HEALTH & GROUP BENEFITS NEWS & DEVELOPMENTS
An Employer Benefits Update
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Milliman

TRENDING

DELAYED CADILLAC TAX

The excise tax on high-cost employer health insurance plans (often referred to as the "Cadillac Tax") has been delayed two years through the Consolidation Appropriations Act of 2016 (Act). The 40% excise tax will now begin to apply in 2020 rather than 2018 as initially outlined. Other changes include:

- The dollar thresholds in 2018 ($10,200 for self-only coverage and $27,500 for family coverage) will continue to be indexed by the changes in the U.S. Consumer Price Index to 2020. The tax will continue to be indexed to 2020. If medical inflation continues to outpace the increase in thresholds, more employers would be subject to the tax in 2020 than in 2018.
- Employers will be permitted to deduct the tax as a corporate expense if the employer is a taxpayer.
- The Act calls for a study on suitable benchmarks for the age and gender adjustments to the dollar thresholds.

While some are still pushing for repeal of the tax, which has some support from Congress, it is important for employers to understand their exposure to the tax. Employers may begin steps to mitigate the tax by:

- Identifying patterns of trend and utilization to identify where to focus their benefits planning.
- Reviewing plan design to help ensure that benefits are provided in the most efficient manner.
- Reviewing aspects of their prescription drug plans, including pricing, network, and formularies to ensure that prescription drug benefits are provided in the most efficient manner.

As employers continue to plan for the excise tax, a common strategy to mitigate cost, control future cost trends, and postpone it is to implement consumer-driven health plans (CDHPs) with health savings accounts (HSAs). The most recent Notice from the Internal Revenue Service (IRS), IRS Notice 2015-16, anticipates that employer contributions and salary reduction contributions toward the HSA will be included as taxable under the excise tax. It is very important to point out this could lead to administrative consequences whereby each employee would in essence have his or her own separate excise tax calculation. This is a concern for employers that have increasingly used HSA contributions combined with high-deductible health plans as a strategy to help postpone the impact of the excise tax.

FULLY INSURED EMPLOYER RELIEF

In addition to the delay in the excise tax, the Patient Protection and Affordable Care Act (ACA) health insurer fee is waived for 2017, as well as the excise tax for medical devices for 2016 and 2017. This health insurer fee waiver should provide relief in annual renewals for those employers that provide fully insured plan options to their employees. The tax is generally worth around 2% to 3% of net premiums written.

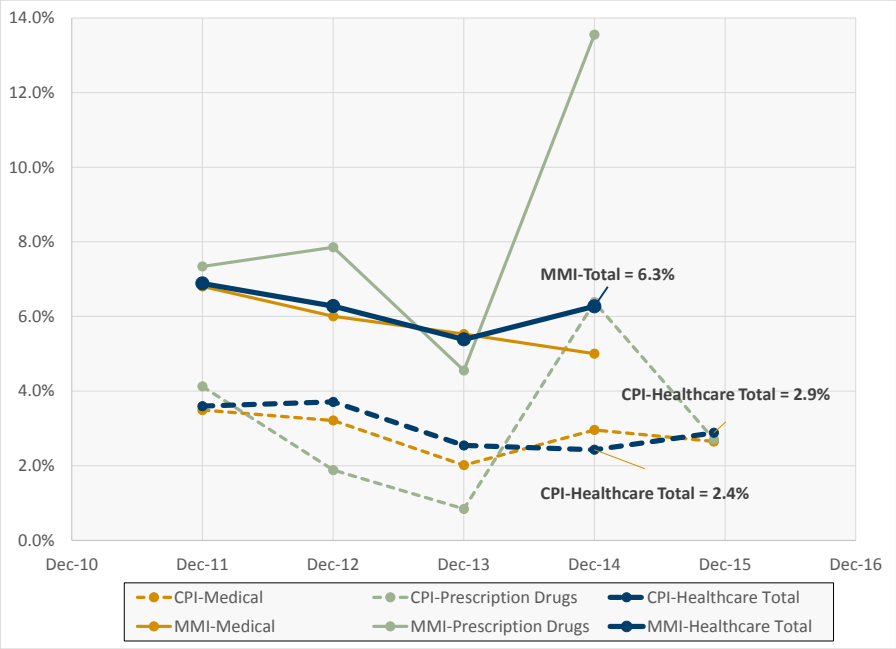
PRESCRIPTION DRUG TREND

Prescription drugs have continued to materially drive overall healthcare trends higher in 2015. Increased brand name drug usage has had a direct impact and is a large component of this material increase.

