HEALTH & GROUP BENEFITS
NEWS & DEVELOPMENTS

An Employer Benefits Update

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HEEDING THE CALL: PRICE TRANSPARENCY

Shyam Kolli, FSA, MAAA

The overall share of the U.S. economy devoted to healthcare spending reached almost 18%[1] in 2015. As a result, methods for cost reduction are getting increased attention. The new administration under President Trump, identified provider price transparency as one of its key healthcare reform goals. Until now, disclosure of provider rates has been very limited due to the confidential nature of this information and concerns with provider collusion. However, rising trends, coupled with the demand for increased consumerism by employer plan sponsors, have started to move the transparency needle a bit. The following provides an overview of price transparency, including the primary drivers in the self-insured market and a short list of employer considerations.

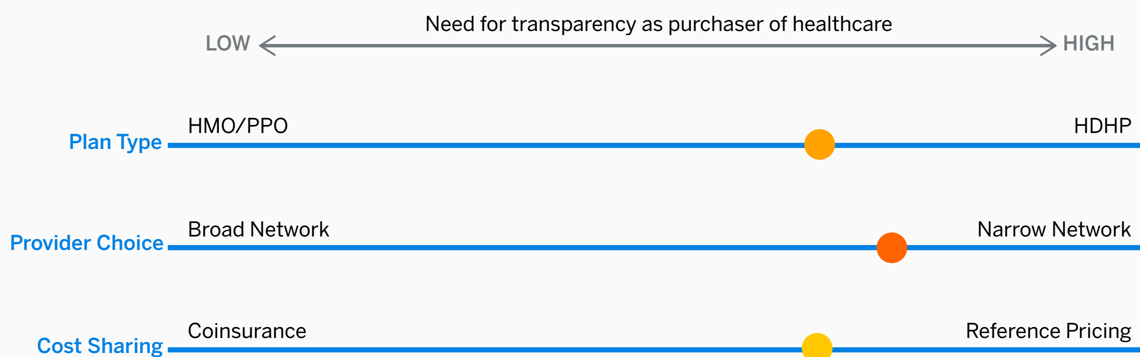
WHAT DOES PRICE TRANSPARENCY MEAN?

In terms of the self-insured market, price transparency means making information more readily available to consumers. This will allow them to make better-informed decisions based on their current health status. Several carriers and independent companies have created tools to assist employees with "de-mystifying" medical rates in a consumer-centric manner. These tools allow employees to price-shop for a given service by provider, as well as factor in current benefits to estimate their out-of-pocket cost.

WHAT FACTORS ARE DRIVING THE NEED FOR TRANSPARENCY IN THE SELF-INSURED MARKET?

The proliferation of High Deductible Health Plans (HDHPs), reference-based pricing, and narrow or custom networks all place a greater burden of cost sharing and decision-making on the employee and employer.

FIGURE 1: TRANSPARENCY SLIDING SCALE



A 2016 Kaiser Survey found that 29% of covered workers are enrolled in a HDHP plan[1]. As this percentage continues to rise, so will the demand for meaningful data about the costs of their medical treatments. Employees enrolled in HDHP plans are generally very price sensitive since they are paying first dollar until they meet their sizeable deductibles. This cost information is generally difficult to obtain given the proprietary nature of provider rates, but is becoming more readily available in the marketplace. In fact, approximately half the states have enacted some form of price transparency legislation.[2]

1 http://kff.org/report-section/ehbs-2016-summary-of-findings/
2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2837489/

Reference-based pricing is another tool in an employer's arsenal for combating rising healthcare costs. This option caps employers' costs for services at a "reference rate," and it applies mostly to services where prices fluctuate considerably but quality remains relatively flat (e.g., high-tech radiology and orthopedic services). Employees are incentivized to comparison shop to avoid getting billed for the difference between the provider's rate and the reference rate. Price transparency is paramount to making this option successful. Employees will look for rates below the reference point, which will lower their out-of-pocket spend.

Narrow or custom networks provide employers with another way to reduce healthcare expenses. These networks limit the providers in the highest tier to those who provide services at a lower cost and/or are more efficient. Lower out-of-pocket costs encourage employees to use these in-network Tier 1 providers. Various organizations[3] are creating these narrow networks as an additional product option for purchase by employers. Price transparency is necessary in a narrow network arrangement, as this information is used by employees to make educated decisions concerning their healthcare.

WHAT ARE THE CONSIDERATIONS FOR EMPLOYERS INTERESTED IN IMPLEMENTING PRICE TRANSPARENCY?

