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Health & Group Benefits

AN EMPLOYER BENEFITS UPDATE

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Is direct-to-provider contracting a potential silver bullet for achieving value-based care for employer-sponsored plans?

Andrew Timcheck | Cory Gusland | Mike Gaal

Recent announcements, such as the one by General Motors (GM) in 2018 directly engaging the Henry Ford Health System to provide healthcare services to a portion of GM's employees, have once again raised awareness of direct-to-provider contracting by employers and plan sponsors. Direct-to-provider contracting is a strategy in which a self-insured entity negotiates a contract directly with a provider of healthcare services rather than through a third-party administrator (TPA), often with the goal of driving value-based care. As part of a value-based contract, the provider is held accountable for improving patient outcomes through achieving key quality, cost, and utilization metrics on a wide range of services. This provides the "value" in value-based care for the self-insured entity.

It's not surprising that direct-to-provider contracting has been considered as a viable route to value-based care. Both providers and employers appear to regard direct-to-provider contracting as an opportunity. Providers see an opportunity to increase volume from employers through a narrower network. Employers see an opportunity to more directly influence the delivery and costs of healthcare.

Direct-to-provider contracts can take many different forms, including establishing onsite clinics, offering direct primary care (DPC), or creating centers of excellence (COE). For the purpose of this article, direct-to-provider contracting is defined as an employer contracting directly with a health system to provide comprehensive healthcare coverage to its employees and their dependents.

Making direct-to-provider contracting work

While the overall concept of direct-to-provider contracting makes sense, key issues present challenges for implementing it broadly in the employer market.

- Employers may not be geographically structured in a way that would make direct-to-provider contracting feasible. For example, an employer may have a geographically dispersed workforce without sufficient scale for direct-to-provider contracting in any one region. Additionally, the majority of an employer's workforce may be located in geographies where there is one dominant health system in the area, thus making negotiations difficult between the employer and the health system due to lack of competition.
- Employers will need to commit on a large scale to value-based, direct-to-provider arrangements for there to be any possibility for meaningful transformation within the U.S. healthcare system. Sufficient scale is needed for direct-to-provider contracting to have a significant impact on cost and improved health outcomes.
- Employers may find themselves in a position where they are negotiating numerous direct-to-provider contracts. For example, if an employer's health benefits program touches 10 different markets, then it might be touching 20 to 40 different health systems that account for the majority of healthcare services delivered to its plan participants. The requirements for negotiating 40 or more contracts with individual health systems quickly become onerous for most employers, and this is before considering professional services (e.g., primary and specialty care) that fall outside of individual health systems. It is simply not practical for an employer to negotiate this many arrangements.
- Providers would like to roll out uniform contracts and models across all the different employers and markets they serve, but this could prove challenging. Providers serve many key populations such as Medicare, Medicare Advantage, Medicaid, and individual commercial insurers as well as individual self-insured employers. Providers

would prefer employers to engage in relatively standard models without extensive negotiation and customization efforts in order to reduce administrative complexity. If one employer wants to negotiate an individual contract, and then another employer, and then 200 more employers, it quickly becomes onerous for providers, too.

Conclusion

Until now, a key role of TPAs and insurers has been to facilitate purchasing between employers and providers. In many ways, all the efforts toward direct contracting have been employer attempts to replace the rate negotiation role of TPAs and tap into more efficiency (i.e., higher value at lower cost) and transparency, and ideally achieve value-based care.

A compelling case can be made that direct-to-provider contracting is worth the effort for employers with enough scale in certain geographies, which is evidenced by marketplace activity. Alternatives to contracting directly with a health system, such as onsite clinics, DPC solutions, and COE facilities for specific procedures and/or conditions, have been effective at reducing costs and increasing efficiencies for some employers. These approaches may continue to gain additional traction. Conversely, a case can be made there is a ceiling on direct-to-provider contracting as employers look to expand value-based approaches in geographies where they lack scale or market leverage. Developing unique value-based care contracts for each individual employer does not make sense administratively or financially for most provider organizations. Many employers are not sold on the concept of varying their programs across geographies due to the added complexity.

