HEALTH & GROUP BENEFITS
NEWS & DEVELOPMENTS
An Employer Benefits Update

Milliman

H&G 16-4

TRENDING STRATEGIES

BENCHMARKING PROVIDER COST USING MEDICARE ALLOWED

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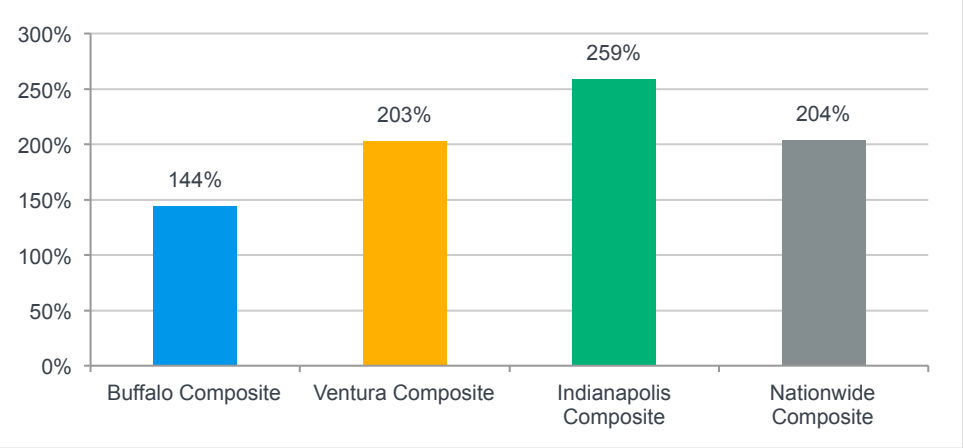
There are many reliable research statistics from the private sector and the federal agencies that support the evidence that medical costs are rising and the current pace is unsustainable. Medical cost trend has two primary components, the number of services provided to patients (utilization) and the cost of each of those services (unit cost). While utilization management can be important for achieving cost savings, some employers are now giving further attention to the significant price variation in unit cost. Chart I below provides an example of the price variation using the average reimbursement as a percentage of Medicare in Buffalo, NY, Indianapolis, IN, Ventura, CA, and nationwide. As shown, going from Buffalo to Indianapolis reflects an 80% increase in cost, based on unit price alone.

Chart 1: Average Charges as % of Medicare



Results based on 2014 commercial payment data. Data reflects $2.3B in allowed charges for select areas and $84.2B nationwide.

