HEALTH & GROUP BENEFITS
NEWS & DEVELOPMENTS

An Employer Benefits Update

Milliman

H&G 18-2

FIVE WAYS THE AMAZON DEAL COULD CHANGE HEALTHCARE IN THE UNITED STATES

Healthcare has the power to transform lives. But who has the power to transform healthcare? The answer seems to be large employers, who are increasingly frustrated with the challenge of providing their employees with affordable, high-quality care. Amazon, Berkshire Hathaway, and JPMorgan Chase recently announced their intent to pursue a similar objective for their employees through the formation of an independent company "free from profit-making incentives and constraints."

These three employers bring a fascinating variety of perspectives to the challenge of healthcare. Amazon disrupts other businesses and does so quickly and creatively. Berkshire Hathaway invests for the long term, prudently managing capital and cash flow. JPMorgan Chase helps businesses and governments through financial crises and has done so for over 200 years. We don't know exactly how these companies will seek to transform healthcare, and there is no reason to think their solution will be the next Kaiser Permanente. But we believe there are five areas where they are likely to focus their efforts.

1. THE INTERNET OF HEALTH

Amazon's success in building a dominant cloud computing business may prove valuable in achieving their goals of increased transparency and simplicity. While many clinicians have adopted electronic medical records, a lack of standardization and incentives to share data has made it difficult to unlock the potential of that data to feed innovative analytics. Amazon has a history of finding ways to break tangled infrastructure problems down into manageable pieces with clear interfaces—in other words, to create simplicity out of complexity and make it easy for systems to talk to each other.

The data collection process might also include information gathered from social media activity, online purchasing, and smartphones or wearable devices. The application of predictive modeling methods to this data could then provide the ability to monitor individuals' health status and risk factors in real time, leading to early warnings of acute medical events or suggested actions to manage heath risk and cost. For instance, does your Fitbit show a higher-than-usual heart rate after your weekly jog? Have you been buying an unusual amount of ibuprofen?

2. ONLINE SHOPPING FOR HEALTHCARE

The lack of competition and pricing transparency among healthcare providers contributes significantly to the high cost of healthcare. What if the same technology that powers businesses like Expedia or Hotels.com were used to create a nationwide transparent cost network of hospitals and physicians? Imagine an online marketplace where providers compete for patients by leveraging cutting-edge technology to update their fees in real time while making it easy for patients to see and compare value across the providers that deliver the care they need. Patients and third-party sources could provide satisfaction and quality rankings to further inform decision-making. The transparent cost network would facilitate innovative benefit designs where patients could get full coverage for the highest-value providers but would need to pay more for higher-cost providers. This solution would also significantly reduce the administrative costs associated with contracting with providers and paying claims.

3. PHARMA OF THE FUTURE

Pharmacy spending represents a meaningful portion of total healthcare costs. Large employers and coalitions of smaller employers have tried to leverage their purchasing volumes to negotiate lower drug prices. However, it seems a more fundamental transformation of the drug purchasing process would be required. How might this occur?

Berkshire Hathaway and JPMorgan Chase are the lesser-discussed employers in this coalition, but they're a part of the equation for a reason. As financiers, they might develop creative value-based contracting solutions to provide pharmaceutical manufacturers with more predictable profit streams over the life cycle of a specific drug—from the immense investment in research and development, to the high returns of a specialty drug under patent protection, to the much lower margins available once the drug becomes generic—all in exchange for lower pricing while the drug is under patent. The data

management and predictive analytics capabilities of Amazon could help improve medication adherence, identify personalized medicine opportunities, and monitor medical outcomes. This information is of immense value and could help bend the cost curve and be returned to drug manufacturers and other entities in the pharmacy supply chain, perhaps in exchange for favorable pricing terms or to hold manufacturers financially accountable for clinical outcomes.

4. CLAIMS COULD BE A THING OF THE PAST

Both providers and payers expend massive resources on submitting and paying insurance claims. Claims do serve a purpose: in addition to providing records for invoicing and payment, claims represent the primary data collection process for insurers. What if there were another way to collect the information the health insurer needs while significantly enhancing the richness of that data at the same time?

The answer is simple: the electronic medical record. Today, most physicians and all hospitals collect information about every patient encounter in an electronic medical record; claims are a relic from a time when medical information was maintained on paper records in color-coded file folders. Direct access to medical records systems by insurance companies could eliminate the claims process–and the accompanying cost–entirely.

