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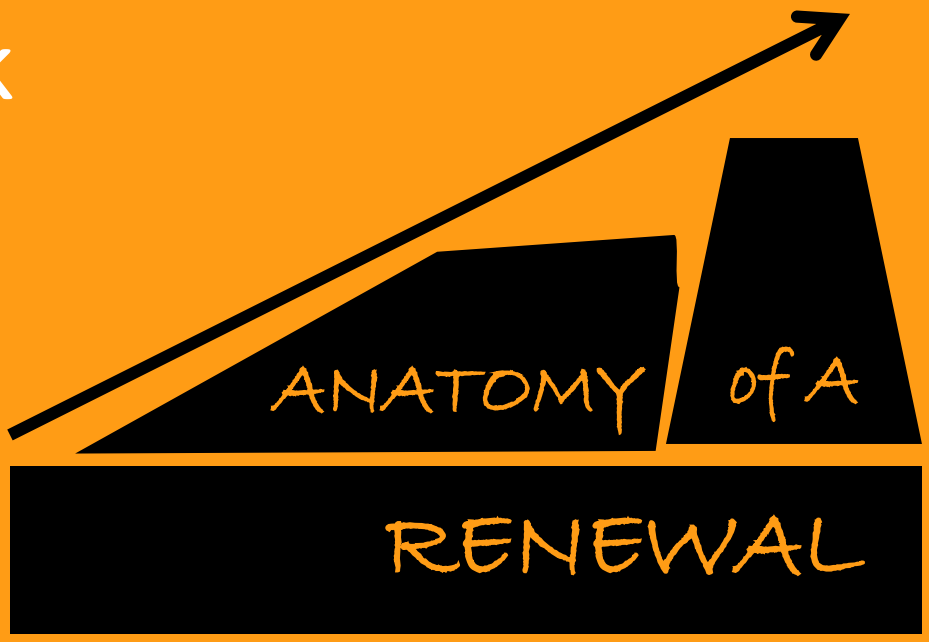
eBook



Your Employee Health Plan Renewal: What You Don't Know Will Hurt You

Part 1: Is it warranted?
How health insurers determine your renewal

Part 2: Did you see it coming?
Renewal planning and analysis

Part 3: What can you do?
Traditional and alternative strategies to control rising health plan costs

Understanding the process insurers go through to price the renewal of your employee health plan—whether you are fully-insured insured or self-funded—can save you anxiety, headaches, and possibly millions of dollars.

This 12-page eBook, revised and updated for 2018, arms you with what you need to know and what you can do to take control—and includes success stories from other employers.

What's Inside:

About the author

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Doug specializes in working with employers on a strategic, analytical approach to benefits, helping them to optimize their plan so that it strikes the right balance between maximizing value to employees and minimizing costs to the employer.

He is also an expert in innovative employee benefits solutions, including group medical captives.

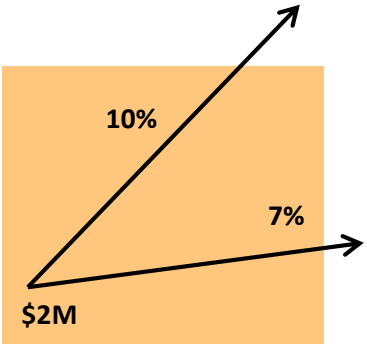
Doug earned the Certified Employee Benefit Specialist (CEBS) designation from the Wharton School at the University of Pennsylvania. Doug is a graduate of the United States Military Academy at West Point.

The informational asymmetry of a renewal

Employee health plans can be so complicated, and the expertise required to fully understand them so specialized, that most employers are at a significant disadvantage when it comes to their annual renewal. The informational asymmetry is so much in the seller's (insurer's) favor, that it's almost like buying a car in the days before internet research.

This eBook, written by an employee benefits executive with almost 15 years of experience analyzing and negotiating renewals with health insurers, will shrink that informational asymmetry by helping you understand the anatomy of how insurers calculate your renewal. It will arm you with enough information to ask the right questions when working with your broker-advisor to ensure that you are getting a fair renewal on your health plan.