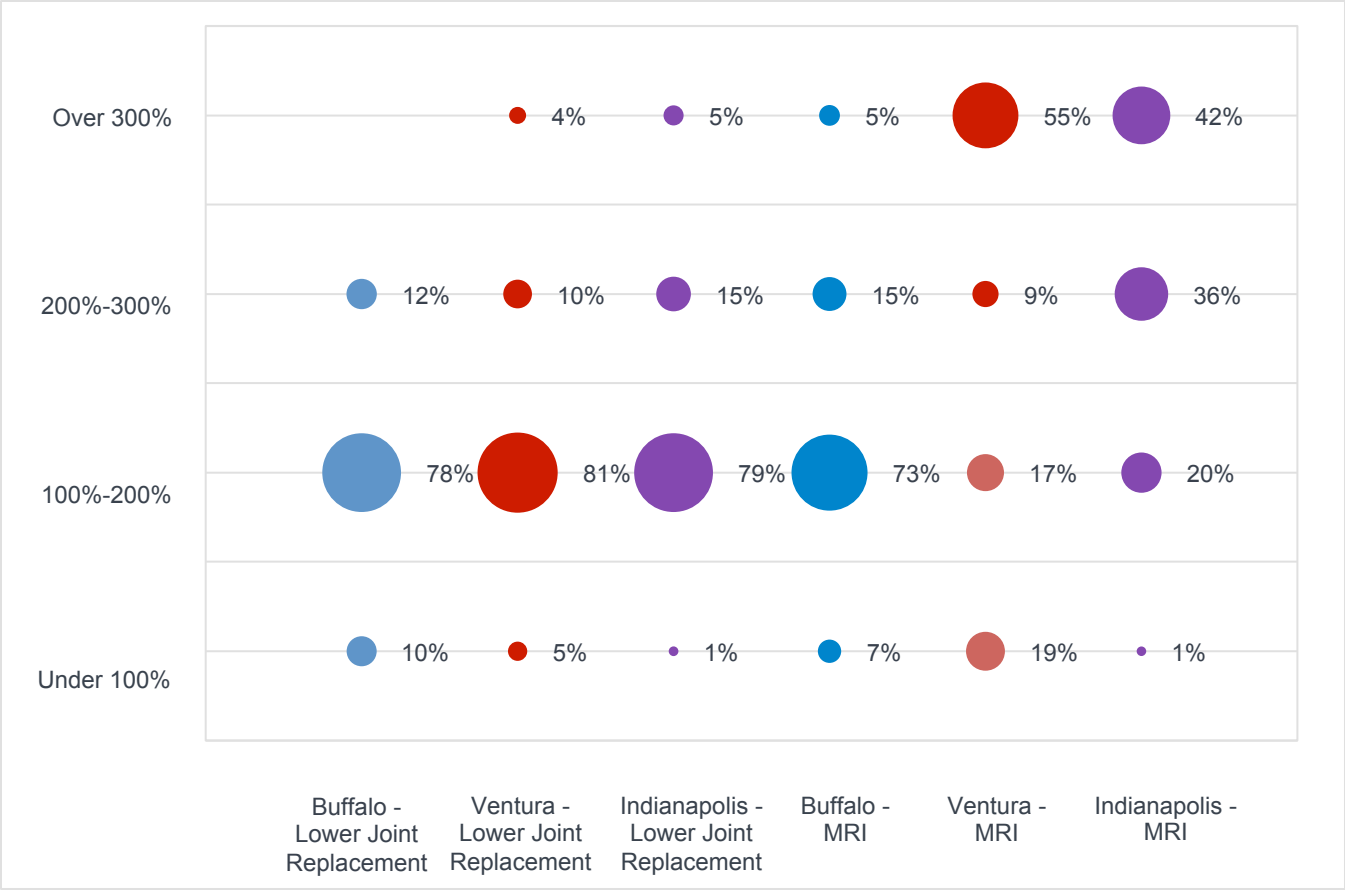
We regularly encounter employers who don't fully understand the impact of provider reimbursement variation on their medical plan's financial performance. This comes as no surprise given the limited transparency and complexity of current provider reimbursements.

Limited transparency of provider reimbursement (allowed charges)

For employers, the industry standard technique of benchmarking commercial allowable charges has historically been traditional discount analyses, which compare discounts to billed charges. However, these approaches do not provide the required rigor and precision to understand medical service reimbursement analysis—both across markets and within a given market. This is because billed charges are not standardized across providers or different services. As a result, the exact same discount could mean very different things depending on the provider and service—in some cases, price differences of over 300%. In addition, providers often optimize their billed charges to enhance reimbursement on contracts based on billed charges.

Complexity
Employers generally have had a difficult time measuring unit cost solely due to the complexity of various medical procedures. There is a large amount of price variation within each inpatient Diagnosis Related Group (DRG) and outpatient type of service. Chart 2 below provides a powerful illustration of how reimbursement can vary significantly across even a single inpatient DRG or outpatient service category. The chart compares the commercial reimbursement for inpatient joint replacement and an outpatient MRI in three different metropolitan areas compared to what the government would pay under Medicare allowable. The variation in inpatient joint replacements, a large bundle of complicated services, is much lower than outpatient MRIs, which reflects a specific service that generally has little variation in intensity compared to a joint replacement.

Chart 2: Area Cost Variances for Same Procedure



Results based on 2014 commercial payment data. Data reflects $2.3B in allowed charges for select areas and $84.2B nationwide.

Measuring unit cost effectively
In our work, we find that using Medicare reimbursement rates as a benchmark can provide much-needed clarity. Specifically, because Medicare is commonly used, and is a widely understood baseline for tracking provider reimbursement, it can serve as an objective measure of the unit price component of employer spend.

Providers are already accepting Medicare payments for a significant portion of their patients, so it provides a meaningful benchmark for making comparisons. Unlike billed charges, Medicare reimbursement can be normalized across providers and geographies. Additionally, pegging allowed charges to Medicare reimbursement can help normalize for changes in service mix (e.g., joint surgery versus MRI) or intensity (e.g., MRI versus X-ray).

Below is an example for an employer whose employees currently utilize two hospitals. In this example, we have repriced the employer's claims to Medicare reimbursement and use Medicare reimbursement as the benchmark.