5. WE BECOME BETTER PATIENTS

Amazon, Berkshire Hathaway, and JPMorgan Chase employees are part of a pilot program to test all kinds of healthcare system strategies. One foundation of successful start-up firms is the concept of A/B testing–that is, a controlled comparison of two groups–to rapidly learn what strategies impact consumer behavior leading to desired outcomes.

The industry to date has used a variety of instruments to influence consumer behavior, such as high-deductible health plans (HDHPs) and wellness programs, but such efforts aren't typically tailored to an individual's personal profile. Machine-learning technology could be employed to incentivize consumers to be more efficient patients. In the same way, artificial intelligence (AI) can learn which movies to recommend or which products you find appealing, value-based insurance design can identify the best incentives to make sure diabetic patients monitor their blood sugar and take insulin as needed, thereby improving outcomes and reducing healthcare costs.

CHANCE OF SUCCESS?

Transformation is by no means certain. While the announcement of this partnership brought excitement to many within the industry, there are still many details to be ironed out and much uncertainty around what issues the group will tackle first. Many would-be disruptors have found healthcare's problems less tractable than they expected, and solutions that worked in other sectors will need to be custom-tailored to have a chance of being successful. Healthcare is personal in ways that are unlike any other industry, and the stakes of getting it right are life-and-death. Studying past failures and successes and partnering with seasoned healthcare experts will allow this new organization to learn from past mistakes and further its goal of transforming and improving the healthcare marketplace.

PAID FAMILY LEAVE GAINING TRACTION IN THE UNITED STATES

Marcella Giorgou, FSA, EA, MAAA

Beginning January 1, 2018, New York joined three other states to offer paid family leave in the United States. California, New Jersey, Rhode Island, and now New York all offer paid family leave programs funded through employee contributions. Washington state will begin offering paid family leave in 2020, funded through a combination of employer and employee contributions. Washington, D.C., will begin offering paid family leave in 2020 through employer contributions.

As more states implement paid family leave programs and the federal government continues to discuss it, paid family leave benefits as part of health and welfare programs have gained traction. Almost 60% of U.S. employers offer or are planning to offer paid leave in 2018 for new parents, and just under 50% offer or are planning to offer paid leave in 2018 to care for a sick family member.

Details of paid family leave programs vary from state to state. Employers with employees in multiple states need to navigate these different requirements in designing their programs. A summary of paid family leave requirements by state is shown in Figure 1.

FIGURE 1: PAID FAMILY LEAVE REQUIREMENTS BY STATE

	CALIFORNIA*	NEW JERSEY	RHODE ISLAND	WASHINGTON, D.C.	NEW YORK*	WASHINGTON
Effective Date	2004	2009	2014	2020	2018	2020
Income Replacement	60%/70%	67%	60%	Up to 90%	50%	Up to 90%
# Weeks	6	6	4	2-8 weeks	8	12-16 weeks
Maximum Weekly Benefit (2018)	$1,216	$637	$831	Not Applicable	$653	Not Applicable
Job Protection	No	No	Yes	No	Yes	Yes

* California income replacement is 60% or 70% in 2018 depending on employee's wages. New York phases in to 12 weeks and 67% income replacement in 2021.

In addition to the difference in benefits summarized above, details such as eligibility, waiting periods, and qualifying events, as well as how the benefits are delivered, differ from state to state. Most states provide the benefits through a state fund, although some allow for private insurers to participate in paid family leave, such as New York and New Jersey. New York also allows employers to self-insure their benefits.

As governments and employers (where self-insuring is an option) consider the cost of paid family leave programs, it is important for them to consider the following:

- There is limited data available with regard to utilization of paid family leave benefits.
  - Although there is experience with respect to other paid family leave programs offered in states such as New Jersey it is important to adjust for differences in design and demographics of individual groups.
  - It is also important to consider disability claims related to maternity, as bonding with a newborn is generally where a majority of employees utilize paid family leave benefits. In New Jersey, approximately 85% of claims are for bonding with newborn children.
- There will be administrative costs associated with the program.
- Employers who self-insure in New York are required to hold a minimum security deposit to fund unexpected losses, which is determined at the employer level using assumptions prescribed by the New York Department of Financial Services (DFS). Also, the employers are required to submit their experience with DFS on an annual basis.

