XV. Plan Costs, Cost-Sharing Features, and Participant Contributions

A. Overview of Plan Costs, Cost-Sharing Features, and Participant Contributions

When designing a self-insured health plan (particularly a major medical plan or other non-account balance plan), the plan's projected cost is a key consideration. Budgetary constraints often influence the type of benefits offered, eligibility for benefits, the amount that participants will be asked to contribute, the level of cost-sharing that will be required of participants, and other plan design decisions.

In simple terms, a self-insured health plan's cost to the plan sponsor is (1) the cost of covered claims; plus (2) administrative costs; less (3) participant contributions; and less (4) participant cost-sharing (for example, deductibles and co-payments). Participant contributions and cost-sharing are particularly important design considerations because they directly reduce the plan sponsor's cost and so can serve as tools to adjust the plan sponsor's projected cost to the desired level. Cost-sharing also serves an important function in regulating utilization of plan benefits. In other words, when participants must pay out-of-pocket for some or all of their benefits, they may be more judicious about incurring claims.

Projecting costs, establishing cost-sharing features, and setting participant contribution levels all require assumptions about the future. For example, a plan sponsor must estimate the number and nature of claims that will be incurred, making assumptions about the extent to which each participant will utilize plan benefits. Fortunately, this is not all pure guesswork; some clarity can be brought to the process by looking at claims history and trend data. Most plan sponsors engage outside actuaries, brokers, consultants, or underwriters to make these projections and help the sponsor evaluate the implications of potential design decisions.

The starting point in the analysis is projecting the plan's expected total costs for the coming plan year, which is discussed in subsections B and C. That projection, along with the plan sponsor's budgetary considerations, desired competitive position, and other relevant factors (for example, collective-bargaining agreements and prevailing-wage contracts) can be used to shape the self-insured health plan's cost-sharing features (discussed in subsection D) and participant contribution levels (discussed in subsection E). While the plan sponsor retains considerable discretion in these design decisions, legal rules impose some constraints. For example, several provisions of health care reform[1] address cost-sharing; these are discussed in subsection D. Health care reform's employer shared responsibility provisions, under which certain large employers may face excise tax liability, have implications for both cost-sharing features (in determining whether the employer's coverage provides "minimum value") and participant contribution levels (in determining whether the employer's coverage is "affordable"); these are discussed in subsections D and E, respectively.

B. What Are the Plan's Costs and Expenses?

Before tackling the details of projecting plan costs, it is helpful to understand the various costs and expenses that make up the total cost of a plan for a plan year. Some plan costs are fixed, making them relatively easy to predict, while others are variable, making them more difficult to quantify. In fact, the largest single cost category for most plans—the cost of claims for covered benefits—is variable and can change significantly from year to year (particularly for smaller plans), depending on the health needs of the individuals covered under the plan.

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (2010) (PPACA), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (2010) (HCERA).

1. Fixed Costs

The primary fixed costs associated with a self-insured health plan are the expenses incurred to administer the plan (including amounts paid to third-party service providers involved in, and internal resources devoted to, plan administration) and premiums for stop-loss insurance purchased by the plan sponsor or the plan.

> **Plan Administration Expenses May Vary.** Even the costs of plan administration may vary over the course of a plan year, because third-party administration fees are often calculated on a "per employee per month" (PEPM) or "per member per month" (PMPM) basis. Although the per-person amount may be fixed for the plan year, the actual amount paid by the plan will fluctuate as the number of employees or members covered under the plan changes during the year. Variations in these costs from month to month are often insignificant, but a major event, such as a merger, acquisition, or divestiture, that substantially changes plan demographics could have a material effect. In addition, some service providers reserve the right to reprice their PEPM or PMPM fees if the number of covered individuals changes significantly during the year or contract period, such as might occur with a merger, acquisition, divestiture, or workforce reduction.