Table 1: CY 2015 Employer-Allowed Costs for Hospital A and Hospital B

Hospital	Cases	Employer Allowed Cost	Cost per Case	Medicare Reimbursement	Employer Allowed / Medicare Allowed
Hospital A	2,000	$1,000,000	$500	$500,000	200%
Hospital B	750	$750,000	$1,000	$500,000	150%
Total	2,750	$1,750,000	$636	$1,000,000	175%

As shown in Table 1, the employer spent $1.75M at two hospitals. The cost per case was higher at Hospital B ($1,000 per case) than at Hospital A ($500 per case). However, Hospital B was performing more intensive services. To effectively compare the two hospitals, we repriced all of the claims to Medicare Allowable to understand how much Medicare would have paid for these same sets of services. The result is that Hospital B is less costly (150% of Medicare Allowed) on a case-mix adjusted basis than Hospital A (200% of Medicare Allowed). In fact, we went even further to realize that if every employee went to Hospital B instead of Hospital A, the employer would save $250,000. See Table 2 below.

Table 2: CY 2015 Employer-Allowed Costs After Shifting to Hospital B

Hospital	Cases	Employer Allowed Cost	Cost per Case	Medicare Reimbursement	Employer Allowed / Medicare Allowed
Hospital A	0	$0	$0	$0	n/a
Hospital B	2,750	$1,500,000	$545	$1,000,000	150%
Total	2,750	$1,500,000	$545	$1,000,000	150%

In summary, using Medicare as a benchmark allows employers to compare the relative prices of all providers and networks. This comparative analysis will drive your potential actions and may include:

- Educating employees on local market price differences
- Refining plan design to reward patients who utilize more price-efficient providers and more appropriate settings
- Renegotiating prices with highly utilized, high-cost providers or modifying your provider network
- Providing feedback to your current carrier or third-party administrator (TPA) about price outliers and negotiating unit-price guarantees
- Joining an employer coalition to negotiate better prices and/or engaging in direct-to-provider contracting
- Adding additional carriers or TPAs or optimizing networks

Measurement is a critical and essential component of management. With many existing and emerging cost-control strategies, it is important that employers properly measure their provider reimbursement levels. Despite the terrible complexity of provider reimbursement, with the proper guidance, data, and tools, employers can assess their current position to guide future action and performance.

To learn more, please contact Charlie Mills at charlie.mills@milliman.com or Cory Gusland at cory.gusland@milliman.com.

EMPLOYER STRATEGIES

HOW IS ACA'S HEALTH INSURANCE COVERAGE IMPACTING EMPLOYER PLANS?

SARAH COATES, CEBS

In the shifting landscape of the Affordable Care Act (ACA), where do employers currently stand, where are we headed—and what is it going to cost? In March, the Congress of the United States Congressional Budget Office (CBO) published its Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026, highlighting health insurance enrollment projections, subsidy amounts, and the impact of the ACA on health insurance. The report encompasses all types of coverage for those under 65; the following summary focuses mainly on the impacts associated with employer-based coverage.

The CBO and Joint Committee on Taxation (JCT) currently estimate that in 2016 total federal subsidies, taxes, and penalties associated with health insurance coverage for those under 65 will result in a net subsidy from the federal government of $660 billion—3.6 percent of gross domestic product (GDP). This is expected to rise at an average annual rate of 5.4 percent, reaching $1.1 trillion (4.1 percent of GDP) in 2026.

The two major culprits in terms of costs are the federal subsidies associated with employment-based coverage, and federal spending for Medicaid and CHIP benefits. Respectively, they take up 41 percent and 43 percent of the total net subsidy for people under age 65.

Who is covered and how?

According to the report, healthcare coverage is more prevalent now than prior to the ACA.

- In 2016, of the total estimated population (272 million lives), approximately 155 million people are covered by employer-sponsored insurance.
- In 2026, of the total estimated population (280 million lives), the CBO estimates that approximately 152 million people will be covered through employer-sponsored plans.

Currently, the number of uninsured is approximately 27 million. This is expected to increase slightly to 28 million in 2026. According to the CBO report, if the ACA had not been enacted, the total number of uninsured would have been 49 million this year and would have reached 52 million by 2026.

