HEALTH & GROUP BENEFITS
NEWS & DEVELOPMENTS
An Employer Benefits Update

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TRENDING

TOTAL COST OF CARE APPROACH: A NEW FRONTIER IN CARRIER SELECTION

Liz Myers, FSA, MAAA

For the last decade, discounts off of billed charges have been the primary measure for identifying the lowest-cost carrier in the self-funded marketplace. Discounts are a key driver in measuring the cost differential between carrier networks. But the increase in various payment innovations and changes due to healthcare reform has created a need for an alternative measure. A Total Cost of Care Approach—a comparison of risk-adjusted allowed per-member per-month (PMPM) costs—provides a viable mechanism for these evaluations. While calculating cost per head is not a new concept in healthcare, using this information to select a low cost carrier for self-funded employers is.

How did we get here?

The proliferation of accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and risk-sharing arrangements aimed at cost reduction and better care management is a major driver of a Total Cost of Care Approach. A discount-only evaluation does not account for reduced utilization in these programs. In addition, a carrier's discount may actually decline—due to increased reimbursement (i.e., lower discounts) for encouraging specific provider behavior under various types of arrangements. Narrow networks, pay-for-performance, and value-based design are a few other examples of current trends that can't be accurately reflected in a discount analysis.

Why not sooner?

While evaluating carriers based on allowed PMPMs is a topic that has long been under discussion in the market, measuring a carrier's book-of-business PMPM is not an easy task. Several key factors, such as population risk adjustment, service exclusions, and provider payments, had to first be addressed so that costs could be evaluated on a comparable basis.

A long-standing workgroup consisting of industry-leading carriers, consultants, and brokers (known as the Uniform Discount Data Specifications workgroup) has worked diligently to establish mutually agreed upon standards for measuring allowed PMPMs. The Total Cost of Care Approach guidelines have taken some time to achieve group consensus but are now finalized.

What specifically does a Total Cost of Care Approach address?

A Total Cost of Care Approach factors in both unit cost and utilization. Provider reimbursement (unit cost) can vary considerably by carrier in the same market. These highly confidential negotiations occur throughout the year and play a substantial role in the carrier's book-of-business costs. Utilization, the often-neglected child, had previously been excluded because we lacked a standard for measuring returns from care management programs.

The underlying member risk in a carrier's book-of-business data is a major factor when evaluating cost. PMPMs must be normalized across carriers so that those with the riskiest populations are not penalized. The carriers most successful at capturing demographic and diagnostic detail in their membership and claims data will receive a relatively larger risk score and therefore lower risk-adjusted cost.

Capitation and settlement fees are collected and factored into the Total Cost of Care Approach as well. There is no place for allocation of these costs under a discount approach. Carriers compile this data and submit as direct or indirect expenses to an employer. Capturing this information is especially important, due to the increase of alternative network arrangements mentioned previously. While administrative costs and network access fees are key components of the total cost equation, they are not included in the specifications and must be evaluated outside of the carrier data submission. *[continued on the following page]*

A Total Cost of Care Approach, *continued*

How does this impact me?

Employers should be aware of this new method for market cost evaluation and how it can assist in a carrier cost comparison. A Total Cost of Care Approach addresses several items not previously considered in a discount comparison. Still, some critical questions must be addressed when using this methodology. How credible are the key ZIP Codes in the carriers' book-of-business data? What confidence interval is given to the risk-adjusted PMPM? Are results under a Total Cost of Care Approach reasonable when compared with the discount analysis? Understanding the nuances and addressing them appropriately will result in a more accurate and robust analysis.

To learn more about this new market approach, contact Liz Myers at liz.myers@milliman.com.

EMPLOYER STRATEGIES HIGHLIGHTED

ONE EMPLOYER'S STRATEGY FOR MANAGING HIGH DRUG COSTS

Stephanie Noonan, CERA, MAAA, FSA

A constant worry for many employers is how specialty drug usage is substantially driving up the prescription drug spend for their employees. The University of Minnesota's self-insured program saw their drug spend increase last year by approximately 8.9%. While every population will have a unique drug trend—the Milliman Medical Index last year reported a 13.6% annual increase in pharmaceutical costs—the key takeaway is the increase in those costs relative to the increase in other medical costs. For Minnesota, the drug trend is nearly double the rate of the University's other healthcare expenditures. Specialty medications for illnesses such as cancer and multiple sclerosis made up approximately 1% of the University's prescription drug volume—but accounted for 28% of its drug costs.