The success of the programs described above is contingent on many factors. The following provides some considerations when implementing these programs:

- Clear and concise communication is a key component for success, as employers and employees are financially impacted by the decisions they make.
- Transparency tools must be easy to use as employees need to acquire new skills including identifying network access, comparing provider rates, and calculating their out-of-pocket costs.
- Identification of required services may require additional support so employees can be sure they're looking at prices for the actual services they need.
- Incentives encourage participation, such as offering an HSA along with the HDHP plan, employer seeding, and/or higher contributions to help lower member premiums.
- Phased-in reference services limit the number of services in the first year in order to acclimate employees to how the program works.
- Cost-share differentials need to be carefully calibrated to encourage greater utilization of top-tier providers to drive down costs.

In conclusion, price transparency offers multiple ways for lowering the overall cost of medical benefits programs. By providing price-transparent programs, employers empower participants to make better-informed decisions about the services they choose.

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3 http://us.milliman.com/insight/2016/Measuring-employer-cost-savings-from-network-changes/

PHARMACY BENEFITS: CARVE-IN OR CARVE-OUT?

Brian N. Anderson, MBA | **Angela Reed**, GBA

Employers and other plan sponsors have the option of carving in or carving out their pharmacy benefit program from their medical benefits. There are a number of important factors that should be considered when deciding whether or not to carve out pharmacy benefits. This article identifies the advantages and disadvantages of both options and raises important questions to consider when contemplating a move to carve-out.

DEFINITIONS

CARVE-IN

When the pharmacy carve-in approach is used, the employer contracts directly with the medical health plan vendor for medical *and* pharmacy benefits. The vendor will either administer the program in-house or contract with a pharmacy benefits manager (PBM) vendor to process pharmacy claims and administer the pharmacy program. Because the employer contracts directly with the medical health plan vendor, there is no direct relationship with the PBM.

A pharmacy carve-in is typically used under the fully insured model. In 2015, the Pharmacy Benefit Management Institute (PBMI) reported 23% of smaller employers (less than 5,000 lives) and 7% of larger employers (greater than 5,000 lives) were fully insured.[1] Under the fully insured model, the employer pays a premium to the insurer and the insurer assumes the risk of the total claims amount rather than the employer.

CARVE-OUT

When the pharmacy carve-out approached is used, employers contract directly with a PBM vendor to administer their pharmacy benefits program.

A pharmacy carve-out is typically used under the self-insured model. In 2015, PBMI reported 77% of smaller employers and 93% of larger employers were self-insured. Under the self-insured model, the employer assumes the risk and benefits from managing costs. Pharmacy stop-loss insurance may be purchased to mitigate the risk of total claims amounts going over a certain threshold. A pharmacy carve-out can also be used with the fully insured model, although this is less common.

CARVE-IN

ADVANTAGES

- The contract for medical and pharmacy is with one vendor, which can simplify administration and management
- Potential for better coordination of care between medical and pharmacy benefits
- Easier coordination with stop-loss insurance

DISADVANTAGES

- Less flexibility with plan design
- A combined medical and pharmacy contract allows for limited transparency and audit rights:
  - Limited access to claims data experience to see if you are “winning” or “losing” under the fully insured model
  - Limited audit rights, if any
  - Penalty fees are typically stipulated by the contract should employers choose to change to carve-out at a later date

1 Prescription drug benefit cost and plan design report: Pharmacy Benefit Management Institute; 2015. Available from: http://reports.pbmi.com/report.php?id=13.

CARVE-OUT

ADVANTAGES

- Flexible plan design and clinical programs that can help reduce costs
- Standard language in the PBM contract allows for increased transparency and flexibility:
  - Access to pharmacy claims data
  - Audit rights, including:
    - Claims audit
    - Operational assessment
    - Rebate audit
  - Annual market check provision to ensure that the rates stay competitive with the current market
  - Service performance guarantees
- Implementation credits to offset expenses of switching to a new vendor
- Annual administration allowance to offset expenses incurred through the administration of the pharmacy benefit program

DISADVANTAGES

- The contracts for medical and pharmacy are with multiple vendors, which can increase the administrative burden
- If the medical and pharmacy accumulators are combined, they will need to be integrated

IMPORTANT CONSIDERATIONS

If you currently have a pharmacy carve-in and are interested in carving out pharmacy benefits, here are some important questions to consider:

- How much are your pharmacy benefits currently costing you?
- Is your medical health plan vendor currently passing through rebates?
- When does your current contract term end?
- Is the timing right to conduct a PBM request for proposal (RFP)—and possibly a medical health plan RFP?
- Will your medical health plan vendor increase your fees if you carve out your pharmacy benefits?
- How is your staff currently overseeing the pharmacy benefits program?
- Do you need additional resources to help you make an informed decision?