Chart 3: Health Insurance Coverage for People Under Age 65

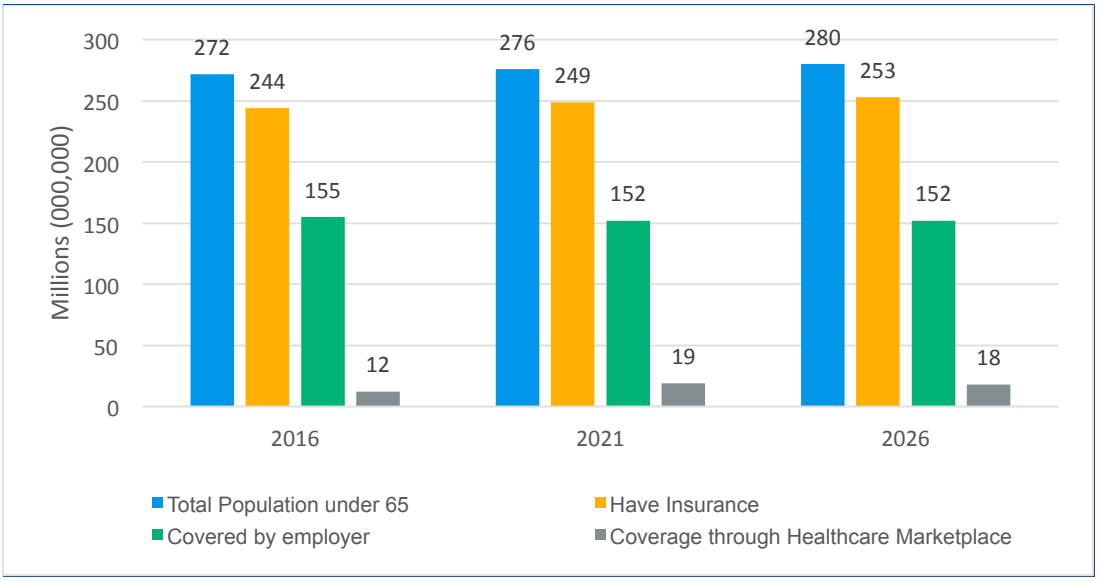
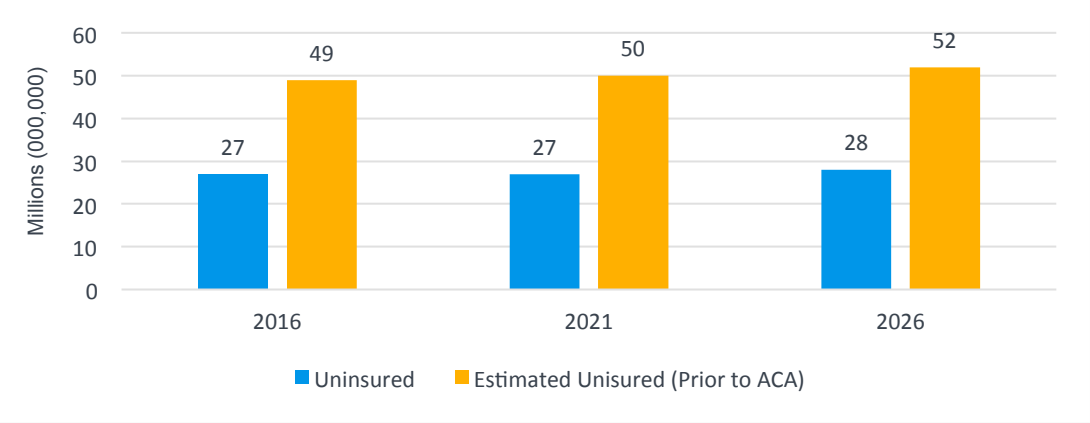
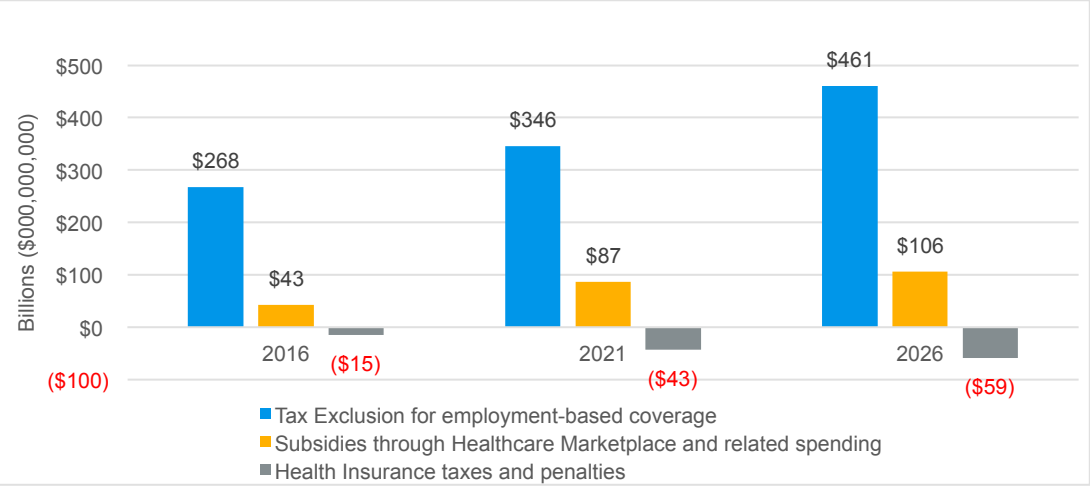


