EMPLOYEE BENEFIT TAXES, THE ACA, AND STRATEGIES TO PREVENT FINANCIAL BLEED

May 16, 2018
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www.usi.com
“Give me a couple years, and I can answer your simple question about the new regulations.”
Increases in Premiums, Earnings, Inflation, & Ee Costs Since 1999

Average Deductible Based On Firm Size

* Estimate is statistically different from estimate for the previous year shown (p < .05).
NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
Current Employee Benefit Tax Issues Impacting Plans

➢ Patient Centered Outcomes Research Fee Paid By Self Funded Medical Plans
  – Applicable Until October 1, 2019—Filed by July 31st of Year ($2.26 to $2.39 Per Enrollee)

➢ Reinsurance Fees Paid by Self Funded Medical Plans--2017 was last year the fee was to be paid

➢ Health Insurance Premium Tax for Fully Insured Plans Moratorium for 2017, not 2018
  Olvier Wyman Study Indicates Annual Impact for Fully Insured Plans 2018 and Beyond
  – $185 per individual and $500 per family in the small employer market
  – $188 per individual and $540 per family in the large employer market

➢ Individual Mandate Gone in 2019 but Sledgehammer and Tack-Hammer Penalties Still Apply
  – Sledgehammer $2,320 for not offering coverage if 50 or more FTEs (All FTEs)
  – Tack Hammer Penalty $3,480 (2018) not offering affordable coverage (Waiver on first 30)
    • Affordability safe harbor for 2018 9.56%
Current Employee Benefit Tax Issues Impacting Plans Cont...

- IRS has Started Issuing 1094-1095 Tax Demand Letters

- Reporting and Disclosure Requirements Have Increased
  - Failure to File 5500 $2,063 per Plan per Day
    (Remember the Voluntary Delinquent Filer Program)
  - Failure to Distribute SBC $1,087 per Failure
  - Failure to Distribute CHIP Notice $110 per Day
Solutions Being Used to Mange the Risk (Direct and Indirect)

➢ Assure Compliance

➢ HRAs and HSAs are an Important Tool Both for the Employer and the Employee

➢ Tax Credit Program

<table>
<thead>
<tr>
<th>Target Group</th>
<th>Max Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans – unemployed or disabled</td>
<td>$2,400 - $9,600</td>
</tr>
<tr>
<td>Long-Term Temporary Assistance for Needy Families (TANF) Recipient</td>
<td>$2,400 - $9,000</td>
</tr>
<tr>
<td>Supplemental Nutrition Assistance Program (Food Stamp) Recipient</td>
<td>$2,400</td>
</tr>
<tr>
<td>Designated Community Resident (DCR)*</td>
<td>$2,400</td>
</tr>
<tr>
<td>Vocational Rehabilitation (VR) Referred Individual</td>
<td>$2,400</td>
</tr>
<tr>
<td>Ex-felon</td>
<td>$2,400</td>
</tr>
<tr>
<td>Supplemental Security Income (SSI) Recipient</td>
<td>$2,400</td>
</tr>
<tr>
<td>Summer Youth Employee**</td>
<td>$1,200</td>
</tr>
<tr>
<td>Qualified Long-Term Unemployment Recipient</td>
<td>$2,400</td>
</tr>
</tbody>
</table>

➢ More Focus on Physician Engagement and Outcomes

➢ Narrower Health Plan Preferred Provider Networks

➢ Employers are Moving to Alternate Funded Plans *FAILURE TO CONSIDER POTENTIALLY MEANS FINANCIAL BLEED*
What is Financial Bleed?

Financial Bleed is unnecessary utilization of organizational resources, ultimately preventing the organization from achieving operational efficiency or impacting profit.
Given inherent tax and fee advantages of alternative funding arrangements, long-term savings are highly likely.

- Using case specific factors and robust actuarial tools, USI demonstrates the very high likelihood of partial self-funding costing less than fully insured over the course of 1, 3, and 5 year periods.
- The inherent cost advantage of 7-12% of premium for alternative funding arrangements drives the long term savings.
- USI helps employers understand the appropriate balance of risk and premium.

* Data Source: Windsor Strategy Solutions, Risk Decision Support Tool
For employers more than 100 employees, claims play the most significant role in determining health insurance rates. Alternative funding strategies offer a different way to manage the rest of the cost. Either way, over time, the employer bears the cost of actual claims.

1. Margin, carrier profit and review of mandated benefits become potential savings for the employer.

2. Partially self funded plans reduce state premium taxes and many ACA fees.

3. Stop loss replaces the pooling charges, protecting the employer from large individual claimants and excessive total claims.
The Affordable Care Act has changed the landscape for healthcare financing. Additional taxes, fees and regulations have made alternative strategies more attractive, with estimated savings of 7-12% of premium or approximately $700 - $1,200 PEY.

- USI identifies case specific factors directly from the fully insured renewal.
- USI analysis begins with conservative carrier profit assumptions that generally have additional upside for savings.
- Further savings upside of alternative arrangements are available due to lower trend, carve out options and increased flexibility of plan design and vendor selection.
Fully Insured vs. Self-Funded Plans: Review the History

Alternative funding options are a long-term strategy. A review of historical claims against expected claims demonstrates healthcare underwriting is a predictable science over time.