The University's solution is multi-faceted. One solution they are implementing is to limit the amount of drug received. For example, if employees start certain high-cost specialty drugs, they receive just a two-week supply. Before they can begin receiving another two weeks' worth, a nurse must confirm each drug's effectiveness. The point of this new provision is to avoid paying for prescriptions that ultimately aren't used if patients develop side effects and discontinue taking them.[1]

The University's prescription drug concerns are not in isolation either. Many employers are struggling with the same obstacle. Total medication costs, including those adjudicated under both the medical and pharmacy benefits, are expected to account for nearly 30% of total healthcare claim costs in 2016.[2]

Other strategies utilized by employers to manage high drug costs could include:

1) **Prior Authorization**: Doctors are required to obtain advance approval from health-plan administrators to prescribe specified high-cost drugs.
2) **Step Therapy**: With this approach, before a health plan approves a more-expensive drug, patients must first try treatment with a lower-cost option. Some 69% of employers currently implement a step-therapy strategy.
3) **Introducing a 4th cost-sharing tier:** An increasing number of plans have created a 4th tier of drug cost sharing, often referred to as a specialty tier, primarily used for expensive drugs. Cost sharing is usually set up as a percentage of the drug's cost (coinsurance).
4) **Eliminating financial incentives:** Current reimbursement is based on ASP plus methodology, which creates higher profit incentives for physicians and hospitals to dispense more expensive medications.[2]

For more on this, contact Stephanie Noonan at stephanie.noonan@milliman.com.

[1] *Adapted from* "Employers Battle Drug Costs," by Peter Loftus, *The Wall Street Journal*, 12/18/2015, http://www.wsj.com/articles/employers-battle-drug-costs-1450488416
[2] "Commercial Specialty Medication Research: 2016 Benchmark Projections", December 2015

EMPLOYER STRATEGIES

GROUP LIFE INSURANCE: MORE THAN A COMMODITY

Daniel D. Skwire, FSA, MAAA

Because group life insurance is so affordable and simple for employees, employers often view it as a commodity. The only perceived difference among insurers providing group life is the premium they charge for it. Appearances, however, can be deceiving. Important differences among group life insurers go far beyond quoted premium rates.

Financial considerations

One of the most widely offered employee benefits, group life insurance is the sole or primary source of this coverage for many working Americans. In most cases, at least a portion of group life coverage is employer-paid and requires no medical underwriting.

Financial analysis of group life plans goes well beyond the premium rate charged for the employer-paid portion of coverage. For example, there are separate premium schedules for spouse and child coverage, as well as for ancillary benefits such as accidental death and dismemberment (AD&D). There are also other financial considerations beyond premium rates, including the length of time for which rates are guaranteed (typically at least three years, but up to five years and beyond for large cases) and the amount of premium at risk for performance guarantees.

Some group life plans are also written on a participating basis, where employers benefit from favorable experience. For these plans, where the employer is ultimately responsible for the cost of benefits paid, the most significant financial considerations are the expenses the carrier charges to the plan and the amount of interest the carrier credits to any surplus the plan accumulates.

Benefits beyond basic coverage

Group life plans offer a number of important benefits beyond just the employer-paid “basic” life coverage on employees:

- Supplemental life coverage allows employees to purchase additional life coverage at their own expense. The amount of coverage employees can buy, the cost of this coverage, and the nature of the medical underwriting required (if any) are major considerations in purchasing group life.
- Coverage for spouses and children is also often available in group life programs. It provides a valuable benefit for employees with nonworking spouses or for dependents whose health conditions might otherwise preclude them from purchasing life insurance elsewhere.
- Ancillary benefits and services can also add value to group life plans. Examples of these items include AD&D coverage, will preparation, grief counseling, and financial planning.

