Session 98PD, Role of the Actuary in Self-Insurance

**Moderator/Presenter:**
John I. Mange, FSA, MAAA

**Presenters:**
Kristi M. Bohn, FSA, MAAA, EA, MSPA
Hobson D. Carroll, FSA, MAAA
Mehboob A. Khoja, FSA, MAAA
Brent W. Seiler, FSA, MAAA
2018 SOA Health Meeting

SELF-INSURANCE TASK FORCE
Session 98, Role of the Actuary in Self-Insurance
June 26, 2018
Active participation in the Society of Actuaries is an important aspect of membership. While the positive contributions of professional societies and associations are well-recognized and encouraged, association activities are vulnerable to close antitrust scrutiny. By their very nature, associations bring together industry competitors and other market participants.

The United States antitrust laws aim to protect consumers by preserving the free economy and prohibiting anti-competitive business practices; they promote competition. There are both state and federal antitrust laws, although state antitrust laws closely follow federal law. The Sherman Act, is the primary U.S. antitrust law pertaining to association activities. The Sherman Act prohibits every contract, combination or conspiracy that places an unreasonable restraint on trade. There are, however, some activities that are illegal under all circumstances, such as price fixing, market allocation and collusive bidding.

There is no safe harbor under the antitrust law for professional association activities. Therefore, association meeting participants should refrain from discussing any activity that could potentially be construed as having an anti-competitive effect. Discussions relating to product or service pricing, market allocations, membership restrictions, product standardization or other conditions on trade could arguably be perceived as a restraint on trade and may expose the SOA and its members to antitrust enforcement procedures.

While participating in all SOA in person meetings, webinars, teleconferences or side discussions, you should avoid discussing competitively sensitive information with competitors and follow these guidelines:

- Do not discuss prices for services or products or anything else that might affect prices
- Do not discuss what you or other entities plan to do in a particular geographic or product markets or with particular customers.
- Do not speak on behalf of the SOA or any of its committees unless specifically authorized to do so.
- Do leave a meeting where any anticompetitive pricing or market allocation discussion occurs.
- Do alert SOA staff and/or legal counsel to any concerning discussions
- Do consult with legal counsel before raising any matter or making a statement that may involve competitively sensitive information.

Adherence to these guidelines involves not only avoidance of antitrust violations, but avoidance of behavior which might be so construed. These guidelines only provide an overview of prohibited activities. SOA legal counsel reviews meeting agenda and materials as deemed appropriate and any discussion that departs from the formal agenda should be scrutinized carefully. Antitrust compliance is everyone’s responsibility; however, please seek legal counsel if you have any questions or concerns.
Presentation Disclaimer

Presentations are intended for educational purposes only and do not replace independent professional judgment. Statements of fact and opinions expressed are those of the participants individually and, unless expressly stated to the contrary, are not the opinion or position of the Society of Actuaries, its cosponsors or its committees. The Society of Actuaries does not endorse or approve, and assumes no responsibility for, the content, accuracy or completeness of the information presented. Attendees should note that the sessions are audio-recorded and may be published in various media, including print, audio and video formats without further notice.
Self-Insurance Task Force

• Mission: To educate health actuaries about the roles actuaries play in the self-insurance marketplace both as advisors to self-insured employers and as developers of tools self-insured employers use to manage the risks they assume

• Produced a monograph that you can find from the Health Section landing page:
  https://www.soa.org/sections/health/health-landing/
To Participate, look for Polls in the SOA Event App or visit [health.cnf.io](http://health.cnf.io) in your browser.

Find The Polls Feature Under More In The Event App

Type **health.cnf.io** In Your Browser

Choose your session

Respond to Polls when they appear
Poll: What role, if any, do you play in the self-insurance marketplace?
What role, if any, do you play in the self-insurance marketplace?
Poll: At what size group does self-insurance become a viable option to fully insured group health insurance?
At what size group does self-insurance become a viable option to fully insured group health insurance?
Fully Insured Transaction

Plan Sponsor → Insurer → Plan Beneficiaries
Self-Insured Transaction

- Plan Sponsor
- Plan
- PBM
- Medical Manager
- TPA
- Stop Loss
- Insurer
- Plan Beneficiaries
Presenters

• Hobson Carroll, FSA, MAAA
• Kristi Bohn, FSA, MAAA, EA
• Mehb Khoja, FSA, MAAA
• Brent Seiler, FSA, MAAA
Why Self-Insurance?

HOBSON CARROLL
Why Self-Insurance?

• Importance of self-insurance to medical expense insurance for persons covered by non-governmental programs (Tricare, VA, Medicare, Medicaid)

• Self-insured plans administered by 1) insurance carriers through ASO arrangements, 2) independent Third Party Administrators (TPAs), or 3) plan sponsor, i.e., self-administered

• Self-insured plans cover nearly 60% of employees with employer-based medical plans

• Over 40% (and growing) of employers offering plans offer at least one self-insured plan option
  • Nearly 80% if over 500 employees
  • Fastest growing segment is employers with under 100 employees.
Why Self-Insurance for Employers?