Direct-to-provider contracting is an idea that has the potential to be successful in specific instances, particularly when there is scale and geographic concentration, and when the objectives of employers and providers are aligned. However, like many other strategies, it's probably not a silver bullet for controlling costs or expanding access to value-based care for the vast majority of employer-sponsored plans.

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Managing an association health plan

Dan Freeman

The article will focus primarily on the identification and understanding of the varying health risks and costs of association health plan (AHP) groups and how best to align premium to these relative costs. While pricing is not the only risk that can have an adverse impact on AHPs, managing it is a key pillar to the long-term sustainability of these plans.

The DOL rule on AHPs

The final rule on association health plans was approved and implemented on June 19, 2018, by executive order, and communicated via the U.S. Department of Labor (DOL). The main purpose of these plans is to provide a platform where similar employers, including single-life owner-employees, could pool their healthcare costs and risks to provide health benefits to themselves and their dependents. The main objectives would be to find more affordable health insurance coverage for small employers, without some of the benefits mandated by the Patient Protection and Affordable Care Act (ACA). The main tenets of the rule are as follows:[1,2]

- Employers may come together under a looser definition of commonality, such as industry or region.
- These AHPs do not need the previous definition of being bona fide associations to form health plans.
- Single-life employer groups, often referred to as employee-owners or self-employed groups, are permitted to enter an AHP.
- AHPs do not have to offer ACA-compliant plans.
- Nondiscrimination practices would be in effect for these new AHPs. Primarily, varying premium or declining coverage based on health conditions is not permitted.

1 The final rule can be found here: **https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans**.

2 The DOL addresses frequently asked questions here: **https://www.dol.gov/general/topic/association-health-plans#FAQs**.

- Premium can vary by other acceptable risk classes, such as group size, area, or industry, for example.

It is important to note the U.S. District Court for the District of Columbia (D.C.) has recently ruled invalid and vacated some key tenets of this new rule[3].

AHP risk management considerations

To bolster the chance of long-term success for these new AHPs, active risk management of their plans is necessary. Certain key areas need to be considered and will require specific attention and monitoring, such as member engagement, pricing strategies, and funding arrangements.

MEMBER ENGAGEMENT AND LACK OF ENGAGEMENT

Low or unstable enrollment in an AHP leads to unstable costs and a greater probability of misaligning premiums to costs. Having an AHP that offers a full array of benefits, ranging in price and coverage, is essential. The AHP will be able to reach a broader spectrum of risks by offering plans that cover all the metallic tier coverage levels, at appropriate price points.[4] However, it is important for these plans to maintain minimum value levels to avoid the financial burden of any catastrophic claimants.

Proper selection of networks can also be key in promoting interest and engagement. A strong provider network, along with quality case management, disease management, and wellness activities, can keep members engaged and invested in the plan. At the same time, this can help in keeping large claims volatility from breaching target loss ratios.

An AHP can consider plan participation requirements of member groups that could increase plan enrollment and reduce volatility. A balanced employee contribution schedule, one that varies by plan design, can help strengthen bonds between members and the plans offered.

PRICING AND MANAGEMENT OF RISKS

Strong pricing, funding discipline, and a clear vision of pricing methodology is essential to the financial health of an AHP.

