'll break these into four categories: fully-insured, self-insured, defined contribution, and no coverage. Within the four options, there are several considerations, including financial, administrative, and compliance issues.

FULLY INSURED

Generally speaking, the fully-insured route will appeal to employers who want to maximize ease of administration and minimize risk. A fully-insured company lets their insurance carrier take most of the burden. It offers certainty; you know upfront what your costs and premiums will be. It allows for easier budgeting and planning. And you can rely on the carrier's already-negotiated agreements with providers—large carriers can usually contract with providers at a significant discount.

Due to ACA fees on **fully insured plans**, health insurance carriers may increase premiums 2-3%.

From the administrative standpoint, this is also the easiest option. You send the check in. The carrier will do most of the administrative work; they manage the claims and provider relations, as well as most of the regulatory side.

However, the big carriers will probably offer very rich benefit sets, and will be subject to more of the regulatory requirements, mandates, and higher taxes that come with the ACA

than with self-insured plans. For example, beginning this year the ACA requires insurance carriers to pay a health insurance industry fee on fully-insured plans. This fee is basically a sales tax, and according to some estimates will result in a 2 percent to 3 percent increase in premiums for most fully-insured plans.

As with most industries, higher taxes and fees will be passed on to the consumer. In addition, fully insured plans generally have less flexibility in plan design, and will need to rely on the insurer (in most cases) to provide customer service and answer employee questions. Sometimes that works well; other times it may not.

SELF-FUNDED PLANS

Put very simply, self-funded plans offer lower premiums and more flexibility at the cost of assuming more financial risk. Self-funded plans have traditionally not been subject to coverage mandates that fully-insured plans must comply with, and so have tended to be less expensive. With the passage of the ACA, that advantage has been affected, but not as much as one might expect.

Although the ACA included a requirement that all insurance plans cover an "essential benefit set," federal regulators have punted, to some degree, on defining those essential benefits. State insurance commissioners are largely in charge of defining essential benefits, so the benefit sets vary from state to state. And companies that choose a national carrier to administer their self-funded plan may find an insurer that has chosen a state with a relatively slim essential benefit set—which could hold down costs. But of course the employer also has to ask how skimpy they want their plan to be—and what effect that might have on employee recruitment, retention, and morale. Employers are not, of course, required to offer the minimum; it's this flexibility with self-funded plans that allows companies to offer a customized health plan that creates a good fit for their employee population.

However, the ACA has several provisions that will make self-funded plans more uniform in coverage—and to some degree, more like fully-insured plans. For example, plans can no longer have annual or lifetime dollar limits on benefits deemed essential. Dependents must be covered by all plans and plans cannot exclude or restrict coverage for enrollees with pre-existing medical conditions. Moreover, there is 100-percent coverage for certain preventive treatments, and enrollee out-of-pocket costs have been capped at no more than $6,350 for an individual plan and $12,700 for a family plan in 2014. For both fully-insured and self-insured plans, the expanded coverage may mean higher premiums. But it could have a more noticeable affect on self-funded plans, which traditionally found it easier to tailor their coverage and therefore avoid some of the costs of these kinds of provisions.

Another downside to the self-funded approach is that companies assume more financial risk. This requires a more sophisticated approach and a close working relationship with whoever administers or oversees the plan, typically a carrier or third-party administrator (TPA). Employers have much more skin in the game here, and can have input in designing the various plan components.

"Put very simply, self-funded plans offer lower premiums and more flexibility at the cost of assuming more financial risk."

The ACA added several requirements to **self-funded plans**, including:

- No annual or lifetime limits on essential benefits
- Dependents must be covered
- Plan cannot exclude or restrict coverage based on pre-existing medical conditions
- 100% coverage for certain preventive treatments
- Out-of-pocket costs have been capped

The additional financial risk means an employer has to be prepared for fluctuations in budgeting, since health costs can swing by tens of thousands of dollars—or more—from month to month. Establishing and maintaining adequate and accurate financial systems that account for not only premiums, but also reserve build-up, market fluctuations and potential incentive plans is therefore essential. An experienced TPA or carrier that handles a lot of self-insured customers provides some security, as will stop-loss insurance, but the final risk is still the employer's.

"The defined contribution plan is relatively new but its popularity with employers has grown quickly."