Big differences among carriers in client service

Customer service and enrollment support are major considerations for employers selecting a group life carrier. The active promotion of supplemental and spouse life programs, for example, will encourage more employees and dependents to participate in these programs. This not only provides more comprehensive protection to the buyers, but a better spread of risk (and thus more affordable pricing) for the insurer. A simple online enrollment process, including real-time underwriting decisions, can also be very helpful in improving participation rates and employee satisfaction with the program.

Claim adjudication for group life is much simpler than for products like group disability, which require intensive investigation—but there are still some important differences among carriers. The best claim departments make the process very easy for beneficiaries. Claim processors should be trained in grief management and should be empowered to take reasonable actions to facilitate the claim process, such as knowing when a copy of a death certificate, rather than an original, can be accepted. They should also actively assist beneficiaries in accessing support services such as funeral planning, grief counseling, and financial assistance.

Group life insurance is, and will continue to be, a price-sensitive offering. Nonetheless, any employer reviewing group life insurance plans should take a comprehensive look at each plan’s overall financials, benefit structure, service model, and claim process before deciding on an insurance carrier.

To learn more about how to best evaluate group life insurance programs, contact Daniel D. Skwire at dan.skwire@milliman.com.

PLAN SPONSOR COMPLIANCE CALENDAR WITH KEY 2016 DATES

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
- **1**: Enrollment Report for Transitional Reinsurance Fee to HHS
- **15**: 2016 Transitional Reinsurance Fee Payment Due

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

THE BACK PAGE

FORM W-2: ARE THERE $916 BILLION DUCKS SITTING ON THE POND?

Charlie Clark, ASA, MAAA, EA

In baseball, there's an old expression, "ducks on the pond," which refers to "runners in scoring position." These are potential runs—but the runs can't appear on the scoreboard unless they're batted in.

Right now, the U.S. government has put some new "ducks on the pond." Have you noticed them on the Form W-2?

Thursday, Jan. 31, 2013 was the date that all working Americans should have received their 2012 Form W-2 from their employers. For the first time, many employers were required to provide new information by Internal Revenue Code §6051(a)(14) in Box 12-DD.[1] Code DD refers to the value of employers' costs to provide "employer-sponsored health coverage" during the previous year. In its instructions for Form W-2, the IRS uses **bold** font to state that "**The amount reported with code DD is not taxable."** Maybe it should have read, **not taxable *yet*?**

Similarly, the Administration's 2017 Federal Fiscal Year budget includes a repeat proposal (from the 2016 FFY budget) that would require the reporting of employer contributions to *defined contribution plans* on Form W-2. Form W-2 already requires employers to disclose employee elective deferrals.

Employer health coverage is exempt for individuals from Federal tax, while savings plan contributions (and appreciation) are tax-deferred from Federal taxes until withdrawn.

In its analysis of the 2017 Federal Fiscal Year Budget, the Office of Management and Budget (OMB) lists income-tax expenditures by the highest amounts for the 10-year period 2016-2025. Employer contributions for medical insurance premiums and medical care (#1 tax expenditure) are estimated as $2,742.3 billion and contributions to savings plans are estimated to be $921.5 billion (#5). That's $3,663.8 billion.

Requiring personal income tax to be paid on these amounts would be a game-changing provision for American workers at every level of compensation. For taxpayers, putting all those compensation values on their Form W-2 will allow easy transfer to personal tax software programs for inclusion in taxable income.[2]

These would be added to taxpayers' Federal Form 1040 taxable income—and taxed at marginal tax rates.

If taxed at 25%, this amounts to $916 billion ducks on a pond. (Many affected workers could see "tax-bracket creep".) It's hard to blame Congress for looking at this closely.

Here's the 916 billion-dollar question: Will the 115th Congress and the 45th POTUS be sitting on a fastball that would allow them to bring those ducks home to the U.S. Treasury's coffers? It's going to be an interesting year ahead for American employers and workers.

For more on this, contact Charlie Clark at charles.clark@milliman.com.

1: The ACA added §6051 to the tax code.

2: Roth savings plan withdrawals are not taxed subject to certain tax code rules; personal state-of-residence taxation assessments are beyond the scope of this article.