In conclusion, when considering a move to a pharmacy benefits carve-out, employers should consider the advantages and disadvantages of both options. They should also bear in mind other important factors—including current cost, appropriate timing, and internal staff expertise—to ensure they're making a well-informed decision.

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LEAVE MANAGEMENT – A HOLISTIC VIEW

Tasha S. Khan, FSA, MAAA

Employers can benefit from a wider, more inclusive perspective on all their leave management programs. This is especially relevant when considering a change to one or more program aspects. This article reviews key factors that should be taken into account when changes are contemplated.

In managing their employees' workplace absences, employers use many different types of programs. These include:

- Paid Time Off (PTO) programs
- Vacation/Holiday/Sick Leave
- Extended sick-leave banks
- State disability plans
- Short-term disability
- Long-term disability
- Workers' compensation
- Family and Medical Leave (FMLA)
- Other paid or unpaid leaves of absence

Given the size of this list, it's not surprising that employers don't always consider how the various aspects of their leave management programs interact. As just one example, adding short-term disability coverage has been seen to increase long-term disability claim incidence. When evaluating the potential cost of changes to a plan design, it's helpful to model costs using an integrated approach. The cost model should include as many aspects of the leave management program as possible in order to capture interactions.

SETTING UP AN INTEGRATED COST MODEL: WHAT TO CONSIDER

When setting up an integrated cost model, many factors beyond the direct impact of plan design changes should be taken into consideration. These include both increased benefit amounts as well as longer benefit durations. If changes are contemplated, the model should also include the impact of these changes on any state disability benefits. In addition, differences in benefits for part-time vs. full-time employees along with differences by years of service should be reflected in the model. And any special circumstances, such as grandfathered provisions, carry-over balances, and conversion credits, must also be taken into account.

An important factor that the model should reflect is the impact of plan changes on employee behavior and utilization—although employee behavior can be difficult to predict. How is this accomplished? In some cases, a similar population of employees can be identified and used to estimate expected employee utilization. If data for a similar population is not available, broader industry data can often be used. If all else fails, sensitivity tests should be produced in order to understand the impact of employee behavior on modeled costs.

Administrative costs are also impacted by changes to a plan, a factor often overlooked by employers. For all but the simplest plan changes, it's likely that the administrative burden for the plan will change—for better or worse. Employers should also keep in mind the impact of any long-term accruals. For this type of cost modeling, a one-year projection is often sufficient to estimate the cost impact of any plan design changes. If, however, any longer-term obligations would be affected, such as leave banks that pay out after a given number of years, these should be taken into account as well.

Finally, when thinking about the leave management program as a whole, employers should consider how well their programs meet all employees' needs. Modeling the benefit pattern over time for a hypothetical employee can help to identify gaps in coverage or instances of over-insurance. Inequities between older and newer employees, which are common in sick-leave bank programs with no short-term disability coverage, should also be identified and examined.

When leave management programs are viewed and evaluated holistically, employees receive more value in their benefits—and employers get a clearer picture of plan design attributes and costs.

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REGULATORY ROUNDUP

SUMMARIES OF RECENT RELEASES AND ANNOUNCEMENTS

MILLIMAN EMPLOYEE BENEFITS RESEARCH GROUP

House Approves GOP's American Health Care Act

Before recessing, the House on May 4 voted 217-213 to approve the American Health Care Act (AHCA, **H.R.1628**), as modified by two amendments negotiated by House GOP conservatives and moderates over the past week. The bill now goes to the Senate, where significant changes are expected before any votes occur. One **amendment**, offered by Rep. Tom MacArthur (R-NJ), would allow states to apply for a waiver from the Affordable Care Act's (ACA) essential health benefits if, in general, they establish a high-risk pool to cover individuals with high-cost health conditions. If approved, states also could permit insurance underwriting that takes into account a person's health status and age (i.e., the 5:1 age rating change (from the ACA's 3:1 ratio) in the underlying AHCA would not apply, allowing for insurance premiums to increase significantly for some individuals, particularly older individuals and/or persons with preexisting conditions). The second **amendment**, from Rep. Fred Upton (R-MI), would add $8 billion (over five years) to further subsidize coverage costs for people with high-cost conditions who could experience premium or out-of-pocket cost increases resulting from the state waiver. The House Republicans pushed through the vote with little advance warning and without a Congressional Budget Office estimate of the cost and coverage implications of the revised bill language.

President Signs Executive Order on Promoting Religious Liberty

The **Executive Order** on Promoting Free Speech and Religious Liberty signed by the President on May 4, aims to make it easier for employers with religious objections not to include contraception coverage in workers' health care plans, although it would be up to federal agencies to issue guidance on how it would be accomplished.