Some states and employers have taken the lead in implementing paid family leave programs in 2018. As others consider implementing paid family leave it is not only important to consider the cost of the program, but also the design, delivery, and funding. All of them are important to an employer's leave management strategy.

To learn more, please contact Marcella Giorgou at marcella.giorgou@milliman.com.

EMPLOYER-SPONSORED COVERAGE: "EXPANDED" VOLUNTARY BENEFIT OFFERING

Heidi tenBroek | **Stephanie Peterson**, CERA, MAAA, FSA

Voluntary benefits are products offered through an employer but paid for partially or solely by employees through payroll deductions. The attraction of these benefits is that they can offer group rates to employees that they would likely be unable to obtain on their own. Voluntary benefits can also help fill coverage holes when an employer cuts back on or eliminates a specific benefit program. Voluntary benefits are a good way for employers to enhance their employee benefit offerings at little or no cost.

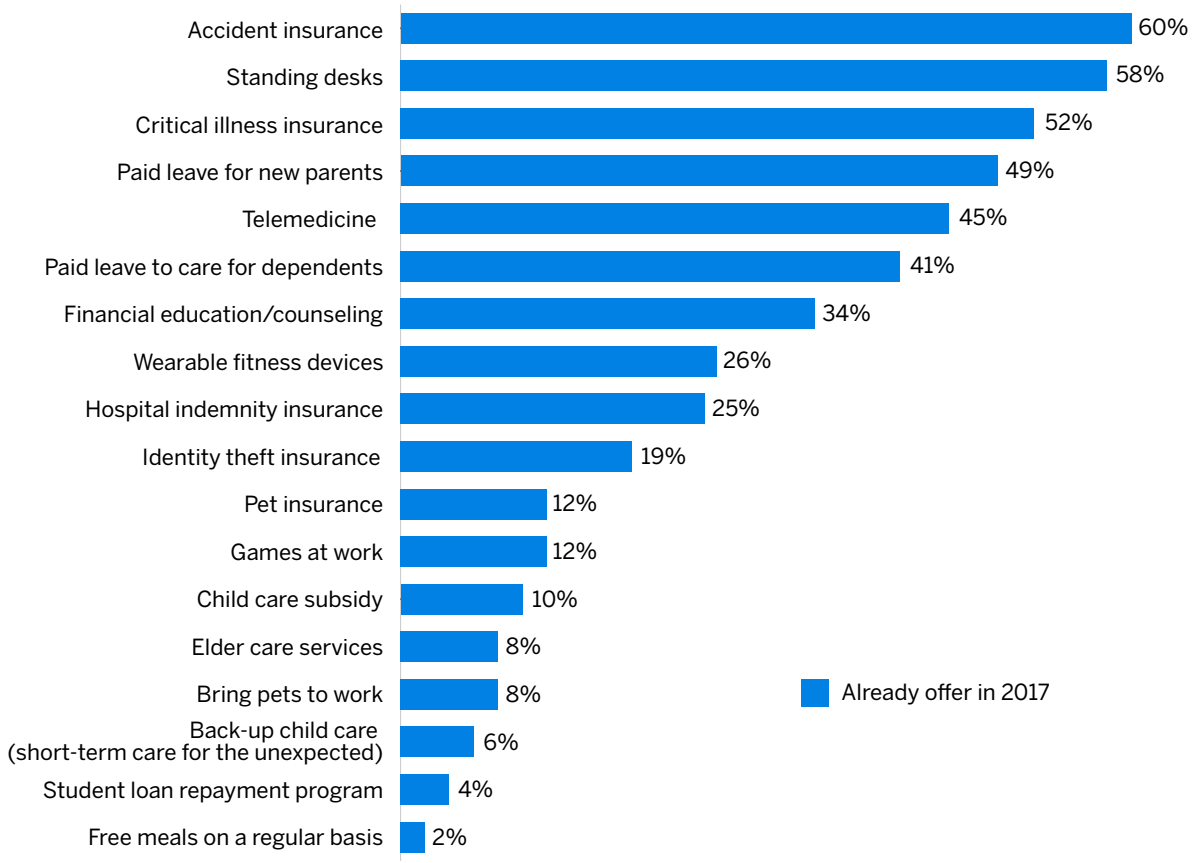
Voluntary benefits have historically encompassed a few basic policies. Today, however, many employers are expanding their offerings to consider their employee demographics (age, marital status, family members), lifestyle, and financial habits. Decisions regarding which benefits should be offered should be made with care. Voluntary benefits should provide clear and convenient options that are easily accessible by employees when needed.