- The AHP should implement a pricing structure that resembles the expected AHP characteristics that it is intended to cover. For example, if the AHP is only covering employers in Columbus, Ohio, and does not anticipate material differences in cost in the area, then they do not necessarily have to vary premiums by geographic location.
- Another recommendation would be to have a monitoring system that revolves around the quantification of risks and the distribution of these risks among the plan members, to gain an understanding of potential sources of financial strain to the plan. It is important to quantify the dispersion of risk, either by demographic scores, or a risk-adjusted score such as Milliman Advanced Risk Adjusters™ (MARA™). This dispersion of risk needs to be grouped by pricing class, whether it's by plan, age/gender, or some other permissible class. While the AHP is not allowed to underwrite or discriminate by these health-based risk scores, it can at least get an idea of how its risks are dispersed.
- Overall, steps should be taken such as defining new risk categories that are more aligned with anticipated costs. For example, premiums will vary by plan offerings. They can create segments of relative experience when a broad array of plans are offered. Healthier and/or younger lives may choose the cheapest, less rich plan. The AHP could realign premiums based on plan design to rehabilitate a pricing segment that may be overheating.
- The next step would be to incorporate historical performance among these pricing classes. Groupings of similar risks could be acceptable as long as the premium for each price class is aligned with its expected relative costs and operating within reasonable loss ratio ranges. However, if certain price classes are causing an overall strain on funding, and too much increase is needed from other risk classes, it can set off a risk spiral, and the plan can never collect enough premium from the remaining risks to cover future costs.

Consistent monitoring of plan performance in this way is essential to the ongoing sustainability of an AHP. As described above, this identification and quantification of potential risks with appropriate triggers and corresponding action items can aid in preventing the start of severe misalignment of premium and rising loss ratios.

PRE-FUNDING AND ONGOING FUNDING

It would be irresponsible of a newly formed AHP, especially if it is self-funded, to not have additional capital on hand to buffer against adverse claims risk. Having a stabilization reserve, or a claims fluctuation reserve, is crucial to help reduce the impact of events such as underpricing of plan costs and higher-than-average rate increases in the future. The quantification of these anticipated risks, either by historical experience or by a risk-adjusted score, can help determine the amount of additional capital that may be needed in an upcoming plan year.[5]

3 For more detail on this ruling, see: https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv1747-79.

4 Plans with actuarial values of 60% or higher, meaning the plan will cover at least 60% of all health costs, on average. This is known as a bronze plan.

5 Some states may require additional capital or reserves for self-funded AHPs, in the form of, for example, actual cash or cash equivalents, a line of credit, or a surplus note.

An appropriate mechanism to generate additional capital or surplus would be to charge an additional premium to all AHP member groups, based on a percentage of premium or a per capita basis, for example. This additional premium would be based on the expected risk characteristics of the AHP and could be charged equitably across all member groups. Once a reasonable surplus is established, future funding would only be necessary if surplus levels drop below an established point. Having an adequate surplus does not necessarily reduce the chance of underpricing in a given year, but it does provide a valuable source to absorb this impact.

Conclusions

AHPs have received recent skepticism from critics and been challenged by the courts, but interest in forming them will continue under the new rule. Time will tell regarding the long-term success of this new rule and whether it achieves its intended goals. However, the association health plans that have the strongest probability of success are the ones that install the strongest pricing and risk management controls and methods, as outlined here.

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Self-funding can give employers more control over every aspect of their medical insurance programs

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To gain control over the ever-increasing cost of employee health insurance, more and more employers are discontinuing their fully insured coverage and switching to self-funded models. Self-insurance is an unbundled approach separating all required functions—medical provider networks, carrier or third-party administrator (TPA), pharmacy benefit manager (PBM), stop-loss insurer, and consultants—subject to competitive bidding. Moving to a self-insured arrangement can result in significant cost reductions—5% to 10% are typical.

The key benefits employers derive from transitioning to a self-funded program are:

- Enhanced cost benefit transparency into every aspect of the program
- Expense reduction
- Flexibility around plan design
- Access to claims data
- Better control of claims payments and investment income on reserves

In this article, we will provide an overview of the actuarial components of the employer-sponsored program: projecting claims and expenses, and evaluating an employer's budget and risk tolerance.

Expense reduction

A significant portion of the annual premium increase under a fully insured arrangement is due to required taxes and mandated fees. These fees are typically required and only add to an employer's burden.

- In 2018, the insurer fee of the Patient Protection and Affordable Care Act (ACA) was approximately 3.9% of premiums. We anticipate this percentage to be even higher in 2020.
- Another fee required as part of a fully insured arrangement is the premium tax of 2%.
- An insurer's profit margins also add an invisible layer of fees to an employer's healthcare expenses.