DEFINED CONTRIBUTION

The defined contribution plan is not new but its popularity with employers has grown quickly. This model differs from the traditional defined benefit because the employer gives the employee a set amount to purchase health insurance, rather than setting the benefit and then figuring out the costs.

With the rise of defined contribution, many insurance carriers have come up with "private exchanges," which allow employees to shop amongst a range of plans. Usually the employer works with the insurer to offer their employees several plan options, and the employee uses their money to buy a plan that best fits their needs.

This approach can significantly lower costs for employers. However, the ACA includes a requirement that companies provide 60 percent of the cost of insurance, so although these plans may involve some cost-shifting to employees, companies still pay a healthy share of the health benefit costs. And of course, the new ACA rules on expanded coverage (mentioned above) apply to defined contribution plans as well.

Under a **defined contribution plan**, the employer provides a set amount to employees, allowing them to select their coverage.

Administration is typically less burdensome and it's "consumer-driven."

The ACA requires employers to pay for 60% of the cost.

While standard defined contribution models can add some administrative burden to employers due to additional payroll and COBRA administrator interactions, and more benefit choices to manage and explain to employees, etc., the administrative role is simplified under many private exchanges. Since the employee is choosing the level of benefits from a menu provided by the insurer, the employer correspondingly has less responsibility for the benefit plan, and the carriers offer online decision support for employees taking this route.

This "choice" feature continues to be one of the more interesting aspects of the defined contribution model. Any physician will tell you that consumers now come to office visits armed with information (of varying degrees of accuracy) found on the Internet. And with the amount of media attention given to the government exchanges, it's likely that consumers will continue to embrace a more active role for themselves as health care consumers. The private exchange model encourages that activism and makes consumers feel more involved in their health care—creating an example of how private industry innovation and health care reform ideals have found common ground.

DROPPING COVERAGE

Although some employers may want to respond to the many changes brought about by the ACA by throwing up their hands and dropping health coverage completely, this is

generally the worst option. For smaller employers (typically, those with fewer than under 50 workers) the decision to not offer coverage or to drop coverage may be feasible; under ACA rules, those small employers are not required to cover workers. Employers with 50-99 workers have recently been exempted from this requirement for 2015, but the requirement is expected to be fully in place for 2016. For everyone else, though, not offering health insurance may be the riskiest strategy of all.

Under the "play or pay" language of the ACA, if an employer with 100 or more FTE employees in 2015 (50 or more in 2016)—which under the health reform law means 30 hours a week—does not provide coverage and one of those employees goes and purchases health insurance on the insurance exchange, that employer will be required to pay a $2,000 penalty for every employee, minus the first 80 employees (30 in 2016).

If a company does offer insurance to 70 percent of its employees in 2015 (95 percent in 2016), it's off the hook for that $2,000 penalty. However, if its health plan doesn't meet ACA requirements for affordability or minimum value, the employer is assessed a $3,000 fee for every employee who seeks coverage on the insurance exchange. These regulations are complicated, and have been subject to change as various parts of the ACA have been delayed. We'll explore the "pay to play" regulations, as well as other issues, in more depth with future articles.

But even given the complexity of the ACA rules, skimping on health coverage is even more of a minefield; and there is an additional cost: the money not spent on providing health benefits is now taxable. When all these factors are weighed, the benefits of dropping coverage are very questionable, when considering the downside.

MOVING FORWARD

Of course, questions will remain about how employers can be sure their plans qualify as affordable or whether they meet the essential benefit standards. Employers will also have to think carefully about which employees are classified as part-time, temporary, or seasonal workers. Sitting down with financial and health benefit advisors and carefully going over your company's policies will be essential to help your company be fully prepared for the health care landscape in 2015.

As we noted at the beginning, offering health insurance is simply a cornerstone of any benefit package. The value it adds to employee retention, recruitment and morale is indisputable. The challenge today is how to structure that benefit so that the new realities of the ACA cause the least possible disruption and burden on your company. To do that requires careful consideration of the pros and cons that these different strategies represent.

> "...not offering health insurance may be the riskiest strategy of all."

ACA EMPLOYER MANDATE DIFFERENCES BY YEAR	2015	2016
Percentage of employees that must be offered insurance	70%	95%
Number of FTEs at which insurance must be offered	100	50

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