The information in this eBook is intended primarily for financial and HR executives with 150 or more employees on their health plan. At that size, you should be able to get at least some claims data from your insurer to work with your broker-advisor on an independent analysis of where your renewal should be. Smaller employers who simply want to better understand health plan renewals will benefit as well.



For an employer who spends $2 million on the health plan, the difference between 7% annual renewal increases and 10% renewal increases is $1.1 million over a 5-year period

What you don't know, will hurt you

Fully-insured insured employers get the renewal in terms of a premium, while self-funded employers get it in the form of an attachment factor, stop-loss premium, and fees. Whatever the funding method, all renewals have the same basic anatomy, and are calculated using the process outlined in this eBook.

If you don't understand the process, you can't assess whether the renewal is warranted and only needs minor negotiation, or whether you need to negotiate hard and be prepared to switch insurers or make other changes.

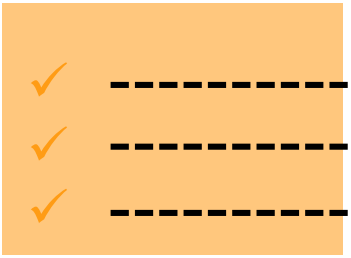
If you and your broker-advisor accept the insurer's renewal every year, or only win minor concessions, then one of two things is happening: either the insurer isn't building any cushion into the renewals, or you are paying too much. This can end up costing you millions of dollars.

On the other hand, even large renewal increases are sometimes warranted, and switching insurers or making other large-scale changes under those circumstances may result in a significant amount of disruption without much savings over the long haul.

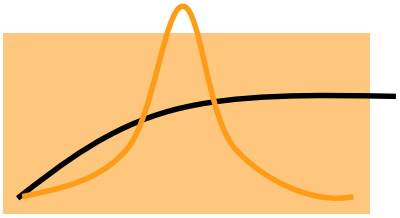
6 key aspects of a renewal

1 | Claims Projections

The first thing insurers analyze when calculating your renewal, obviously, is your most recent available claims data. They use this to project what your claims will be in the future. Insurers look at the claims themselves, the members who produced those claims, and the medical conditions that generated the claims. In projecting future claims for the renewal, insurers also make adjustments for the lag between when the claims were incurred and when they were paid (typically two months).



Even fully-insured insured plans with 150 or more members can typically get access to some level of claims data from insurers to conduct their own independent analysis.



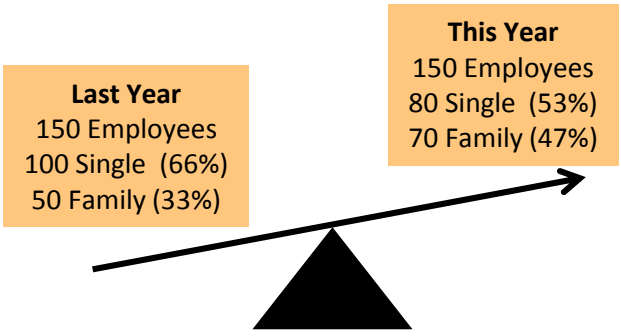
All large claims should not be treated equally. Some of the medical conditions that generate large claims can be resolved relatively quickly, while others can persist for years.

2 | Large Claims

Insurers pay special attention to large claims. They look at what medical condition is causing the claim and if it is a condition that is likely to persist (e.g., dialysis), or something from which the claimant typically either recovers or, unfortunately, dies (heart attack). They also look at the age of the person making the claim and whether or not the condition requires a high-cost treatment, such as a long-term specialty drug regimen.

3 | Demographic Adjustments

It's no surprise that some demographic groups incur more claims than others. Insurers look for changes to the demographics of your plan participants. Did you hire more younger, single males, or did you make an acquisition with a larger number of employees with family coverage? Significant changes in demographics can impact your renewal even if your claims experience remains consistent.

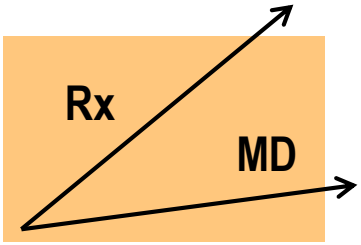


Claims will be projected to change, even on a per employee basis, due to shifting demographics.

