

An insurance executive, an actuary and an attorney have identified 11 factors in the areas of cost increases, cost shifting and new expenses that they believe will affect multiemployer health plans now and in the future. They advise trustees to take these anticipated increases into account as they plan ahead. The article also includes reactions from two executives of multiemployer health plans.

Storm Coming for Self-Funded Multiemployer Health Plans

The Wise Will Prepare, Starting Now

by David McSweeney, Barbara P. Niehus and David Ermer

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Anyone who has watched a storm blow in over the Midwest plains can envision what's on the horizon for self-insured multiemployer health plans. Trustees and administrators should anticipate 11 health plan cost factors—all in the categories of increases, cost shifting and new expenses—that will result from economic conditions and recent or pending legislation. The authors think these factors will pack a punch over the next four to five years.

The authors balance their observations with comments from two multiemployer plan executives in New England: John Barrasso, executive vice president of the Mechanical Contractors Association of Connecticut, and Michael Daly, executive director of the CT Pipe Trades Health Fund. Together, they administer health plans that cover over 4,000 participants, including 700 members on Medicare. Both plans fall under the larger Connecticut Coalition of Taft-Hartley Funds, whose members in New England cover over 50,000 lives.

Five Cost Increases

COBRA Premium Subsidy

The Consolidated Omnibus Budget Reconciliation Act (COBRA) premium subsidy called for under the American Recovery and Reinvestment Act of 2009 (ARRA) is one factor that may lead to increased cost. Under ARRA, eligible individuals pay only 35% of their COBRA premiums. The remaining 65% is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage beginning on or after February 17, 2009 and lasts for up to nine months for those eligible for COBRA during the period beginning September 1, 2008 and ending December 31, 2009 due to an involuntary termination of employment during that period.

Employers are allowed to charge 102% of average premium to COBRA participants. And they are allowed to change premiums once per year. Many employers set their COBRA premiums before they knew about this change. COBRA participation has typically been low because of the high cost of premiums, so some employers set premiums without a complete actuarial review and may not have anticipated the increased claim costs pressures in the current environment. The International Foundation of Employee Benefit Plans found that 500,000 plan participants were eligible for the COBRA premium subsidy as of April 2009.¹

Even if premiums were set properly, there is likely to be self-selection, which will have the effect of causing many COBRA participants' claim costs to exceed their premiums. Clearly, participants with the most pressing needs and highest claim costs are the most likely to participate in COBRA.

Another feature of the subsidy that will cost plans money is the participant's ability to select how long to stay enrolled in COBRA. For example, to save premium costs, a participant may enroll for only a month or two but have all outstanding medical needs taken care of immediately. Costs that normally might be spread over nine months worth of premium, for instance, now might be spread over only a month or two of premium.

Barrasso and Daly said they do not anticipate cost increases directly related to COBRA. Nonetheless, they reported sending about 160 COBRA notifications—26 of

them to members who were already on COBRA—during two weeks in April. As of early May, they had received 12 subsidy applications.

A benefits consultant is the best source of guidance on this issue.

Financial Pressures

Financial pressures being placed on providers is a second potential reason for cost increases. In tough times providers experience more uncollectible debts. Hospitals see their endowments shrink, and physicians see their pension plans shrink. All of this creates pressure to bill more to insurance plans, ultimately resulting in higher claim payments than anticipated. One of the authors, McSweeney, whose company analyzes self-insured plans, is seeing this happening already.

Forward-Buying of Medical Services

People who think they're going to lose their jobs tend to focus on medical needs for themselves and their dependents that otherwise might be postponed or ignored. Instead of putting off a knee operation, for example, many people will have the procedure while they're still on the employee health plan.

This is particularly significant with multiemployer health plans, because in this environment coverage often continues for one to three months after termination, and plan sponsors can expect participants to get procedures done before coverage runs out. Additionally, in these tough economic times employees who are stressed financially and fear losing their jobs may have more medical issues.