a. Plan Administration Expenses

The expenses of plan administration may take a variety of forms. If a plan sponsor handles its own plan administration, the expenses are those costs the plan sponsor incurs (directly and indirectly) to handle enrollments, process and adjudicate claims, communicate with participants, and so forth. These expenses will, broadly speaking, include the incremental wages, benefits, and other overhead costs associated with the personnel necessary to administer the plan. However, most plans engage a third-party administrator (TPA) or other similar entity to assist with processing claims and handling other aspects of plan administration. (This may be an insurance company, engaged under an "administrative services only" (ASO) agreement to provide administrative services—but not insurance—to the plan.) The fees paid to those service providers are expenses of plan administration. Sometimes, in addition to a TPA or ASO agreement, separate service providers are engaged to provide discrete tasks in administering the plan, such as COBRA administration, pharmacy benefit management, or case management services. (Selecting, engaging, and monitoring third-party service providers is covered in Section XXIII.)

(i) Fees Under a TPA or ASO Agreement

Under a TPA or ASO agreement, the service provider generally charges a fee that is calculated on a "per employee per month" (PEPM) or "per member per month" (PMPM) basis.[1.1] For example, a TPA may charge a PEPM fee of $15 to administer a plan, meaning that the TPA will provide all of its services for a monthly fee equal to $15 multiplied by the number of employees covered under the plan that month.

The PEPM or PMPM fee charged under a TPA or ASO agreement may reflect multiple discrete services or costs, including some or all of the following:

- claims processing and adjudication;
- access to a provider network (network fee);
- pharmacy benefit or prescription drug management;
- utilization review (UR) services;
- case management services; and
- disease-management services.

In some cases the PEPM or PMPM fee charged under the agreement may also include premiums for stop-loss insurance purchased by the plan or plan sponsor. (This is common under an ASO agreement if the insurance company providing administrative services is also providing stop-loss insurance to the plan sponsor or the plan.)

[1.1] Per member per month (PMPM) fees are particularly common in contracts with pharmacy benefit managers that assist in the administration of a prescription drug plan or benefit.

"Bundled" vs. "Unbundled" Services. When a self-insured health plan contracts with an insurer to provide services under an ASO agreement, the various services provided under the agreement are often "bundled" together as single package and not separately identified as components of the PEPM or PMPM fee. The agreement may not even permit the plan sponsor to carve out services to be provided by a separate vendor. In contrast, TPA agreements are often "unbundled," giving the plan sponsor greater flexibility. In those cases, the PEPM or PMPM fee may be itemized to show the specific categories of services the plan sponsor has contracted to receive.

The difference between bundled and unbundled arrangements affects not only the plan sponsor's flexibility but also the basis on which proposed contracts and fees from two or more potential vendors should be compared. It may not be as simple as merely comparing the quoted PEPM or PMPM fees because they may reflect different packages of services.

PBM Rebates. Pharmacy benefit managers often manage large quantities of drug purchases on behalf of many health plans and other purchasers. This volume allows them to negotiate discounts or rebates with drug manufacturers or distributors. Depending on the fee structure of the TPA or ASO agreement (or a separate contract directly with the PBM, if applicable) the plan may be entitled to share in these rebates; this should be discussed in the contracting process. Often the contract will provide that any shared rebates will be used to offset or reduce the administrative fees otherwise payable.

In addition to a PEPM or PMPM fee, a TPA or insurer may charge other miscellaneous fees, such as—

- a first year "setup" fee;
- fees for drafting or modifying documents, such as a plan document, summary plan description, or summary of benefits and coverage; or
- hourly fees for consulting, data conversion, or special projects.

(ii) Fees Under Contracts With Other Vendors

The fixed costs of plan administration may include fees for services provided under contracts other than the TPA or ASO agreement, such as—

- *COBRA Administration.* The plan sponsor may engage a separate COBRA administrator if COBRA administration is not provided under the TPA or ASO agreement and the plan sponsor does not want to self-administer COBRA.
- *Pharmacy Benefit Manager (PBM).* Although prescription drug benefit administration is often included in the general TPA or ASO agreement, it is also possible to contract separately with a PBM to administer a prescription drug program.
- *Subrogation and Overpayment Recovery.* A TPA or ASO agreement usually covers services related to subrogation and recovery of plan overpayments.[2] Compensation for these services often is structured as a percentage of the recovery (rather than on a fixed-fee, hourly, or other basis). If the TPA or ASO agreement does not address these services, the plan sponsor may wish to contract separately for them.

