Health Care Reform: 
Major Provisions and Bargaining Strategies for Self-Insured Healthcare Plans

GRANDFATHERED STATUS

Summary of Issue: Grandfathered plans are those that were in existence on March 23, 2010 and haven’t been changed in ways that substantially cut benefits or increase costs for consumers. There is no deadline on how long grandfathered status can be maintained, but the following changes cause plans to lose grandfathered status:

- Plan eliminates all or substantially all benefits to diagnose or treat a particular condition
- Plan increases a percentage cost-sharing requirement by any amount above the level at which it was set on March 23, 2010
- Plan increases a fixed-amount cost-sharing requirement other than a copayment by more than medical inflation plus 15%, as measured from March 23, 2010
- Plan increases a fixed-amount copayment for any service by more than the greater of $5 adjusted for medical inflation or medical inflation plus 15% measured from March 23, 2010
- Decrease in employer contribution rate by more than 5% below the contribution rate for the coverage period that includes March 23, 2010

Challenge: Loss of grandfathered status means:

- Preventive care at 100%
- Emergency room treatment out-of-network same as in-network
- Limit on out-of-pocket maximums with medical and prescription drug combined in 2015 ($6,350 individual/$12,700 family includes co-payments, coinsurance, deductibles)

Will any of these changes pose a challenge to long-term viability of your plan?

Strategy: Do cost projections

- Data mining – claims/cost analysis
- Make sure employees know about the rules that apply to their plans, as well as about the coverage that would be available on their state’s exchange

PRESCRIPTION DRUGS

1 Some health plans are fully administered and controlled by insurers who collect premiums paid by the employer and then pay out claims based on the benefits in the employee’s plan. These are traditional fully-insured plans in which insurance companies assume the financial risk of paying for necessary health coverage. However, some fire fighters have their healthcare needs covered by arrangements other than fully-insured plans. For municipal self-funded plans, the employer/local government takes the place of the insurer by taking on the financial risk of covering the costs of any medical claim issued by employees. For the local union self-administered plans, the union or a trust established by the union receives a finite sum of money from the employer/local government, and the union (or trust) itself bears the financial risk of paying for its members healthcare needs. In either of these alternative arrangements, a third party administrator (TPA), in many cases an insurance company, may handle claims administration, processing, etc, but, the jurisdiction, the union, or the trust assumes the risk and responsibility to pay the claims. Both self-funded plans and self-administered plans may be referred to as self-insured plans.
**Summary of Benefit:** The ACA aims to control the amounts patients must spend to obtain prescription drugs. For instance, a health plan that loses grandfathered status will have to cover all costs above patients’ out-of-pocket maximums, with medical and prescription drug combined in 2015 ($6,350 individual/$12,700 family includes co-payments, coinsurance, deductibles).

**Challenge:**
- Obligations on self-insured plans may increase.

**Strategies:**
- Decide whether to shift costs through adjustments to prescription formularies.
- Consider adjustments to co-pays to encourage generics and mail-order drugs.
- Separate specialty high cost drug plans (such as injectables/chemo) may need to be restructured.
- Consider comparative analysis to examine how changes to the prescription drug plan would affect a typical member of the local.

**TRANSITIONAL REINSURANCE PROGRAM ASSESSMENT FEE**

**Summary of Issue:** Health insurance issuers or TPAs on behalf of self-insured group health plans will be required to pay a fee for each beneficiary they cover (including employees, non-Medicare retirees, and dependents) in the years 2014-2016. The fee applies to both grandfathered and non-grandfathered plans, and it is designed to stabilize premiums for high-risk individuals buying coverage on the exchanges.

**Challenges:**
- Fee applies to group health plans including multi-employer plans (MEPs)
- In 2014, the fee is $5.25/month ($63 for the year) for each covered life. The fee in 2015 and 2016 has yet to be determined.

**Strategies:**
- Remember to include fee when planning for and calculating your health plan’s liabilities in years 2014-2016.
- Document the impact of this fee and others to support IAFF arguments that the exchanges place an undue burden on non-profit independent health plans.