Combining the insurer's profit with the required fees above (ACA insurer fee and premium tax), the employer's fully insured healthcare program can easily raise the cost by 5% to 10%. Thus, exploring other market alternatives under a self-funded arrangement can potentially result in baseline savings of at least 5% to 10%.

Flexibility around plan design

Insurers offer a variety of set plan designs that may or may not meet employers' needs. With a self-funded plan, employers can design every aspect of the program. There are no state-mandated benefits, and it is up to each employer to decide which coverages will work best for its employee population. You can select a broad or narrow network, design a program with multiple service tiers, implement a high-deductible plan, and offer wellness and disease management programs.

Access to data

One very important consideration associated with a self-funded program is access to data. Within a fully insured arrangement, the carrier receives all data to process and pay claims. While carriers will typically issue standardized reports, these standard reporting templates are typically inadequate for an employer desiring more insight into the population's experience. Under a self-funded program there is an implied understanding employers will have greater access to their own claims data, allowing for more effective delivery of healthcare benefits to their participants. This information will allow an employer to determine how well its benefit strategy is working.

Better control

A self-funded program provides a better way to put the employer in control when paying its own claims and reserving for those claims. When self-funding, reserve amounts are held in an account until bills for medical claims become due. In doing so, employers can capture investment income earned on these reserves. Under a fully insured arrangement, the carrier holds these dollars in its reserve accounts and will collect on the investment income instead.

It is important to note that, even though an employer has more control of its cash flow, it also has to deal with the claims volatility associated with self-funded programs. Thus, risk management is critical to the success of any self-funded program. By "law of large numbers," fully insured carriers are able to reduce total claims volatility and diversify the risk associated with catastrophic events. A self-funded employer will need to manage its risk through stop-loss insurance. The type and level of coverage will vary by employer and should align with an employer's risk tolerance.

Feasibility study

Because self-funded programs still carry fees and expenses, the first step for an employer is to evaluate its fully insured arrangement in a detailed feasibility study. The feasibility study should provide a side-by-side comparison between both self-funded and fully insured scenarios.

Components to consider within the feasibility study include:

- Claims cost projections where key components such as historical medical and prescription drug claims, large claims information, participant enrollment, and plan design information are evaluated. Any significant changes in networks and demographic shifts of the covered population should be incorporated.
  - It is important to note that, if the group size is not large enough, or historical data is limited or unavailable, then an expected claims cost will need to be estimated using the group's demographics and plan design information (i.e., manual rating) and blended in with the group's actual experience.
- A difference in fees (i.e., fully insured versus self-insured arrangement) should be evaluated and compared. Expense components to be considered include (but are not limited to) administration or administrative services only (ASO) fees, reinsurance/pooling charges (i.e., large claims risk management), carrier profit and risk margin, PBM fees, network access fees, premium tax, and the ACA insurer fee.
  - If actual fees are not available, we would recommend fees to be estimated based on market-comparable employer rates.

Next steps

Self-funding may be a great option to managing the rising cost of fully insured premium rates. That said, self-funding may not be appropriate for every business. An employer will want to evaluate provider and network options under both self-funding and fully insured arrangements. Employers should also compare all fees and expenses under both programs. It is important to note that a fully insured quote may be available at a lower cost than a self-funded approach. Overall, it is important to work through a detailed feasibility study to evaluate the risk and fully understand the cost savings that may be available moving to a self-funded program.