- While overall prescription drug utilization has been trending negative to flat in recent years, the average cost per unit has been increasing significantly. This indicates a trend to the more expensive brand name drugs as opposed to generics. Areas for employers to monitor would be:
    - Increasing utilization of specialty drugs, including continued utilization of hepatitis C drugs and newer drugs such as PCSK9 drugs used to treat cholesterol for employees with certain genetic indications.
    - Increasing utilization of orphan drugs (or drugs used to treat rare disorders).

QUARTERLY COMPARISON: CPI-U AND MMI

The Milliman Medical Index (MMI) represents national healthcare trend. Historically, the MMI has been almost triple the U.S. Consumer Price Index for All Urban Consumers (CPI-U) for medical services as of 2014, with the MMI at *6.3%* versus the CPI of *2.4%*, as shown in graph. The CPI-U increased slightly to *2.9%* through November 2015.



Notes

MMI represents the projected total cost of healthcare for a hypothetical family of four, assuming an employer-sponsored preferred provider organization (PPO) plan. The MMI projection includes total claims spent plus out-of-pocket expenses.

A consumer price index (CPI) measures inflation at the retail level, and reflects the average price change over time for a constant quality, constant quantity market basket of goods and services.

--"CPI-Medical": Measures professional medical services, hospital services, nursing home services, and health insurance imputation.

--"CPI-Prescription Drug": Measures all drugs dispensed by prescription. Mail order outlets are included.

--"CPI-Healthcare Total": Measures all levels of medical care commodities and medical care services.

Sources: Bureau of Labor Statistics for CPI and 2015 Milliman Medical Index

EMPLOYER STRATEGIES HIGHLIGHTED

TELEHEALTH

Telehealth services are gaining traction and becoming an efficient alternative access point to care to fill provider gaps and provide access to specialists. Telehealth services provide access to U.S. board-certified doctors and pediatricians via phone or online video consultations for a set reduced fee. They have been shown to save money for the employee and employer and significantly reduce hospitalizations and emergency room (ER) visits, while improving the patient's access to care.

It is interesting to note that 24 states have telemedicine parity laws in place. Employers considering a telehealth program should ask the following:

- How does my state's telemedicine policies compare with others?
- Which states offer the best coverage for telemedicine-provided services?
- Does my state impose barriers to telemedicine access for patients and providers?

PRIVATE EXCHANGE

Private exchange platforms create an online shopping experience that includes decision-support tools and a comprehensive benefits administration solution. Reasons for moving to a private exchange include but are not limited to:

- Defined contribution strategy, making it easier for employers to budget each year
- Benefits administration is handled—automating eligibility and enrollment, managing payroll deductions, and addressing employee questions throughout the year.
- Financial Incentives, taking advantage of network optimization and lower fees.
- A potential solution for employers with 500 or more employees.

HEALTHCARE THOUGHT LEADERSHIP

PUT HEALTHCARE DATA TO WORK WITH BENCHMARKING ANALYSIS

Marcella Giorgou, EA MAAA FSA

Five years after the healthcare reforms of the Patient Protection and Affordable Care Act (ACA), finding solutions to manage healthcare costs beyond cost shifting is more important than ever. Squeezing dollars out of the system can help manage the excise tax on high-cost employer health insurance plans in 2020 and makes for a "win-win" situation, financially benefiting both the employee and employer. Where to squeeze is generally specific to each employer. The answer is found in the data, where patterns of trend and utilization can lead to useful benchmarking for employers.

The two major components of healthcare trend are:

1) Changes in utilization of services, which may be attributable to:
    - Modifications in medical practices, new technologies, or practices, and increases in the supply of services.
    - Changes in overall health and/or attitude of the insured population.
    - Adjustments in benefit designs, utilization review programs, and health insurance industry changes from laws or mandates.
2) Changes in average cost per service, which is primarily due to inflation, as well as changes in provider reimbursement agreements, service severity mix, shifting of utilization among service categories (such as increased use of outpatient services versus inpatient services), medical practice patterns, increased use of expensive modern technology, and the expiration of patent protections.

A benchmarking analysis involves comparing detailed target performance benchmarks with corresponding claim experience. Target performance benchmarks are based on "Well-Managed" and "Loosely Managed" benchmarks for utilization, allowed amount levels, and plan paid levels, using Milliman's Health Cost Guidelines™ (HCGs). The HCG benchmarks are calibrated to reflect the demographic profile, geographic profile, and benefit design of the plan.