- USI reviews prior renewal and paid claim calculations to produce a 4 year analysis.
- Expected self-funded total costs will generally start 7-12% below fully insured due to reductions of taxes, fees, and carrier profit.
- Individual years may produce varying results, however long-term savings are highly likely.

### Fully Insured vs. Self-Funded Plans: Review the History

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Employees</th>
<th>Fully Insured Premiums</th>
<th>Fully Insured Loss Ratio</th>
<th>Self-Funded Admin Fees</th>
<th>Stop Loss Premium</th>
<th>Net Paid Claims</th>
<th>Total Self-Funded Costs</th>
<th>Potential Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>198</td>
<td>$2,050,155.14</td>
<td>66.8%</td>
<td>$126,996.80</td>
<td>$325,762.50</td>
<td>$1,370,404.04</td>
<td>$1,823,163.34</td>
<td>$226,991.80</td>
</tr>
<tr>
<td>2012</td>
<td>318</td>
<td>$3,568,218.48</td>
<td>56.0%</td>
<td>$203,354.96</td>
<td>$521,630.63</td>
<td>$1,999,092.22</td>
<td>$2,724,077.81</td>
<td>$844,140.67</td>
</tr>
<tr>
<td>2013</td>
<td>422</td>
<td>$5,169,093.00</td>
<td>91.2%</td>
<td>$320,160.00</td>
<td>$821,798.00</td>
<td>$4,712,796.00</td>
<td>$5,854,967.00</td>
<td>($685,874.00)</td>
</tr>
<tr>
<td>2014</td>
<td>457</td>
<td>$4,624,101.00</td>
<td>76.8%</td>
<td>$270,002.00</td>
<td>$692,588.00</td>
<td>$3,552,660.00</td>
<td>$4,515,249.00</td>
<td>$108,852.00</td>
</tr>
</tbody>
</table>

**Total 4-year savings** $494,110.47
USI evaluates and recommends funding alternatives based on employer size, demographics and risk tolerance. Employers' needs vary, however all employers will reduce exposure to taxes and ACA fees.

- Given higher volatility of claims, smaller groups may purchase products with greater protection.
- Additional flexibility of alternative arrangements allow for greater transparency and reductions in costs.
- À la carte vendor relationships create best in class programs tailored for each employer.

**Alternative Funding with USI:**

**The Spectrum of Funding Alternatives**

- Fully Insured
- Minimum Premium
- Level Funded
- Carrier Partially Self-Funded
- TPA Partially Self-Funded
- Self-Funded

**Risk/Reward and Plan Design Flexibility**
Alternative Funding with USI:
The Spectrum of Funding Alternatives

Identifying options within the spectrum of funding alternatives creates savings.

As employers move to the right on this spectrum, vendor options increase; creating competition, greater transparency and reduced cost of each component.
Pharmacy expense is the fastest growing line item for most employer plans. USI’s review uncovers excessive spread pricing, overly broad definitions and poorly negotiated terms that lead to added expense for employers.

- Pharmacy costs are unique in that the carrier/Pharmacy Benefit Manager (PBM) typically earns profit in the cost of the claim as opposed to the cost of insurance or administration.
- Employers have little to no visibility into the carrier or PBM profit embedded in their plan.
- Cost savings opportunities exist in both drug pricing and drug utilization.
- USI’s review of an unmanaged plan can produce savings of 15-25% of pharmacy costs or $120,000 for a group of 300 employees.
Poorly negotiated contract terms drive profit for the carrier and PBM.

### Contract Language that Drives PBM Profit

5. **Rebate Administration**
   a. Customer acknowledges that XXXX contracts for its own account with pharmaceutical manufacturers to obtain rebates attributable to the utilization of certain prescription products by individuals who receive benefits from plan sponsors for whom XXXX provides pharmacy benefit management services. XXXX and Customer agree that XXXX shall retain any and all of the rebates received by XXXX based on the utilization by Plan Participants of rebateable drugs covered under the Plan.

V. **Important Information about the Pharmacy Benefit Management Services**
   a. Customer acknowledges that from time to time, XXXX receives other payments from drug manufacturers that are not rebates and which are paid separately to XXXX or designated third parties (e.g., mailing vendors, pharmacies). These payments are not attributable to XXXX for the cost of various educational programs. These programs are designed to achieve XXXX’s goals of maintaining access to quality, affordable health care for its members and customers. These goals are typically accomplished by educating physicians and Plan Participants about established clinical guidelines, disease management, appropriate and cost-effective therapies, and other information. XXXX may also receive payments from drug manufacturers that are not rebates as compensation for bona fide services it provides, such as the analysis or provision of aggregated information regarding utilization or health care services.