Chart 4: Uninsured for People Under Age 65



What are the ACA's subsidies costing taxpayers?
The CBO and JCT have estimated the costs of federal subsidies associated with health insurance coverage for people under age 65. Shown below, these include the tax exclusion for employment-based coverage (of this, $1 billion per year is attributed to small-employer tax credits), and subsidies offered through the Healthcare Marketplace and related spending.

Chart 5: Federal Subsidies Associated with Health Insurance Coverage for People Under Age 65



Health insurance taxes and penalties are projected to reduce total subsidies by $15 billion in 2016 and to grow to $59 billion in 2026:

Taxes and penalties related to coverage ($ in billions)			
	2016	2021	2026
Excise Tax	$0	$2	$4
Individual Mandate[1]	$3	$4	$5
Health Insurer Fee[2]	$11	$16	$21
Employer Penalties	$0	$21	$29
Total Penalties	**$14**	**$43**	**$59**

[1] Penalty payment by uninsured people
[2] Tax on health insurer providers

To learn more, please contact Sarah Coates at sarah.coates@milliman.com.

REGULATORY ROUNDUP

SUMMARIES OF RECENT RELEASES AND ANNOUNCEMENTS

MILLIMAN EMPLOYEE BENEFITS RESEARCH GROUP

IRS announces 2017 HSA limits

The IRS announces the 2017 Health Savings Account (HSA) limits in Revenue Procedure 2016-28. For 2017, the annual limitation on deductible contributions is $3,400 for individuals with self-only coverage (up by $50 from 2016) and $6,750 for family coverage (unchanged from 2016). For 2017, the lower limit on the annual deductible under a high-deductible plan is $1,300 for self-only coverage and $2,600 for family coverage (both remain unchanged from 2016). The annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,550 for self-only coverage or $13,100 for family coverage (unchanged from 2016).

IRS Releases Draft 2016 Forms and Instructions for ACA Reporting

The IRS released draft 2016 Forms 1094/1095 returns for the 2016 tax year (for filings in 2017). Forms 1094-B, Health Coverage Information Returns, and 1095-B, are used to report health coverage by coverage providers. Forms 1094-C, Employer-Provided Health Insurance Offer and Coverage, and 1095-C, are used by applicable large employers (ALEs) to comply with Internal Revenue Code reporting. Draft 2016 draft instructions were also released for Form 1094-C and Form 1095-C and Form 1094-B and 1095-B were also released. Comments on the draft forms and instructions may be submitted via the agency's comments page.

Agencies Propose New, Expanded Group Health Plan Reporting on Form 5500 Series

The Departments of Treasury, Labor and the Pension Benefit Guaranty Corporation published a proposed rule to modernize and improve the Form 5500 Annual Return/Report filed by private-sector, employment-based pension welfare benefit plans. On the same day, the DoL also published a related notice of proposed rulemaking on annual reporting and disclosure. Specifically for all health and welfare plans, these proposed rules would significantly increase the annual reporting obligations. The revised reporting requirements when finalized generally would apply for plan years beginning on and after January 1, 2019.

CMS Issue Q&As on 2017 Edition of SBC Template

The Centers for Medicare and Medicaid Services issued four undated and unnumbered question and answers addressing the applicability date of the Summary of Benefits Coverage (SBC) template and associated documents that were published on April 6, 2016. The guidance state that "health plans and issuers that maintain an annual open enrollment period will be required to use the April 2017 edition of the SBC template and associated documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017, with respect to coverage for plan years (or, in the individual market, policy years) beginning on or after that date."