This forward-buying of medical services was the subject of a story in the March 14, 2009 issue of the *New York Times*, and the forward-buying of dental services was cited by *Time* magazine on March 9, 2009 as the reason for a mini-boom in dentistry. On the other hand, some participants may be delaying covered elective procedures because they are unable to afford deductibles. This could result in even greater medical cost down the road. Either way, self-funded plans will be affected by the cost implications.

Barrasso and Daly said they have no hard evidence of forward-buying of medical procedures, and member coverage is protected somewhat with an hour bank. An *hour bank* allows members to build up eligibility credits while working for a

participating employer. Those credits can be used between jobs to extend eligibility. Nonetheless, they also report that claims were up significantly in April 2009. By the tenth month of their plans' fiscal years, the cost of claims had already exceeded the cost for the entire 12 months of the prior year. Their plans had experienced an overall 8% increase in prescription drug claims over the past year, as well.

Expanded Dependent Eligibility

Expanded dependent eligibility is the fourth cost escalator. A recently enacted federal law, Michelle's Law, is named after a college student who faced losing her dependent coverage if she reduced her course load to fight cancer.

The law is likely to affect plans that cover dependents and determine eligibility by student status, although it does not extend dependent age ceilings. The law requires most of those plans with plan years starting on or after October 9, 2009 to provide extended coverage to postsecondary students who might otherwise lose coverage because of a medical leave of absence. Plans that don't offer dependent coverage or don't tie dependent coverage to student status will essentially be unaffected.

There are some murky areas with this law. For example, it begs the question of who should pay for the extended coverage, but does not specify the employer, or the parents. Dependents are not eligible for the COBRA premium subsidy.

Michelle's Law comes at a time when the majority of states also have enacted this type of legislation to expand dependent eligibility to young adults beyond the age of 19 and up to the age of 25 or even 30 in some cases—a demographic that includes a large number of America's uninsured. The problem state legislation attempts to solve is that young adults lose dependent eligibility coverage at the age of 19 to 22 under most private plans and public programs such as Medicaid and the State Children's Health Insurance Program (SCHIP). Because of this, many young people can end up uninsured while looking for their first full-time job.

State legislation varies substantially and in most cases does not apply to self-

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funded plans. State insurance departments can help educate health plans on this subject.²

ICD 10

A fifth potential cost escalator—the worldwide updating of the International Statistical Classification of Diseases known as ICD 10—won't be a factor until October 2013, the extended date for implementation. But beginning at that time, it may be a very large escalator.

In an effort to track diagnoses and hospital procedures, the updating expands some 17,000 codes currently being employed to 155,000. This enormous change is likely to create the environment for widespread coding errors, up-coding, unbundling and the like. While public health officials say the change will be beneficial, physicians are balking because of anticipated added technology and administrative expense. Hospitals may see the changeover as an opportunity to negotiate new contracts or to work around the contracts they have. The authors find it ironic that the change is mandated by an administrative simplification act—the Health Insurance Portability and Accountability Act (HIPAA).³

Three Types of Cost Shifting Will Occur Simultaneously

Disparity of Payments

Perhaps the most significant factor in the cost-shifting category is the disparity of payments to providers between Medicare and Medicaid and commercial plans. According to a report developed by the actuarial consulting firm Milliman for America's Health Insurance Plans (AHIP), the American Hospital Association (AHA), the Blue Cross Blue Shield Association and Premera Blue Cross, the cost shift to commercial health plans in 2007 because of Medicare and Medicaid underpaying providers was almost \$89 billion dollars.⁴ That's about 15% of everything commercial payers currently spend on hospital and physician services.

The Milliman report also noted that the Medicare/Medicaid cost shift represents a total of 18% of commercial hospital cost and 12% of commercial physician cost. Put another way, the \$88.8 billion that Medicare and Medicaid don't pay places an additional annual burden of \$1,115 on an employer for a covered fam-

ily of four and nearly \$700 more for the family in terms of increased premium, co-insurance and deductibles.