### Contract language that Drives Employer Savings

#### Administrative Services and Fees

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebate Sharing</td>
<td>100% of reimbursement</td>
</tr>
<tr>
<td>Administrative Fee</td>
<td>$3.00 per paid claim</td>
</tr>
</tbody>
</table>

The minimum rebate guarantees are:

- 2016 3-tier rebates per qualified brand claim
- Retail 1:30: $33.12
- Retail 31:90: $49.68
- Mail: $113.94
- Specialty: $148.44

- Carrier/PBM specifically states that they are contracting with manufacturers for their “own account” or benefit AND that the customer acknowledges that Carrier/PBM will retain any and all of the rebates received.
- Employer acknowledges that Carrier/PBM receives other payments from drug manufacturers that are not rebates but are additional sources of profit.
- This contract has 100% sharing of rebates back to employer in addition to minimum rebate guarantees.
Unclear or vague language drives profit for the carrier and PBM.

**Contract language that Drives PBM Profit**

- This fee schedule shows discounts & fees that are not market competitive. This is indicative of a PBM that is retaining a large amount of spread on the price of the drugs.
- This asterisk indicates that these rates are illustrative and not actually a guarantee of performance. Therefore, the same prescription could double in price from one day to the next without penalty.
- Without clear pricing terms, employers are unable to hold PBM’s accountable.
- Clear, competitive guarantees spelled out in the contract.

**Contract that Drives Employer Savings**

Minimum retail effective rate discount guarantees and dispensing fees for retail are:
- Brand (1-83 days) AWP-15.25% plus $1.05
- Generic (1-83 days) AWP-74% plus $1.05
- Brand (84-90 days) AWP-19.25% plus $0.10
- Generic (84-90 days) AWP-74% plus $0.10
- Nonexclusive Specialty AWP-14.75% plus $1.05

Client will receive the full benefit of performance beyond the stated minimum guarantees.
Unclear or vague language drives profit for the carrier and PBM

Contract Language that Drives PBM Profit

B. Customer acknowledges that in evaluating clinically and therapeutically similar drugs for selection for its Formularies, XXXX considers the costs of drugs and takes into account rebates negotiated between XXXX and drug manufacturers. Consequently, a drug may be included on the Formularies that is more expensive than a non-formulary alternative, and even when rebates are taken into account, certain drugs may be chosen for the Formularies because of their clinical or therapeutic advantages or their level of acceptance among physicians even though they cost more than non-formulary alternatives. The net cost to a self-funded customer for covered prescriptions will vary based on (i) the terms of XXXX’s arrangements with Participating Pharmacies; (ii) the amount of the Plan Participant’s copayment, coinsurance or deductible obligation under the terms of the plan; and (iii) the percentage, if any, of Rebates to which the Customer is entitled under its agreement with XXXX. As a result, a self-funded customer’s actual claim expense per prescription for a particular formulary drug may in some circumstances be higher than for a non-formulary alternative.

Contract Language that Drives Employer Savings

Formulary Management. XXXX will assist Client in developing a Formulary for the Plan. CLIENT hereby authorizes XXXX to manage the Formulary for prescription drug benefits covered under the Plan for retail and mail order Covered Prescriptions dispensed in accordance with this Agreement. The cost of postage, printing, and distribution of the Formulary and any subsequent update thereto or reports hereunder will be borne by the CLIENT as set forth in Exhibit “A” under Administrative Services and Fees. CLIENT agrees that XXXX may certify to XXXX’s contracting pharmaceutical manufacturers that CLIENT is participating in such Formulary Program for the CLIENT’s retail and mail order Covered Prescriptions as provided herein. CLIENT acknowledges that XXXX maintains a Formulary that allows, subject to the determination of an independent pharmacy and therapeutics committee, the inclusion of any covered prescription drug product approved by the FDA for use in the United States. CLIENT’s Formulary will be identified in Exhibit C and made available to CLIENT.

- Carrier/PBM disclose that they may choose drugs for the formulary that are more expensive than non-formulary drugs and that this decision could be driven by rebates paid to Carrier/PBM.
- This formulary management definition is much clearer with no intent to steer members to higher cost drugs.
Pharmacy Contract Review:
Definitions Matter

Another example of contractual terms that favor the Carrier and PBM.

Contract language that Drives PBM Profit

“Brand Drug” means a prescription drug or insulin with a proprietary name assigned to it by the manufacturer and distributor and so indicated by MediSpan or any other similar publication designated by Company. Brand Name Drug does not include those drugs classified as a Generic Drug hereunder.

“Generic Drug” means a prescription drug, whether identified by its chemical, proprietary, or non-proprietary name that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient, or it is deemed by XXXX to be pharmaceutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient.

Contract language that Drives Employer Savings

Brand Drug - Single or multisource brand drugs which are classified as a brand drugs, based upon indicators provided by Medi-Span’s National Drug Data File and denoted in the Multi-source Code field as “M”, “N”, and “O”.

Generic Drug - A multisource prescription drug, which are classified as generic drugs, whether identified by its chemical, proprietary, or nonproprietary name provided by Medi-Span’s National Drug Data File and denoted in the Multi-source Code field as “Y”.

- This language allows Carrier/PBM to use any source they choose to determine a brand name drug.
- Carrier/PBM can determine which drugs are generic.
- This language is a much clearer definition of name brand vs. generic drugs as defined by Medi-span (a nationally recognized independent database).
- This prevents manipulation of drug categorization in order to meet pricing guarantees
Questions?