Milliman recently conducted an employer-based survey focused specifically on the menu of "expanded" voluntary benefits. Across a range of voluntary benefits, employers indicated which benefits they were currently offering in 2017 as well as those benefits they planned to offer in 2018.

VOLUNTARY BENEFITS ALREADY OFFERED IN 2017

As shown in the table in Figure 1, accident insurance options, standing desks, and critical illness insurance options were the top three offered voluntary benefits in 2017. Others also leading the pack included paid leave for new parents and to care for dependents, telemedicine, financial education/counseling, and wearable fitness devices.

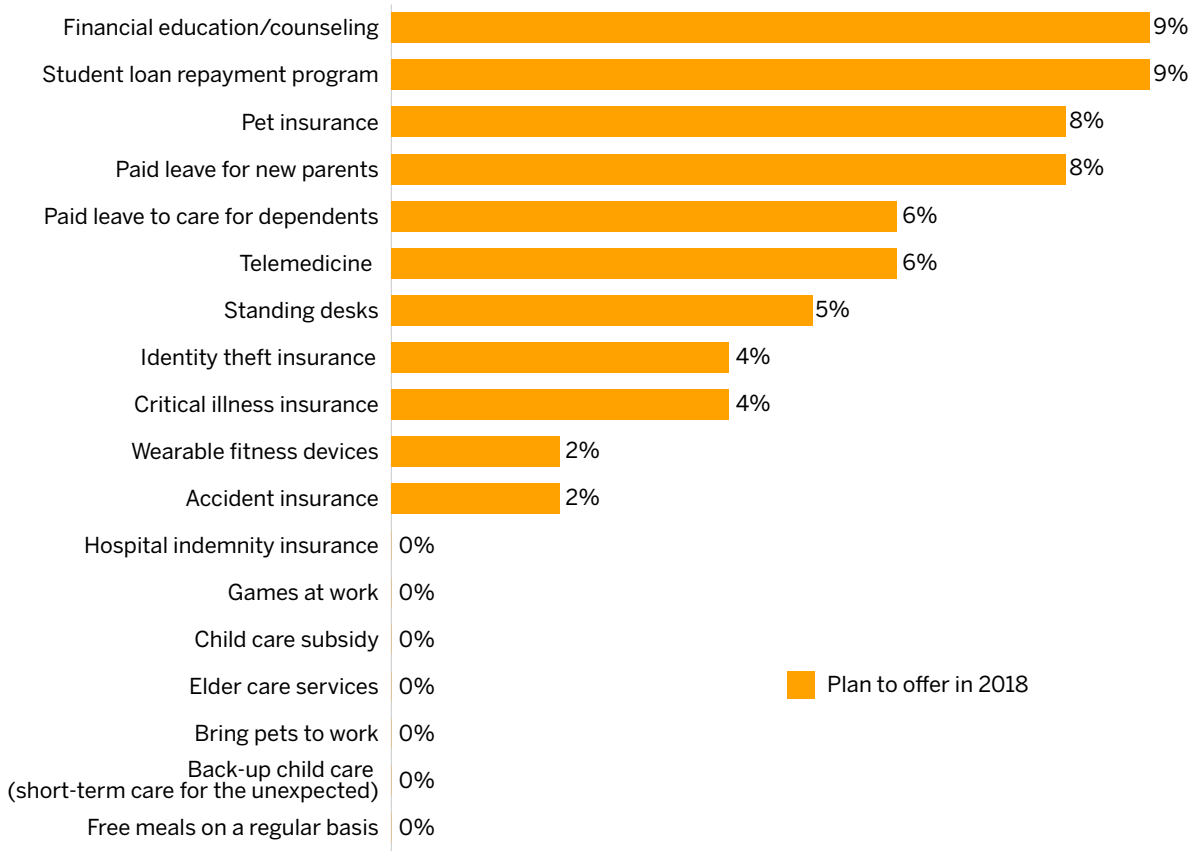
FIGURE 1: PREVALENCE OF "EXPANDED" VOLUNTARY BENEFIT OFFERING, 2017



VOLUNTARY BENEFITS PLANNED TO OFFER IN 2018

The table in Figure 2 shows that the top three voluntary benefits where employers planned to expand in 2018 were financial education/counseling, student loan repayment program, and pet insurance. Other options of interest included paid leave for new parents and to care for dependents, telemedicine, standing desks, and identification of insurance options.