Loosely Managed utilization levels are representative of plans with some utilization review, preauthorization, and case management. Well-Managed values represent nationwide claim cost and utilization targets in a managed care environment, such as a staff model health maintenance organization (HMO) or a globally capitated provider group, which effectively applies utilization management principles across the entire continuum of medical care, including inpatient care, outpatient facility care, ancillary testing, routine office care, referral physician care, and prescription drugs.

Utilization metrics can be used to measure the effectiveness of utilization management programs or suggest additional opportunities. Utilization is primarily managed by medical management functions. By comparison, unit costs are managed primarily through provider negotiations.

PLAN SPONSOR COMPLIANCE CALENDAR WITH KEY 2016 DATES FOR CALENDAR-YEAR PLANS

JANUARY
- **15**: 2015 Transitional Reinsurance Fee Payment Due

FEBRUARY
- **1**: 2015 Forms W-2, 1099-R to Employees
- **29**: Rx Drug Coverage Disclosure Notice to CMS
- **29**: 2015 Paper Forms W-2, 1099-R to IRS

MARCH
- **31**: 2015 Electronic Forms W-2, 1099-R to IRS
- **31**: 2015 Forms 1095-B and 1095-C to Employees

MAY
- **31**: 2015 Paper Forms1094-B and 1094-C to IRS

JUNE
- **30**: 2015 Electronic Forms 1094-B and 1094-C to IRS

AUGUST
- **1**: Patient Centered Outcomes Research Institute (PCORI) Fee Due
- **1**: 2015 Form 5500 Annual Report to Employees

SEPTEMBER
- **30**: 2015 Summary Annual Report to Employees

OCTOBER
- **15**: Notice of Rx Drug Creditable Coverage to Employees
- **31**: Summary of Benefits and Coverage to Employees

NOVEMBER
- **15**: 2016 Transitional Reinsurance Fee Payment Due

DECEMBER
- **31**: Election Notice of Opt-Out From Certain HIPAA Portability Requirements

REGULATORY ROUNDUP

OUT-OF-POCKET MAXIMUM REQUIREMENT

The U.S. Department of Health and Human Services (HHS) required in the final 2016 Notice of Benefit and Payment Parameters that family coverage must include an embedded individual out-of-pocket limit. This regulation increases plan costs for sponsors whose plans had individual limits and family limits at the statutory maximums. For 2016, the maximum out-of-pocket limit for family is $13,700, but the out-of-pocket maximum can't be greater than $6,850 for an individual, including an individual covered by family coverage.

ACA REPORTING: FORMS 1094/1095

In order to implement key provisions of the ACA (premium tax credits, play/pay penalties), the IRS needs to collect information from employers and others relating to the offer of health coverage. The forms that will be used to collect it are Forms 1094/1095. Calendar year 2015 reporting is due in 2016. The first forms, 1095-C, are to be issued to employees. The 1095-C is a health benefits reporting form equivalent to the W-2. The 1094-C is an employer-required transmittal form reporting the health coverage information to the IRS. The forms applicable to coverage providers (primarily insurers for fully insured plans) will be 1094-B/1095-B. Form 1094 will contain employer-level information transmitted to the IRS, while Form 1095 will contain individualized information delivered to the employees.

At the end of December, the IRS announced a delay in the requirement that insurers and employers are needed to file the ACA-required forms. Forms 1095-B and 1095-C have been extended from February 1 to March 31. Forms 1094-B and 1094-C has been extended from February 29 to May 31 for non-electronic filing and from March 31 to June 30 for electronic filing. Any employer with more than 250 forms is required to file electronically.

Failure to furnish or file these forms on time—or filing incorrect forms—can result in penalties of $250 per form. Some penalty relief is available for incomplete or incorrect 2015 forms but only if the employer is making a good faith effort to comply with the reporting requirements.

2016 COST-OF-LIVING ADJUSTMENTS FOR MEDICARE BENEFITS

The HHS's Centers for Medicare and Medicaid Services (CMS) announced increases for Medicare Part A and Part B for 2016. In addition to increases in participant cost-sharing, which may impact the cost of retiree medical plans that coordinate with Medicare, of note to employers who supplement Medicare Part B premiums, is the increase in the Part B premium for new enrollees or enrollees not receiving Social Security benefits. For example, premiums increased from $104.90 to $121.80 for those individuals or families earning, respectively, $85,000 or $170,000, or less.