The authors see no immediate change in this disparity. In fact, it is likely to stay the same or, even more likely, worsen over the next four to five years. For example, the Centers for Medicare and Medicaid Services (CMS) recently announced a miniscule increase in inpatient hospital payments by traditional Medicare for the next federal fiscal year.⁵

Barrasso and Daly largely agree that the financial plight of providers and cost shifting between commercial plans and Medicaid/Medicare have resulted in additional costs. They cited the problems health care providers have been facing in their region. One Connecticut hospital was denied a requested 15% increase in reimbursements by Anthem, Barrasso and Daly's administrator. In another case, a hospital was dropped as an in-network provider for excessive demands. "Long term, this could be a problem in New England, where the availability of in-network providers is not as great as in other areas of the country," Barrasso said.

Medicaid Rebates

Closely related to this is the second cost-shift factor: the Medicaid rebates states receive quarterly from prescription drug manufacturers.⁶ The president's fiscal year 2010 budget proposes to increase these rebates from 15% to 22.1% of average manufacturer's price. The rebates that states receive are shared with the federal government based on their federal medical assistance percentage (FMAP).

Rebate amounts have risen along with increases in Medicaid prescription drug spending and will most likely continue to do so. The authors predict this can result only in more cost shifting, as manufacturers strive to make up revenue shortfalls.

CHIP Reauthorization Act

The authors believe the third factor in cost shifting is the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, signed by President Obama on February 4.⁷ The act allows states to subsidize health insurance premium payments for "certain low-income children who have access to employer-sponsored health insurance coverage." The act requires group health plans to offer a special enrollment opportunity for depen-

dent children who either lose Medicaid coverage or qualify for this state premium. This law may be expected to impact particularly employers that employ low-wage workers.

New Costs

Mental Health Parity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which soon will modify the Mental Health Parity Act of 1996, does not require self-insured multiemployer plans and employers to offer mental health coverage.

However, for plans that do offer mental health coverage, plan sponsors and insurers are forbidden from using stricter cost-sharing requirements (e.g., higher deductibles, higher copays, higher coinsurance, different dollar limits, different treatment limits) on mental health than on medical health conditions. Out-of-network coverage for medical and mental health claims must be at parity.

The act applies to group health plans of 51 or more employees. The effective date for calendar-year plans is 2010. For multiemployer plans the effective date is January 1, 2010 or the date that all of the collective bargaining agreements ratified before the October 3, 2008 enactment date, under which the plan operates, have terminated, whichever date is later.

Plans may want to consider a mental health carve-out arrangement to a specialized mental health benefits network vendor that provides for risk sharing and active management of cases. While the act creates a cost exemption, it's expected that few plans will want to use it. A qualified actuary retained by the plan first must prove an actual—not projected—cost increase caused by compliance with the law (2% in the first year and 1% in subsequent years) based on at least six months' experience. Moreover, the exemption is valid for the next plan year only. Thereafter, another actuarial proof is required.

Ingenix Database Dispute

Health plans historically have paid a lower share of out-of-network doctor claims in order to steer members to visit in-network doctors. This approach also is followed in the Medicare Part B program, which favors participating providers over

nonparticipating providers. The arrangement benefits everyone who follows the rules, and helps to keep premiums reasonable. Because out-of-network providers are not subject to fee schedules, their charges are typically reimbursed based on “reasonable and customary” prevailing fees.