FIGURE 2: PREVALENCE OF "EXPANDED" VOLUNTARY BENEFIT OFFERING, 2018



Health insurance (i.e., medical, Rx, dental) still makes up the main health and welfare offering. However, an ever-expanding range of voluntary benefits gives employers more flexibility and employees more options. As a general rule, the selection of a voluntary benefits programs must be strategic. These benefits must be chosen, managed, and communicated with care, keeping in mind the employer's overall financial goals as well as its employee population needs. There are many voluntary options available but an employer should only choose those that will provide the most relevance and appreciation to its employees.

To learn more, please contact Heidi tenBroek at heidi.tenbroek@milliman.com or Stephanie Peterson at stephanie.peterson@milliman.com.

PLAN SPONSOR 2018 COMPLIANCE KEY DATES

APRIL 2, 2018
- 2017 Form 1099-R (electronic) to IRS
- 2017 Forms 1094-C and 1095-C (electronic) to IRS

JULY 31, 2018
- Send Form 720 to IRS for payment of the Patient-Centered Outcomes Research Institute (PCORI) fee (plan year ending before 10/1/2018)
- 2017 Form 5500 Annual/ Return Report, unless extension applies

SEPTEMBER 30, 2018
- Summary Annual Report (SAR) to employees

OCTOBER 14, 2018
- Rx Drug Creditable Coverage Notice to Medicare Part D-eligible individuals

DECEMBER 1, 2018
- Summary of Benefits and Coverage (plans without open enrollment) to employees

DECEMBER 31, 2018
- Notice of election to opt out of certain HIPAA portability requirements to CMS and to enrollees

REGULATORY ROUNDUP

RECENT LEGISLATIVE IMPACT ON EMPLOYER-SPONSORED INSURANCE

MILLIMAN EMPLOYEE BENEFITS RESEARCH GROUP

Tax Cuts and Jobs Act of 2017 (TCJA)

Passed on December 22, 2017, most of the healthcare-specific coverage was related to the individual mandate penalty being reduced to $0 beginning in 2019. There are other provisions, in this bill and others, that will more directly impact the group market.

- There is a change to the methodology in which thresholds are indexed for the high-cost health plan excise tax (known as the "Cadillac tax"). Originally, the Patient Protection and Affordable Care Act (ACA) specified that increases in the cost thresholds at which the tax applies were based on the consumer price index (CPI). However, the TCJA changed the basis from CPI to Chained CPI, which has, on average, measured approximately 0.25 percentage points lower than CPI (or about 90% of CPI). The effect of this change will be that employer health insurance plans will cross the cost thresholds earlier than under the previous law and will then be exposed to a higher excise tax. The estimated impact of this change is an increase of approximately 2% to 4% in a plan's long-term cost, based on Milliman's long-term trend model.

Continuing Appropriations Act, 2018 (CAA '18)

Signed on January 22, 2018, this delayed the effective date of the Cadillac tax from 2020 to 2022. For any employer health insurance plan that was projected to have to pay the excise tax in 2020 or 2021, the delay will save the plan from paying the tax for one or two years. For plans that were not projected to have to pay the Cadillac tax prior to 2022, this delay will have no effect.

- Also in CAA '18, for 2019 only, fully insured plans are not required to pay the health insurer fee (HIF), an annual fee assessed by the federal government under the ACA that health insurance companies charge plan participants through premiums. The estimated impact of this moratorium could be a one-year savings of 2% to 3% for fully insured employer health insurance plans covering active employees and/or non-Medicare retirees.

Bipartisan Budget Act of 2018

There were two changes that impacted employers who have an employer group waiver plan (EGWP).

1. The Part D coverage gap (which occurs when a beneficiary accumulates $3,820 in total drug cost in 2019) will be eliminated in 2019 instead of 2020, with a reduction in beneficiary coinsurance to 25% from 30% in 2019. That is the same coinsurance the member pays prior to the coverage gap (hence, the coverage gap is "closed").
2. Simultaneously, the pharmaceutical manufacturer discounts are increased to 70% from 50%, also occurring in 2019.

The net effect of these two changes on EGWPs is that the liability of the employer's health insurance plan is reduced to 5% from 20% of total prescription drug costs in the coverage gap, which will result in savings to employers.

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