The Effect of the ACA on Self-Funded Plans & Free Market Providers

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Glossary of Terms

You have been provided a glossary of terms that may be helpful to you during my presentation.

What is the Purpose of the ACA?

- Expand number of people with coverage
  - Why: the more covered, costs should decline as the risk is spread among more people
  - Make it accessible and easy to buy on the internet "exchange" or "marketplace"
    - » Target – get participation of 2.7 million uninsured 18-35 year olds, sometimes referred to as the "young invincibles" who are healthier
    - » But 18 – 26 are covered under parents plans!
- Define scope of benefits that must be provided

What is the Purpose of the ACA?

Make healthcare "affordable."

Why: so that more people can have coverage.

- "Affordable" is tied by ACA to what **people pay to get coverage**.
- The cost of the premiums on exchange plans is approved by government.
  - Popular with Americans – **87% qualified** for:
    - Premium subsidies
    - out-of-pocket costs subsidies

    in both state run and federally run exchanges.

Premium costs are expected to rise for 2016.

Source: HHS: Health Insurance Marketplace 2015 Open Enrollment Period: January Enrollment Report For the period: November 15, 2014 – January 16, 2015 dated January 27, 2015

What is the Purpose of the ACA?

Make healthcare "affordable."

- Affordable is also tied by ACA to limitations on out-of-pocket costs, and expanded services with no cost sharing
  - BUT - deductibles have risen significantly
  - AND networks are being narrowed offering fewer provider choices
  - AND narrow networks are forcing some to go out-of-network with additional uncontrolled out-of-pocket costs being incurred.

What is "Affordable" Under the ACA?

ACA limits in-network maximum amount individuals can be out-of-pocket

- $6,600 for individuals ($6,850 in 2016)
- $13,200 for families ($13,700 in 2016)
- Includes: Deductible, out-of-pocket and co-pays on medical services **and** prescriptions
- BUT LIMITED TO IN-NETWORK ONLY
  - » Result in insured markets - narrow networks or "exclusive provider networks"

These amounts do not include cost for coverage.

What is the ACA?

- Forces employers with 50 FT/FTE to offer coverage to a broad base.
  - *Why:* more than 80% of employers with 200+ employees have self-funded plans

    SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2014
  - Employees are not taxed on benefits received
  - Employers cannot pay employee premiums to buy other coverage or pay employee medical expenses outside a group health plan
    - » Most likely to avoid adverse selection on exchanges
    - » Prevent tax free benefit to employee
  - In 2016, must offer coverage to 95% of FTE
  - Penalty for non-compliance: “Pay or Play” excise tax

What is the Effect of ACA on Self-Funded Plans?

- Shifts more costs to self-funded plans/employers
  - » No annual limitation
  - » No lifetime limitation
  - » No pre-existing conditions
  - » Limited out-of-pocket maximums
  - » No cost sharing on preventive services
  - » Expand dependents to age 26 without conditions
  - » Shortened wait time to be covered

What is the Effect of the ACA on Employer?

- Imposes taxes on employers to subsidize insurance companies
  - Pay or play excise tax (4980H)
  - Transitional reinsurance tax - Section 1341 of ACA
  - Cadillac tax (4980I)
  - Tax for non-conforming plans (4980D)
  - PCORI tax (4375,4376)
  - HIT tax (insurance companies and some multiple employer welfare arrangements) but not union plans - Section 9010 of the ACA

What is the ACA?

The ACA is built around the concept that healthcare costs will decline if people are healthier:

- Expand preventive services to participants
  - » no cost sharing
  - » an ever growing list of required covered services
- **Mandate** group health plan to provide preventive services
  - » BUT grandfathered plans, are allowed to have cost sharing
- Insured plans must offer all minimum essential coverage including pediatric dental and vision services

What the ACA Actually Does:

- Shift first dollar costs to individuals:
  - Deductibles are rising
  - Networks are shrinking forcing more out-of-network services
  - Reduces the amount employees may set aside on pretax basis (flex plans) $2,550
  - Won’t allow employers to help pay for premiums to buy insurance coverage

What the ACA Actually Does:

- Tax more income
  - Individuals - because they are paying more first dollar costs with after-tax earnings
  - Reduce amount that can be deducted on tax returns – must be more than 10% of adjusted taxable income
  - Tax amounts previously deferred pre-tax in flex account contributions (limit is $2,550)
  - Tax employers to fund ACA programs through the individual mandates

What ACA Does NOT Do -

- Address the **REAL** cost of healthcare
  - *Not premiums* – real total cost of healthcare
  - *Why:* because ACA is linked to "networks"
    - » PPO providers can set "billed charges" without constraint
    - » Then offer a "discount" on billed charges
    - » Self-funded employer plan is expected to pay the billed charge amount less the discount – no questions asked!