CMS Releases HIPAA and ACA Compliance Checklists for Self-funded, Non-federal Governmental Plans

The Centers for Medicare and Medicaid Services' Center for Consumer Information & Insurance Oversight (CCIIO) released new Affordable Care Act (ACA) and Health Insurance Portability and Accountability Act (HIPAA) compliance checklists for self-funded, non-federal governmental plans:

- Market Reforms (ACA & HIPAA) Grandfathered Plan Provisions, Self-funded, Non-Federal Governmental Group Health Plans/Compliance Checklist
- Market Reforms (ACA & HIPAA) Non-grandfathered Plan Provisions for Self-funded, Non-Federal Governmental Group Health Plans/Compliance Checklist

EEOC Makes Available a Sample Notice for Employers Offering Wellness Programs

The Equal Employment Opportunity Commission (EEOC) posted on its website a sample notice and brief question and answer document intended to assist employers offering wellness programs comply with their obligations under a recently issued Americans with Disabilities Act (ADA) rule. The ADA final rule, which was released in May, states that employer wellness programs that ask employees about their medical conditions or that ask employees to take medical examinations (such as tests to detect high blood pressure, high cholesterol or diabetes) must ensure that these programs are reasonably designed to promote health and prevent disease, that they are voluntary, and that employee medical information is kept confidential.

To learn more, please contact Maria Saavedra at maria.saavedra@milliman.com.

PLAN SPONSOR COMPLIANCE CALENDAR WITH KEY DATES

SEPTEMBER 2016
- 30: 2015 SUMMARY ANNUAL REPORT TO EMPLOYEES

OCTOBER 2016
- 15: NOTICE OF RX DRUG CREDITABLE COVERAGE TO EMPLOYEES
- 31: SUMMARY OF BENEFITS AND COVERAGE TO EMPLOYEES

NOVEMBER 2016
- 1: ENROLLMENT REPORT FOR TRANSITIONAL REINSURANCE FEE TO HHS
- 15: 2016 TRANSITIONAL REINSURANCE FEE PAYMENT DUE

DECEMBER 2016
- 31: ELECTION NOTICE OF OPT-OUT FROM CERTAIN HIPAA PORTABILITY REQUIREMENTS

JANUARY 2017
- 17: REMIT FULL PAYMENT OF TRANSITIONAL REINSURANCE FEE OF $27.00, IF PAYING IN ONE CONTRIBUTION
- 31: 2016 FORM W-2 TO IRS WHEN FILING USING PAPER FORMS OR ELECTRONICALLY
- 31: 2016 FORM 1099-R TO EMPLOYEE
- 31: FORM 1095-C TO EACH OF EMPLOYERS' FULL-TIME EMPLOYEES

FEBRUARY 2017
- 28: 2016 FORM 1099-R TO IRS
- 28: 2016 FORMS 1095-B AND 1095-C TO IRS, IF FILING ON PAPER

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THE ELUSIVE NATURE OF PRIVATE EXCHANGES

Mike Gaal, FSA, MAAA

Private exchanges continue to be a hot topic as employers seek new, innovative, and cost-effective ways to deliver benefit programs to active employees.

Early forecasts projected exponential growth in private exchange enrollment, anticipating that as many as 40 million active employees and dependents would be covered by 2018 (and 20 million or more by 2016). However, the actual adoption rate has been far slower than anticipated. Current estimates of 4 to 6 million active employees and dependents covered are at least 70 percent to 80 percent below the initial forecasts.

One of the key factors driving slower than anticipated growth is the reluctance of large employer groups to make the move to private exchanges. Although many large employers have evaluated private exchanges, relatively few have actually migrated. Why is this the case?

Are they really delivering savings?
The primary reason appears to be related to the lack of cost savings. The fact is that private exchange operators have not been able to make a compelling argument that the exchange model is more effective at controlling costs than a traditional employer-managed self-funded model. While exchange operators have demonstrated that net employer savings can be achieved through employees buying down to lower levels of coverage, they have not yet demonstrated how the model will curb the growth of overall healthcare costs.

The concept of benefit buy-downs is often referred to in a positive manner, in that employees are "right-sizing" their insurance choices. But ultimately the "savings" in this model are driven by a cost shift to employees—not through more effective management of the program.

As employers continue to evaluate private exchanges, it's important to be asking the right questions:

- What does the private exchange model offer that isn't available under a traditional self-funded arrangement?
- Is our program getting objective, unbiased advice to assist with this decision?

For a more detailed discussion of the current state of the private exchange marketplace, including cost savings considerations and key questions to contemplate before making the leap, please review the article "The elusive nature of private exchanges."

To learn more, please contact Mike Gaal at mike.gaal@milliman.com.