• Great flexibility in plan design as compared with the regulatory boundary conditions placed on fully-insured plans, whether small large

• Potential net cost-savings (beneficiary claims, taxes, vendor costs, cash flow, and risk charges) in exchange for taking responsibility

• Great flexibility in choosing the vendors, service providers, and risk partners to fulfill those responsibilities
Why Self-Insurance for the Actuary?

• Opportunities for actuarial creativity in plan design, provider payment methodology, and cost control features

• Leveraged emphasis of routine actuarial concerns/issues provide for interesting challenges in adaptation of actuarial tools. (i.e., trends, “tail” risk management, sources of risk/profit margin)

• Myriad opportunities for actuaries as consultants to employers, vendors of various products and services offered to self-insured employers (TPAs, PBMs, Medical Management), or working for or consulting with players in the stop loss risk structure behind many self-insured plans
Why The Role of the Actuary in Self-Insurance?

• Literature for actuaries, whether plan consultant or stop loss
• Association Health Plans may change key definitions
• Potential source of adverse selection, viz., Small Group fully-insured business and Individual Exchange plans
• Level Funding variations
Self-Insurance Regulatory Environment

KRISTI BOHN
Early History

• Stabilization Act of 1942
• Taft-Hartley Act of 1947
• 1954 Internal Revenue Code
• McCarran Ferguson Act of 1945
• ERISA of 1974 (a lot more on this law later)
Post-ERISA Regulations

• COBRA (1985)
• HIPAA (1986)
• Newborns’ and Mothers’ Health Protection Act (1996)
• Women’s Health and Cancer Rights Act (1998)
• Genetic Information Nondiscrimination Act (2008)
• Michelle’s Law (2008)
• Health Information Technology for Economic and Clinical Health Act (2009)
Post-ERISA Regulations (continued)

• Mental Health Parity and Addiction Equity Act (2008)
  • Final Rule November 2013
  • Affordable Care Act made MHPAEA applicable to individual and small group insurance markets

• Affordable Care Act (2010)
• 21st Century Cures Act (2016)
• 0% setting of individual mandate penalty (Dec. 2017)
Major Affordable Care Act Affects on Self-Insured Plans

• Employer and individual mandate
• Taxes on health insurers and TPAs, also medical device and pharmaceutical manufacturers
• Age 26
• Lifetime and annual limits prohibited
• Waiting periods limited to no more than 90 days
• Prohibits pre-existing conditions
• Appeals requirements
• 100% coverage for preventive services

The ACA did a whole lot more...feel free to ask!
Employee Retirement Income Security Act (ERISA) of 1974

• Mostly pension, but health and welfare there too
• Whether fully-insured or self-insured
• Non-governmental, Non-church, employer plans

• Reporting and Disclosure
  • Summary Plan Description (SPD)
  • Form 5500 if over 100

• Administration and Enforcement
  • Claims review procedure required
  • Limits financial challenge to cost of benefits
ERISA of 1974: Plan Fiduciaries

• Anyone with discretion or control, official or unofficial

• Every plan must have at least one named fiduciary

• Insurers, TPAs, and consultants can become fiduciaries if they exercise control and take on decision-making responsibilities

• Fiduciaries must discharge their duties solely in the interest of participants and beneficiaries for the exclusive purpose of paying benefits and defraying unnecessary or high administrative expenses
ERISA of 1974 (continued)

• Conduct of plan fiduciaries (continued)
  • Must use care, skill and prudence...like a prudent person skilled in the subject at hand
  • Incompetence or unawareness not an acceptable defense
  • Must seek (and follow) legal counsel
  • Must also monitor the conduct of other plan fiduciaries and take action when necessary
  • Actuaries are not a fiduciary...unless they take on control or decision-making responsibility over the plan
ERISA of 1974 (continued)

• Interaction with state law
  • **Preemption Clause** voids state laws relating to ERISA-governed employer plans
  • Except the **Savings Clause** keeps state laws that apply to insurance products used by the plan, such as small group, large group, stop loss, disability, group life, dental insurance, vision insurance, etc.
  • The **Deemer Clause** prohibits states from deeming self-insured plans as being in the business of insurance
  • Lots of case law on these subjects
ERISA of 1974: Nondiscrimination

• Applicable to all self-insured plans, including even governmental and church employer plans
• Highly compensated and key employees
• Eligibility Test, Benefits Test
• Controlled Group
• Operations, appeals and coverages testing
  • Facts and circumstances matter
• The Affordable Care Act extended these laws to insured small employer plans
ERISA of 1974: MEWAs