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Regulatory Roundup

Compliance topic summaries

Fall 2019 HAWCS Newsletter

The Internal Revenue Service (IRS) released 2020 high-deductible health plan (HDHP) and health savings account (HSA) amounts:

	CALENDAR YEAR 2019		CALENDAR YEAR 2020	
	Self-Only Coverage	Family Coverage	Self-Only Coverage	Family Coverage
Annual Contribution	$3,500	$7,000	$3,550	$7,100
HDHP Minimum Deductible	$1,300	$2,700	$1,400	$2,800
HDHP Maximum Out-of-Pocket Expenses	$6,750	$13,500	$6,900	$13,800

Plans May Exclude Value of Drug Manufacturers' Coupons Until Further Notice

Link to original article: Plans May Exclude Value of Drug Manufacturers' Coupons Until Further Notice

Summary: The U.S. Departments of Labor (DOL) Health and Human Services (HHS) and the IRS have issued a notification addressing whether drug manufacturers' coupons count toward cost-sharing limits under the Patient Protection and Affordable Care Act (ACA). New 2020 cost-sharing limits were released earlier this year and stipulated that, for plan years beginning on or after January 1, 2020, the value of drug manufacturer coupons do not count toward the cost-sharing limits when a *"medically appropriate generic equivalent is available."* This provision creates conflict with some other HDHP provisions. Regulatory agencies acknowledge the conflict and intend to address it in 2021 parameters.

Third Circuit Upholds Nationwide Injunction Blocking Expansion of Contraceptive Coverage Exemptions

Link to original article: Third Circuit Upholds Nationwide Injunction Blocking Expansion of Contraceptive Coverage Exemptions

Summary: Currently, certain religious employers are eligible to be excepted from the ACA's contraceptive coverage mandate. Final proposed regulations were set forth to expand that exemption to include both individuals and organizations with sincerely held religious beliefs or moral convictions. *This regulation was blocked by trial courts in two states, and the Third Circuit Court of Appeals has upheld this block.*

IRS Announces Indexing Adjustments for 2020 Affordability and Premium Tax Credit Determinations

Link to original article: IRS Announces Indexing Adjustments for 2020 Affordability and Premium Tax Credit Determinations

Summary: In July, the IRS released guidelines adjusting the indexing of two provisions under the ACA. First, the required contributions percentage (used to determine affordability under the ACA definition) has changed to 9.78% in 2020 (higher than the baseline, but lower than the threshold for 2019). Second, the percentage determining the amount of income individuals must contribute toward exchange coverage (if eligible for premium tax credits) has similarly changed (higher than the baseline, but lower than 2019). This percentage varies across income bands but in 2020 it ranges from 2.06% to 9.78%.

Court Declines to Enforce Indemnification Provision Against Negligent Pharmacy Benefits Manager

Link to original article: Court Declines to Enforce Indemnification Provision Against Negligent Pharmacy Benefits Manager

Summary: A health system engaged in a contractual dispute with its PBM for failure by the PBM to auto-enroll the plan sponsor in its fraud, waste, and abuse program. The plan sponsor filed a claim and was awarded $4.5 million for fraudulent prescription claims, and subsequently sued the PBM for indemnification, alleging that the contractual language between the plan sponsor and the PBM, specifically the indemnification provision, required the PBM to pay the full cost of negligence. *The court dismissed the claim, highlighting the importance of contracting clarity.*

Agencies Issue Final Regulations Expanding Use of HRAs

Link to original article: Agencies Issue Final Regulations Expanding Use of HRAs

Summary: In a joint release, the IRS, DOL, and HHS have issued regulations expanding the scope of health reimbursement arrangements (HRAs), finalizing proposed regulations from 2019. The following are applicable to plan years beginning on or after January 1, 2020:

- HRAs can be integrated with individual health coverage, if certain conditions are met.
- Employers may offer nonintegrated HRAs that qualify as excepted benefits and are therefore not subject to Public Health Service Act (PHSA) mandates, with certain requirements met.
- Employers with individual coverage HRAs (ICHRAs) may allow employees to use cafeteria plan salary reductions (pretax) to pay a portion of their individual premiums, under certain conditions.
- Members covered by or offered an ICHRA are ineligible for premium tax credits.
- The DOL definition of "employee welfare benefit plan" and "welfare plan" exclude individual coverage funded by an ICHRA, with certain requirements met.
- HHS implemented a special enrollment period for members who gain access to an ICHRA.