(iii) Other Costs Incurred by the Plan Sponsor

The plan sponsor should also expect to incur other costs related to plan administration and participant communications. These may include—

- printing and mailing costs;
- website/intranet design and modification costs; and
- legal, accounting, and consulting fees.

[2] Subrogation and overpayment recovery are discussed in Section XXV.E.

b. Stop-Loss Insurance Premiums

Another fixed cost incurred in connection with many self-insured health plans is the stop-loss insurance premium. As noted above, the stop-loss premium may be included in the PEPM or PMPM fee under the TPA or ASO agreement. Or it may be separately stated, even if it is part of the agreement. Alternatively, the plan sponsor (or its broker) may separately arrange for stop-loss insurance outside of the TPA or ASO relationship. Stop-loss insurance is discussed in Section XVII.

2. Cost of Covered Expenses

Unlike administrative costs and stop-loss premiums, the cost of claims under a self-insured health plan generally is not fixed.[3] The claims cost for a plan will vary from year to year based on factors such as (a) the cost charged by providers for covered services or products; (b) the number of individuals covered under the plan; and (c) the health needs of those individuals.

Although claims costs are variable, plan sponsors need to be able to budget for plan expenses in advance and determine employee contribution levels before open enrollment for the upcoming plan year. The cost of claims under a self-insured health plan must be estimated each year, to provide the plan sponsor a framework within which to make decisions about the plan.

As discussed in subsection C, there are several ways to estimate a plan's cost of claims for a year. In general, the estimate involves looking at prior claims experience for the group covered by the plan and making adjustments for anticipated increases or decreases in plan coverage, utilization, and health care costs. Often, the plan sponsor engages an outside actuary, consultant, broker, underwriter, or similar service provider to assist in forecasting the cost of claims for a year. The cost estimate will be used to evaluate the plan sponsor's projected expense under the plan and to set participant contribution levels.

> **Caution: Variable Cost Estimates Differ from Insurance Premiums.** Plan sponsors sometimes treat the estimate of the cost of claims for a given plan year like the premium for comparable fully insured coverage. But it is important to remember that cost estimates are just that—estimates. Actual costs often will be smaller or larger than the estimate. A key difference between a self-insured plan and a fully insured plan is that the plan sponsor, not the insurer, bears the risk that actual costs will exceed the estimate. If actual costs exceed expected costs, the plan sponsor still must pay the claims. The plan sponsor may mitigate this risk by purchasing stop-loss insurance,* but there may be a gap between the plan sponsor's cost estimate and the point at which stop-loss insurance will cover the remaining claims.

* Stop-loss insurance is discussed in Section XVII.

C. Estimating the Plan's Expected Costs

Except in the case of a defined-contribution plan (e.g., an HRA or health FSA), it is generally not possible to predict definitively the cost of providing coverage under a plan for a given plan year. The actual cost will depend on factors that are not known in advance, such as how much participants will utilize the plan during the year. Consequently, estimating a plan's expected costs for a year often involves looking at a known quantity—the plan's prior costs—and making adjustments to account for expected differences in the future period.

> **New Plan vs. Existing Plan.** The processes described below for estimating costs apply in largely the same manner to existing plans and new ones (e.g., plans that are making the initial change from fully insured to self-insured or that will be self-insured from inception). However, new plans may lack robust data to use when making the initial cost estimates. Data regarding prior claims may not exist or may not be available (e.g., because a prior insurer cannot or will not make it available). In those cases, more assumptions about future claims must be made in the plan's early years, so there is a greater possibility that actual claims costs will exceed estimates in those years.

[3] The key exceptions are defined contribution plans, such as health FSAs and HRAs, where the plan sponsor's cost is limited to the amount it agrees to credit to each participant's account under the plan. Such plans are not the focus of this Section.