The New York attorney general recently investigated the Ingenix/URC databases that health plans commonly used to set their out-of-network reimbursements. Ingenix was alleged to be understating the actual prevailing charges, resulting in lower reimbursement of claims. In January 2009, Ingenix settled the investigation without conceding liability. In order to eliminate any perception of conflict of interest, Ingenix agreed to transfer its UCR databases to a qualified university named by the New York attorney general.⁸ When the qualified university takes control of the database, Ingenix will stop offering its commercial databases. The New York attorney general has explained that

(These) reforms will remove conflicts of interest and lead to reimbursement rates (for out-of-network providers) that are more accurate and fair. The Attorney General’s reforms will also lead to a new website available to consumers that will allow them to make more informed decisions about (their) health care costs. The website will for the first time enable health plan members to look up in advance how much they are likely to be reimbursed if they choose an out-of-network doctor.⁹

The New York attorney general has convinced several major insurers, including Ingenix’s parent UnitedHealthcare, to use the qualified university’s database. Health plans should discuss the potential impact of this with their consultants and consider alternatives such as the Medicare Resource-Based Relative Value Scale (RBRVS) schedule.

GINA

Changes wrought by Title I of the Genetic Information Nondisclosure Act (GINA) may adversely impact the design of health risk assessments, wellness programs and disease management programs, which are being advocated by large insurers and the federal government as a means to control health care spend-

ing. GINA generally prohibits a group health plan from requesting or requiring genetic information for underwriting purposes or prior to enrollment, or from adjusting premiums or contributions on the basis of genetic information. The law’s definition of *genetic information* includes the collection of a person’s family health history.

Anticipated regulatory guidance was expected to resolve several ambiguities created by the law. Group health plans currently are asking members to fill out health risk assessments, including family medical history, at the time of enrollment, or they may reward a member for filling out the assessment. (Earlier this year, the Equal Employment Opportunity Commission Office of Legal Counsel issued guidance that staff believes mandating health risk assessments as a condition of enrollment would violate the Americans with Disabilities Act.) The regulatory guidance was expected to tell plans whether the first situation may be deemed impermissible for underwriting purposes and whether the second situation involved an impermissible premium adjustment. Without the family medical history, it would be difficult to proactively place members in particular wellness and disease management programs. The law takes effect for group health plan years that begin after May 21, 2009.

Recommendations

As members of the Connecticut Coalition of Taft-Hartley Funds, both Barrasso and Daly are optimistic about their funds during what may be a rough period for self-funded plans. “As a group, we’ve been very successful at negotiating great contracts,” Daly said. Their health insurance contract and their prescription drug contract are “excellent,” Daly said, “and they go on for three more years. . . . We’ve also gotten into ‘mining’ our data and creating wellness programs. There’s a diabetes program in place with a coalition member, and probably most members will take it on.”

The authors’ response: “That’s our kind of Taft-Hartley thinking!”

The traditional way of looking at health plan performance (the retrospective—rearview mirror—audit) will not serve a multiemployer plan well in this turbulent new environment. Trustees are

advised to face the storm head-on, be forward-thinking, monitor their plan’s performance on an ongoing basis (at least quarterly), and be prepared to absorb the impact of what looms ahead.

Specifically, the authors offered the following advice for multiemployer plans.

- Focus on plan oversight more than ever before.
- Establish plan reserves based on what’s happening now and what will happen in the immediate future—not on what happened in the past.

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- Demand timely, electronic information. This is imperative in order to keep small problems from becoming financial catastrophes.
- Audit dependent eligibility, third-party administrators (TPAs) and prescription drug managers. Audits help TPAs and pharmacy benefits managers (PBMs) maintain their oversight, as challenges mount for both medical and prescription drug plans.
- Get sound actuarial advice in establishing COBRA rates, reserves, etc.
- Foster better lines of communication in the organization, to quickly identify problem areas.
- Explore the “medical home” concept, which places a premium on the value of care coordination, telemedicine, electronic visits and other technology-enabled approaches to

Continued on next page

improving the efficiency and effectiveness of care.

- Consider the value-based insurance design approach by focusing more benefit resources (funding) on the prevention and early detection of chronic conditions such as diabetes and heart disease.¹⁰ **B&C**

Endnotes

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