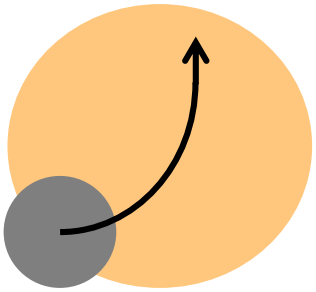
Part 1 : Is it warranted?

4 | Trend

Trend is simply inflation in health care costs. Actuaries at insurers project what the cost of care will be in the future, and they factor this into your renewal. Insurers look at the inflation in medical costs and in drug costs separately, because they can be dramatically different. They then blend the two to determine the overall inflation trend for health care costs.



Trend, or inflation, in medical costs has been around 5-7% in recent years, well below the roughly 15-18% trend in drug costs, which has been driven by specialty medicines.



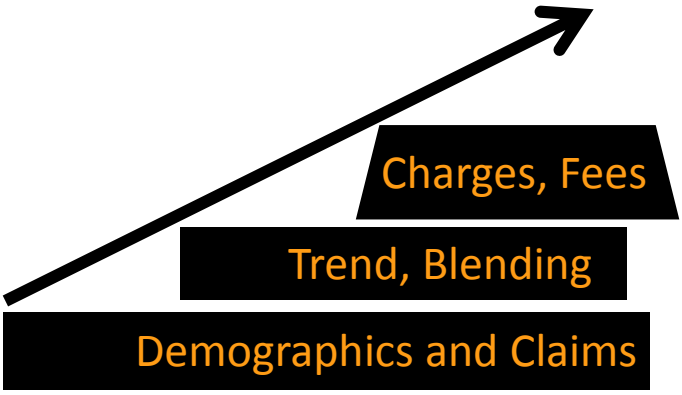
In some instances, employers with a younger, healthier population on their plan still get higher renewal increases because their experience is blended with the insurer's other groups.

5 | Blending

Insurers look at how "credible" your plan is from an actuarial standpoint. If your group is sufficiently large and has a long enough history, the group is deemed credible. The renewal can then be calculated using a statistical analysis of your own claims experience. If your group is too small or too new, then the insurer will "blend" your actual experience with the claims experience from all of the groups that they insure, or what is referred to as their "manual" cost. This blend of your claims experience with the manual experience is used to calculate your renewal.

6 | Charges and Fees

The final piece of the renewal is charges and fees. Employers with self-funded plans see a more detailed breakout that includes an attachment factor, stop-loss premium, and administration and other fees. For fully-insured insured groups, insurers bundle everything, including a pooling charge (the equivalent of a stop-loss fee), into the premium. Regardless of the method of funding, insurers incorporate their profit margin into the renewal.



Part 2 : Did you see it coming?

Preparation and planning

No surprises

For employers who have access to their claims, there should be no big surprises at renewal time. Your broker-advisor should analyze claims on a monthly basis, and by mid-year (or earlier for large employers) they should conduct an extensive mid-year review with you. The mid-year review should include an analysis of historical claims data on a rolling 12-month basis and an estimate for where costs will be in the next plan year, which should be updated as the year progresses.

Renewal Planning Start Dates	
EEs On Plan	At Least
150	3-4 Months
500	5-6 Months
1,000	6-8 Months

Timing

The time to start your annual renewal process depends upon how many employees are on your plan, but starting as early as possible is advisable—unless your projections indicate you are going to get a large increase, then it is crucial. Starting at least three to eight months before the renewal preserves your flexibility to make changes if needed. Wait too long, and you may have to swallow a large renewal simply because there is not enough time to make changes**. DO NOT WAIT TO RECEIVE THE INSURER'S RENEWAL TO START THE PROCESS—IT COMES TOO LATE.**

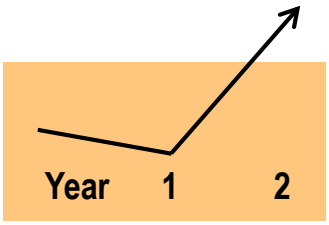
Analysis and Projections

As noted in the previous section, you and your broker-advisor should analyze the same things the insurer's underwriters do. Look at claims, large claims and what is driving them, and changes to the size and demographics of your group. Combine this with your broker-advisor's estimation of health care cost inflation, and develop you own projections for where your costs will be in the coming year.