**COVERAGE FOR CHILDREN UNDER AGE 26**

**Summary of Benefit:** Under the ACA, benefits for adult children are the same as those for dependent children. Adult children who need coverage no longer must be students, live at home, or be financially dependent. They can even be married, although coverage does not have to be provided to the spouse or children from the marriage.

**Challenge:** Additional plan cost for extra years of dependent coverage.

**Strategies:**
• Make sure that terms are the same as for other dependent children as the law specifies that coverage for all dependent children must be the same.
• Figure out how to manage the costs associated with the coverage of adult children of employees.

**EXCISE TAX ON “CADILLAC” PLANS**

**Summary of ACA Provision:** There is a 40% excise tax scheduled to go into effect in 2018 that will apply to plans that charge premiums of $10,200 or more for single coverage or $27,500 or more for families. This tax will apply to amounts in excess of the thresholds. For high risk occupations, the thresholds are $11,850 for single coverage and $30,950 for family coverage. To use these thresholds, the majority of those in the plan must be in the high risk occupation.

**Challenges:** The tax will be imposed on the insurance companies that sell the plans, so for self-insured plans the tax is to be paid by the plan itself. This will put pressure on employers/trusts/administrators of self-insured plans to either stop offering high-quality coverage, causing a reduction in benefits, or to pass the cost on to members.

**Strategies:**
- Use current plan costs for both single and family plans as a starting point for projecting costs in 2018 and beyond.
- Consider implementing cost containment programs, such as chronic disease management, wellness programs, etc.
- Analyze data relating to high costs and high usage rates
- Engage in comparative analysis to find out how similarly situated locals are dealing with rising costs in preparation for 2018.

**CATASTROPHIC CLAIMS AND STOP-LOSS COVERAGE**

**Summary of Issue:** The elimination of annual dollar limits on health insurance coverage for the 2014 plan year is one of the biggest cost drivers for self-insured plans.

**Challenges:** Health plans can no longer put a dollar limit on the coverage they may have to pay for a member’s healthcare. This means that the price of the stop-loss policies self-insured plans buy to protect against members incurring catastrophic or extremely expensive claims

**Strategies:** Consider alternative arrangements to spread risk; for instance, intergovernmental risk pools (IRPs) are made up of public entities, such as government agencies, that come together to form a pool, which can provide protection to the individual agencies against catastrophic risks. (This may not be appropriate for all self-insured funds.)

**PCORI FEE**
**Summary of Issue:** To fund the Patient-Centered Outcomes Research Institute (PCORI), the ACA introduced an annual fee on insured and self-insured plans, for plan years ending on or after October 1, 2012, and before October 1, 2019.

**Challenges:**
- For plan sponsors of applicable self-insured health plans, the fee for a plan year ending before October 1, 2013 was $1.00 multiplied by the average number of lives covered under the plan for that plan year.
- Plan sponsors of applicable self-insured health plans must use one of three alternative methods to determine the average number of lives covered under a plan for the plan year.
- The fee is to be adjusted annually for future plan years.

**Strategy:** Though the fee is not large, funds should plan accordingly to account for it.

**REPORTING HEALTH INSURANCE COST ON W-2s**

**Summary of Benefit:** The ACA requires employers to report the cost of coverage under an employer-sponsored group health plan on an employee’s W-2. An employer is not required to include in the aggregate reportable cost the cost of coverage provided under a self-insured group health plan that is not subject to any federal continuation coverage requirements (such as COBRA, ERISA, or PHSA). Employers who provide coverage under a self-funded group health plan that is subject to federal continuation coverage requirements must report the cost of coverage on form W-2.

**Challenge:** Members may not understand why the amount is listed on the W-2 form.

**Strategy:** If the employer determines this amount needs to be reported on the W-2, the fund should give such information to the employer and educate plan members about the change, most importantly to say that this amount is not taxable.