What ACA Does NOT Do -

- Control the Networks - the BUCA's or maybe the Big Three
  - Providers – PPO tends to demand price that it will pay
    - » These amounts keep going down for doctors
  - For facilities – they generally get a percentage discount or a fee for DRG
    - » There is no mechanism to control costs
    - » Result increase costs of other items – implants for example
  - Mergers and consolidations limit free markets and tend *to increase* cost of services
    - » There is a push back on current plans for Anthem-Cigna and Aetna-Humana.
    - » Result: these two merged groups and United Healthcare - each with approximately $100 billion in annual revenue.

What ACA Does NOT Do -

- Prevent more consolidation of providers:
  - Hospital acquisitions/mergers
  - Hospital acquisition of physician practices
  - Hospital acquisitions of doctor owned facilities
  - One outcome is inevitable
    - » Result: prices will continue to rise with less competition

What ACA Does NOT do -

- American Academy of Actuaries report for 2016 premium costs rising:
  - Risk pool does not have enough healthy people to pay for the sick people
  - Cost of healthcare is rising
    - » Not premiums – real cost of healthcare, specialty drugs, and more consumption when out-of-pocket limit is satisfied
  - New taxes imposed on health plans and insurance companies

So What Does FMMA Have To Do With This?

- FMMA is addressing the TOTAL COST of healthcare:
  - » Transparency in pricing
  - » Real alternative for self-funded employers to control cost of healthcare
  - » Offer real alternatives to employees to be better consumers with the amounts they must spend to get coverage

But Be Wary of Traps for Transparent Providers

- Employers must play within ACA rules or risk high excise taxes.

- Cannot ignore ACA rules on plans.
  - » Penalties are onerous
  - » For example - $100 per day per employee for non-compliant plan

Can Employer Pay Premiums Only?

- NOT without a group health plan.
  - Agencies consider any arrangement to pay premiums only as “a group health plan” subject to the ACA
    - » Violates the no annual limitation requirement
    - » Does not include preventive services with no cost sharing
    - » ALL Employers with 2 or more employees are affected
    - » Excise taxes under section 4980D of the Code apply.

- YES, if the amount is paid as additional **taxable** compensation not tied to buying insurance coverage.

Can Plans Eliminate All PPO Networks?

- Probably not.
- It's a problem because ACA is build around networks.
- If there are no networks – ACA agencies seem to think everything is considered in network.
  - » Maximum out of pocket amounts apply to everything so plans would be required to pay "billed" amounts after the individual meets the limitation
  - » Agencies concern - balance billing of patients
  - » Medicare Plus only – not liked by agencies

Plans with no PPO Networks

FAQs ACA Implementation XII Q/A 3:

Out-of-Network Services Generally

Q3: My plan does not have any in-network providers to provide a particular preventive service required under PHS Act section 2713. If I obtain this service out-of-network, can the plan impose cost-sharing?

No. While nothing in the interim final regulations generally requires a plan or issuer that has a network of providers to provide benefits for preventive services provided out-of-network, this provision is premised on enrollees being able to access the required preventive services from in-network providers. **Thus, if a plan or issuer does not have in its network a provider who can provide the particular service, then the plan or issuer must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.**

There will be more on this subject from regulators.

Direct Primary Care Providers

- If used with employer plans – can direct employees to DPCs
  - Current problem – not enough DPCs to give sufficient choice to employees
  - Can be a valuable resource to direct patients to other transparent providers

Direct Primary Care Providers

- IRS position on fees to DPCs
  - Concierge fees – access only not a fee for medical services is not a health care expense for tax purposes
    - » If all you get is access -- the fee doesn't pay for any services -- there's no deduction.
  - Only costs for medical services that meet IRS section 213 criteria are deductible
    - » Requires employee to maintain documentation of actual medical services rendered.
    - » If your fee pays for you to get a physical once or twice a year, plus ready access in emergencies, then you're paying for deductible services and the retainer is also deductible.
    - » Generally, you cannot include in medical expenses current payments for medical care (including medical insurance) to be provided substantially beyond the end of the year.

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QUESTIONS