Then, as needed, work with your broker-advisor to model various scenarios such as the impact of plan design changes and changes to the stop-loss specific deductible (taking into account leveraged trend).

Traditional and alternative approaches

A large renewal increase and/or projections of unsustainable increases in your health care costs require action. Following are both traditional and alternative approaches to getting your health plan costs under control.



If internal analysis shows a high renewal is in fact warranted, then "shopping the plan" may only result in a competing insurer lowballing to win the business in Year 1 and hiking the Year 2 renewal to make up for it.

Change Insurance Carriers

When presented with a significant renewal increase, the first instinct of many employers is to have their broker-advisor "shop" the plan among competing carriers. There is nothing wrong with taking the plan to market periodically, but it should be done in a well thought-out manner.

Here's where the analysis comes in. Is the renewal warranted? If the renewal looks warranted then shopping the plan may not be productive. A new insurer may lowball to win the business in year one, but odds are they will hike the renewal in year two to make up for it. The result will be a significant amount of disruption to the HR staff and employees without much savings over the long haul.

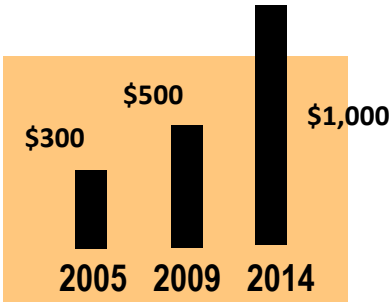
If the renewal does not look like it is warranted, then look at alternative carriers. Work with your broker-advisor to develop a thorough and detailed RFP that will address issues like discounts, network coverage and provider disruptions, and services the insurer will provide.

Change Plan Designs

Changing the design of the health plan can have a big impact—both good and bad. Plan design changes can yield significant savings, but they can also produce anxiety among employees and even harm recruitment and retention.

The first thing to do is have a strategy for health benefits. Do you need a rich plan to recruit scarce talent, can the company afford only the bare minimum in benefits, or something in between? Then, work with your broker-advisor to benchmark where your benefit plan is relative to competitors and other similar employers. This will set the framework for where your plan designs should be.

You and your broker-advisor should carefully model the financial impact of changes, including issues like deductible leveraging and impact on utilization.



Plan design benchmarks change quickly in today's environment. According to actuarial services firm Milliman, the median deductible for PPO single coverage has doubled since 2009 from $500 to $1,000. CDHPs grew from 2% of plans offered in 2005 to 25% in 2014, and they now have a median deductible of $2,500.

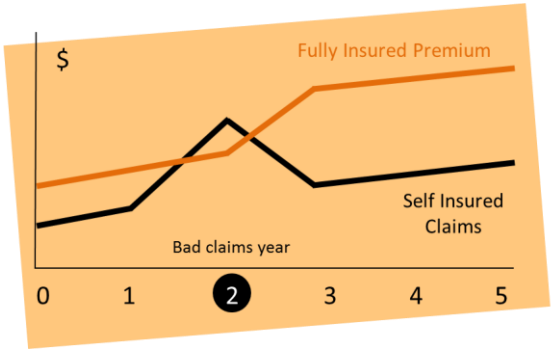
Part 3: What Can you Do?

Self-Funding

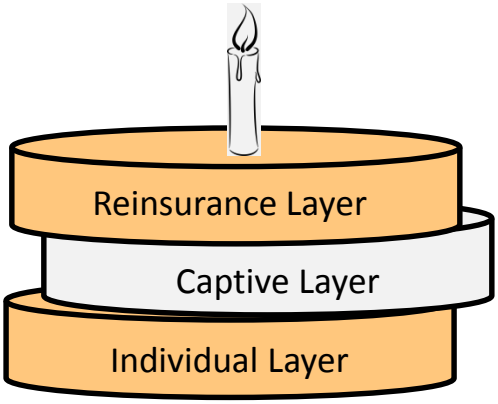
For a fully-insured insured plan, the most effective thing an employer can do to control renewal increases is to self-fund.

In a nutshell, with self-funding, the employer pays the claims of those covered on their plan, plus a fee to have an insurer or TPA to administer the plan, plus a premium for stop-loss insurance to limit liability on large claims.