IRS Issues Inflation Adjusted Amounts for Health Savings Accounts for 2018

The IRS issued **Revenue Procedure 2017-37** providing the inflation-adjusted figures for calendar year 2018 for the annual contribution limits for health savings accounts (HSAs) and the minimum deductible amounts and maximum out-of-pocket expense amounts for high-deductible health plans. For 2018, the annual limit on deductible contributions is $3,450 for individuals with self-only coverage (up $50 from 2017) and $6,900 for family coverage (up $150 from 2017). For 2018, the lower limit on the annual deductible under an HDHP is $1,350 for self-only coverage and $2,700 for family coverage, both increased from 2017. The upper limit for out-of-pocket expenses is $6,650 for self-only coverage and $13,300 for family coverage, also both increased from 2017.

IRS Indexing Adjustments for Premium Tax Credit for Individuals Eligible for Employer-Sponsored Coverage

The IRS released **Revenue Procedure 2017-36** which provides the Applicable Percentage Table for 2018, used to calculate an individual's premium tax credit and updates the required contribution percentage for plan years beginning after calendar year 2017, which is used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage.

Patient-Centered Outcomes Research Institute (PCORI) Research Results (May 2017)

PCORI funds studies that compare healthcare options to see which will work better for patients based on outcomes important to them. More than **500 such studies and related projects** have been funded through May 2017. For example, to date $301 million has been spent on mental/behavioral health research and $214 million on Cardiovascular disease studies.

Future Updates to the Retiree Drug Subsidy System to Accommodate the CMS Social Security Number Removal Initiative

The Centers for Medicare and Medicaid Services (CMS) has published a **memorandum** regarding the Social Security Number Removal Initiative (SSNRI) and how it will affect RDS Plan Sponsors and Vendors. There will be a transition period where CMS will accept either the HICN or the MBI when submitting data to the agency. The transition period will begin no earlier than April 1, 2018, and run through December 31, 2019.

PLAN SPONSOR 2017 COMPLIANCE KEY DATES

JULY 31, 2017

- File form 720 and payment of Patient-Centered Outcomes Research Institute (PCORI) fee
- 2016 form 5500 Annual Return/Report

SEPTEMBER 30, 2017

- Summary Annual Report (SAR) to employees

OCTOBER 14, 2017

- Notice of Rx drug creditable coverage to employees

DECEMBER 1, 2017

- Summary of benefits and coverage (calendar-year plans without open enrollment)

DECEMBER 31, 2017

- Election notice of opt-out from certain HIPAA portability requirements

JANUARY 31, 2018

- 2017 Form W-2 to employees when filing using paper forms or electronically
- 2017 Form 1099-R to recipient

FEBRUARY 28, 2018

- 2017 Form 1099-R to IRS
- 2017 Forms 1095-B and 1095-C to IRS, if filing on paper. (Note: The IRS has not issued 2017 forms, ACA filers can go the to the "What's Trending" page on the **ACA Tax Provision** page for additional information.)

MARCH 1, 2018

- Rx Drug Coverage Disclosure to CMS for calendar year plans

APRIL 2, 2018

- 2017 Form 1099-R to IRS if filing electronically

CRS Issues Report on Frequently Asked Questions about Prescription Drug Pricing and Policy

The Congressional Research Service issued **Frequently Asked Questions about Prescription Drug Pricing and Policy** addressing frequently asked questions about government and private-sector policies that affect drug prices and availability. Among the prescription drug topics covered are federally funded research and development, regulation of direct-to-consumer advertising, legal restrictions on re-importation, and federal price negotiation. The report provides a broad overview of the issues as well as references to more in-depth CRS products. The appendixes provide references to relevant congressional hearings and documents and a directory of CRS prescription drug experts.

CRS Issues Report on American Health Care Act (AHCA)

The Congressional Research Service released **H.R. 1628: The American Health Care Act (AHCA)**, which provides a summary for Congressional Members of the current version of the AHCA, incorporating each of the eight amendments referenced in H.Res. 228 and H.Res. 308. This report contains three tables that, together, provide an overview of all the AHCA provisions.

Congressional Budget Office Issues 2017 Long-Term Budget Outlook

The Congressional Budget Office issued **2017 Long-Term Budget Outlook** projecting that deficits will rise over the next three decades—from 2.9 percent of Gross Domestic Product (GDP) in 2017 to 9.8 percent in 2047—because pending growth is projected to outpace growth in revenue. In particular, spending as a share of GDP will increase for Social Security, the major health care programs (primarily Medicare), and interest on the government's debt. Much of the spending growth for Social Security and Medicare results from the aging of the population and rising health care costs per person, which are projected to increase more quickly than GDP per capita (after the effects of aging and other demographic changes are removed).

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