HEALTH & WELFARE KEY DATES FOR JANUARY 2020-DECEMBER 2020

JANUARY 1
- Application of tri-agency final rule permitting use of health reimbursement arrangements (HRAs) for coverage purchased on insurance exchanges, Medicare coverage, and limited excepted benefits
- Expiration of 2019 moratorium requiring health insurance providers—including those covering group health—to pay the Patient Protection and Affordable Care Act (ACA) health insurance tax, requiring payments for the 2020 plan year
- "Responsible Reporting Entities" of group health plans to begin reporting expanded primary prescription drug coverage for Medicare-eligible individuals

JANUARY 31
- 2019 Form W-2 to employees and to the Social Security Administration
- 2019 Form 1095-C/1095-B to covered individuals

FEBRUARY 28
- 2019 Forms 1094-B, 1095-B, 1094-C, or 1095-C (paper) to Internal Revenue Service (IRS)

MARCH 2
- Medicare Part D creditable coverage notification to the Centers for Medicare and Medicaid Services (CMS)
- Reporting to the U.S. Department of Health and Human Services (DHHS) of HIPAA breaches covering fewer than 500 individuals in 2019
- Form M-1 filing to the U.S. Department of Labor (DOL) by multiple employer welfare arrangements providing health coverage in 2019

MARCH 30
- Provide a Summary Plan Description to individuals who became a plan participant on January 1, 2020 (otherwise, within 90 days of becoming covered by the plan)

MARCH 31
- 2019 Forms 1094-B, 1095-B, 1094-C, or 1095-C (electronic) to IRS

JULY 28
- Provide a Summary of Material Modifications to participants if the plan adopted amendments for the plan year ending December 31, 2019, unless the information was included in an updated Summary Plan Description that was distributed on time

JULY 31
- Payment of the final Patient-Centered Outcomes Research Institute (PCORI) fee, covering the plan years ending from January 1, 2019, to September 30, 2019, to IRS on Form 720
- File 2019 Form 5500 Annual Return/Report, unless an extension applies

AUGUST 3
- Maximum penalties begin to apply for failures to file, or for filings of Forms 1094-B, 1095-B, 1094-C, or 1095-C after August 1, 2019

SEPTEMBER 30
- Summary Annual Report (SAR) to plan participants, if the Form 5500 was filed on July 31 and no extension applies
- Medical loss ratio (MLR) insurance rebates to policyholders, including ERISA-covered plans

OCTOBER 15
- Medicare Part D creditable/non-creditable coverage notice to Medicare-eligible participants
- File 2019 Form 5500 Annual Return/Report if July 31 filing date was extended

NOVEMBER 1
- Open enrollment begins in the federal health insurance exchanges/marketplaces for coverage to begin January 1, 2021

DECEMBER 1
- Distribution of Summary of Benefits and Coverage (SBC) for plans without an open enrollment period (for plans with an open enrollment period, provide the SBC to participants and beneficiaries with the enrollment materials and upon renewal or reissuance of coverage)

DECEMBER 15
- Open enrollment ends in the federal health insurance exchanges/marketplaces for coverage to begin January 1, 2021
- Summary Annual Report to plan participants, if the Form 5500 was filed with an extension

DECEMBER 31
- Deadline to make discretionary plan amendments implemented in 2020 or that will take effect in 2021 but need to be adopted before implementation
- Nondiscrimination testing for Section 125 cafeteria plans
- Pay any MLR rebates received on September 30 to participants or use the amounts for benefit improvements or establish a trust to hold the rebates as plan assets
- If not previously provided to plan participants along with other communications (e.g., open enrollment materials), furnish the Children's Health Insurance Program Reauthorization Act notice, the Women's Health and Cancer Rights Act (WHCRA) notice, and any other notices that must be provided annually
- Deadline for self-insured nonfederal governmental group health plans to notify plan participants and CMS of the plan opting out of the Mental Health Parity and Addiction Equity Act, the WHCRA, the Newborns' and Mothers' Health Protection Act, and Michelle's Law requirements

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