• Joint oversight with states, since ERISA amended in 1983
  • Erlenborn-Burton Amendment
  • Saved state regulation from the preemption and deemer clauses

• State laws over MEWAs varies greatly
  • States’ oversight over MEWAs varies too
  • Due to budgetary constraints and expertise needed, many states choose a similar oversight stance as federal regulators, basically performing investigations and enforcing MEWA laws when complaints or financial concerns arise (which is frequent)
What’s Next? (Federal Possibilities)

• Cost Sharing Reduction
• Association Health Plans
• Short Term Health Plans
• Sales Across State Lines
• Employer Mandate
• Cadillac Tax
• Mental Health Parity Clarity
What’s Next in Many States?

• Section 1332 Waivers and Appropriations to save the individual market
• Short term health plan laws, timing and coverage
• State level “mandate” penalty
• MEWAs and subsets
• Stop loss laws under change: in both directions
• Parity Clarity
Employee Benefits Consultant

MEHB KHOJA
# Should the Employer Self-Insure?

<table>
<thead>
<tr>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cost savings</td>
<td>• Plan expense volatility / unpredictability</td>
</tr>
<tr>
<td>• Premium tax, health insurer tax, mandated benefits</td>
<td>• Additional risks (fiduciary, legal, reputational)</td>
</tr>
<tr>
<td>• Positive experience and savings from wellness and care management</td>
<td>• Additional expertise needed (legal, actuarial, stop loss)</td>
</tr>
<tr>
<td>• Flexible plan design</td>
<td></td>
</tr>
</tbody>
</table>

- **Advantages**
  - Cost savings
  - Premium tax, health insurer tax, mandated benefits
  - Positive experience and savings from wellness and care management
  - Flexible plan design

- **Disadvantages**
  - Plan expense volatility / unpredictability
  - Additional risks (fiduciary, legal, reputational)
  - Additional expertise needed (legal, actuarial, stop loss)
Claim Lag - Flow of Funds

- Member incurs a claim
- Billed claim is sent to the TPA for repricing
- Billed claim is discounted to allowed
- Provider is notified of allowed amount and reimbursed
- Provider bills member for outstanding balance

July 1 to Aug 15
Selecting a Third Party Administrator

<table>
<thead>
<tr>
<th>Quantitative</th>
<th>Qualitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Admin fees</td>
<td>• Technology / data</td>
</tr>
<tr>
<td>• Network access</td>
<td>• Member services</td>
</tr>
<tr>
<td>• Provider reimbursement analysis</td>
<td>• Compliance</td>
</tr>
<tr>
<td>• Medical Management</td>
<td>• Medical Management</td>
</tr>
</tbody>
</table>
Medical Management

- Wellness
- Disease Management
- Pre-authorization
- Pre-Certification
- Smoking Cessation
- Health Savings Accounts
- Chronic Care Management
- Step-Therapy
- Plan Design / Steerage
- Contribution Strategy
Budgeting / Rate-Setting

• Request data from TPAs
• Adjust historical data: networks, plan design, age/gender mix, population changes
• Large claims: ongoing vs catastrophic event
• Project claims: trend, credibility/weights to past experience
• Fixed expenses: admin fees, network access, stop-loss, wellness/DM/CM
• Adjust per employee composite to rate-tiers
Setting Reserves

- IBNR vs IBNP
- Frequency: quarterly to annual
- Reserving methods: development method, projection method, loss ratio method, case reserves method
- Lag by line of service: medical, Rx, dental, vision
Stop Loss Insurance

BRENT SEILER
Interests of a Stop Loss Actuary: Actuarial Theory

• Actuarial pricing: specific stop loss manual
• More actuarial modeling: aggregate stop loss rates
• Risk aspects of specific & aggregate stop loss coverages
• Extra volatility/leveraging for high cost claimants
• Compare actual to expected – annual update & leveraged trend projections
• Approaching with less data
Interests of a Stop Loss Actuary: Partnerships & Interactions

• Partner with Underwriting on stop loss risk management
• Collaborate with clinicians on catastrophic claimants
• Advice re: expectations for high cost claimants
• Communicate with leadership on developing experience
Challenges Faced by Stop Loss Actuaries

• General stop loss reserving plus “known” situations
• Forecasting plus “known” situations
• Contemplating extreme claimants
  • Is it frequency or severity driving results?
  • What’s the upper limit $5M, $10M, $20M?! 
• High cost specialty pharmacy
More Challenges Faced by Stop Loss Actuaries

• Product development – *no lasers, level funding, captives, refunding, etc.*

• Regulatory changes

• Predicting high cost claimants
  • Low probability of high cost claimants
  • Many predictive health care risk models focused on first dollar or general population health risk and conditions
Questions