There are many advantages to self-funding, but the two most valuable are control and savings. Typically, a plan will have one bad claim year in five years. Insurers usually hike the renewal premium following such a year, but will almost never reduce it when claims costs return to a more normal level. Under self-funding, you know your costs will mirror the actual claims—and you'll have stop-loss insurance to protect against abnormally large claims.



Insurers raise premiums on fully insured plans when claims go up, but almost never lower them when claims drop. Under self-funding, your costs more closely mirror the actual claims.



Stability and savings. Members pool their claims in the Captive Layer. This reduces volatility in claims costs and enables members to get a portion of their stop-loss premium back in an average or good claims years.

Alternative Approaches: Stop-Loss Captive

Even employers with self-funded plans are still at the mercy of stop-loss carriers. When the employer has a good claims year, the stop-loss insurer raises the premium a little; in a bad claims year, they raise it a lot.

Increasingly, middle market employers are funding their stop loss through group medical captives. Unlike often complex Property & Casualty captives, Veritas offers a simple group medical captive option: Everlong Group Medical Captive Services.

Members of Everlong pool their claims above the specific deductible but below the reinsurance level. This reduces volatility in claims costs. More importantly, members participate in the surpluses or deficits of the pooled claims, which means they can get a portion of their stop-loss premium back in an average or good claims year. And members further reduce stop-loss premium increases through group purchasing power. This can save members a significant amount of money—without reducing benefits.

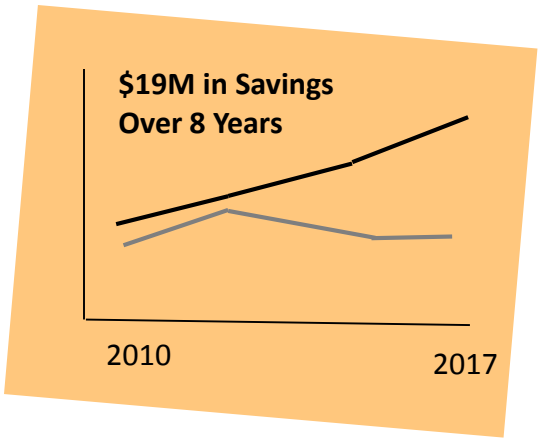
Part 3: What Can you Do?

Success: Saving $19 Million Self-Funding in the Everlong Captive

Frustrated with a 23% renewal increase on their fully-insured health plan and a lack of options, a holding company with several hundred employees needed better solutions to control their health care costs. Veritas transitioned the health plan from fully insured to self-funded and got them to join Everlong Group Medical Captive Services, an innovative medical captive. The employer received a 4% *decrease* in year one and, through Everlong, was able to keep long-term health plan increases far below what they would have been had the company remained fully insured—saving $19 million over eight years with no reduction in benefits.

The Everlong Captive takes the profits that health insurance carriers make and pays that money back to members with an innovative insurance and funding solution.

The savings can be significant: one employer saved $19 million on a per employee per year basis over eight years compared to what they would have paid had they remained self-funded at trend.



Alternative Approaches: PBM Carve-out

Today, almost all health insurers have their own internal Pharmacy Benefit Manager (PBM). The quality of these PBMs varies, however. Employers with a self-funded plan can carve the PBM service out from the health plan insurer or administrator and select a PBM that best meets their needs.

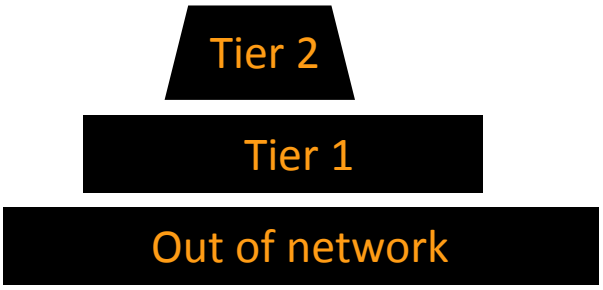
Carving the PBM out can be complicated, and doing so requires careful analysis regarding whether or not the savings justify the reduced level of integration between the health insurer and PBM. Given the rising cost of prescription drugs, however, this is an option you may want to explore to reign in rising drug costs without cutting employee benefits.

Part 3: What Can you Do?

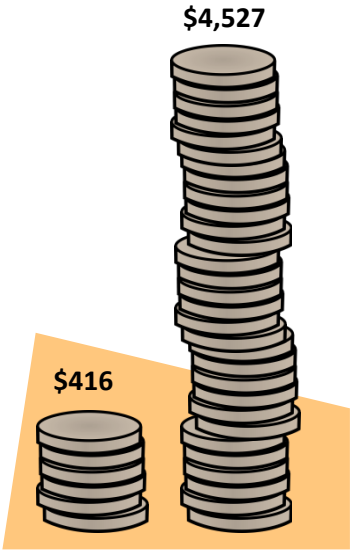
Alternative Approaches: Tiered Network

A plan design option that is gaining popularity is a Tiered Network approach. Under a typical tiered network, employers offer their employees the existing broad provider network at standard cost-sharing and Out-of-Pocket levels (plus the option to go out of network at the highest cost), but also offer a more narrow network of less expensive providers where the employee cost sharing and OOP levels are lower.

Tiered networks are only viable in more populated areas with larger numbers of providers, and you need to ensure the narrow tier provides adequate access to health services. Implemented properly, however, a Tiered Network can save you money and give your plan members more choice.



A Tiered Network option provides employees the choice of a smaller provider network with lower cost sharing and OOPs or a larger legacy network with existing cost sharing and OOPs (plus the option to go out of network).



Castlight Health 2014 Survey: Lowest and highest prices for an MRI of lower back in New York City.

Alternative Approaches: Referenced-Based Pricing

A growing number of larger employers are implementing reference-based pricing (RBP) in their plans for high-cost health services that have wide ranges in prices between providers, such as hip replacements and MRIs.

With RBP, the employer places a limit on what it will pay for a particular service, based on a reference price such as the Medicare fee schedule.

RBP programs come in different flavors and can be complicated to implement. You need to select a quality RBP vendor to manage the program and to deal with providers who balance bill the plan member. You also need to educate plan members so they clearly understand the implications of RBP. The cost savings, however, can be worth the effort.

Part 3: What Can you Do?

Success: Saving the Health Plan with Referenced-Based Pricing

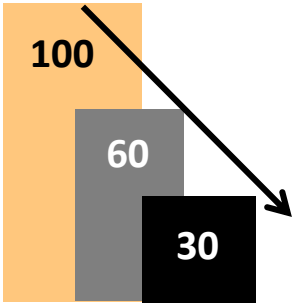
High claims costs were driving 30%-plus increases in in a non-profit's health plan costs, making the plan unaffordable for the organization. Shifting costs to the employees wasn't an option: the monthly premium for a single employee in the PPO, for example, would have jumped from $3,396 to $5,122.

The other option was to quickly and significantly reduce claims costs. Veritas worked with the organization to implement a Reference-Based Pricing (RBP) program to address the largest component of claims costs: hospital claims.

Veritas implemented the program through a highly respected RBP vendor. We worked with the employer's management and HR team to educate employees on the implications of the RBP program, including turning any balance-billing issues over to the vendor.

As a result of the RPB program, overall medical plan cost increases were slashed to 0%—all without significant plan design changes or cost shifting to employees.

A non-profit turned a 30% renewal increase into a 0% with an RBP Program. Since hospital claims typically make up 60% of total claims costs, and implementing a RBP program can result in roughly a 50% reduction in hospital claims, this level of savings is not uncommon.



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About Veritas

There is a best employee benefits offering for every employer, one that finds the sweet spot between affordability and employee satisfaction and recruitment. Veritas works with employers to develop that optimal benefits offering and to implement and manage it effectively.

Veritas provides solutions and service for every aspect of employee health benefits, including strategy development, plan structure and design, vendor selection and management, compliance with ever-changing regulations, and employer and employee communications.

We bring to clients a strategic approach and level of expertise more typical of large national consulting firms, yet we partner with our clients, providing them with exceptional service and hands-on support—all at a reasonable fee that is fully disclosed up-front.

The result is health and welfare plans that provide the biggest impact for the cost, are delivered effectively, and are understood and appreciated by employees.

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