

CAA and other transparency measures: Timing and implications of surprise billing for plan sponsors

Sean Silva, FSA, MAAA, CEBS
Michael Halford, FSA, MAAA
Kathryn Elizabeth Mohr



Signed into law on December 27, 2020, the Consolidated Appropriations Act (CAA) of 2021 requires the most comprehensive changes to active employee health plans since the Patient Protection and Affordable Care Act (ACA).

The CAA protects consumers from certain surprise bills for out-of-network (OON) medical services and establishes the first federal procedure to handle disputed OON medical claims. The CAA also includes several provisions to increase health plan transparency around medical costs and coverage. Additional price and quality transparency measures, including new disclosure requirements, took effect when the U.S. Departments of Labor, Treasury, and Health and Human Services issued the Transparency in Coverage final rule on January 11, 2021.

Compliance with the new legislation places major administrative burdens and potentially higher costs for compliance on plan sponsors. With some regulations going into effect in 2021, and many in 2022, plan sponsors need to immediately take steps toward compliance. This paper is designed to help plan sponsors gain an understanding of the new provisions and how they will impact their specific plans.

Health plan status under the ACA is a key factor. Plan sponsors with grandfathered status are relieved of having to comply with the new consumer protection and transparency provisions required of non-grandfathered plans, such as pharmacy and drug cost reporting. Grandfathered plans must have been in place before the ACA was signed into law on March 23, 2010, and since then must not have made any changes that would cause them to lose their grandfathered status.

Becoming compliant with this legislation will require a coordinated effort on the part of plan sponsors, the medical insurance carriers that cover participants, self-funded plan administrators, entities offering medical networks to self-funded plan sponsors, and other vendors and advisors involved in the delivery and management of active employee health plans. While the legislation does not clearly define the role of each involved party, it is the plan sponsor's responsibility to ensure compliance. To that end, plan sponsors should commence the process of determining how they will become compliant by the required dates and determining whether any formal modifications to their plan documents will be needed in response to the legislation.

NO SURPRISES ACT

Balance billing protections

✓ TAKES EFFECT JANUARY 1, 2022.

✓ INTERPRETED TO APPLY TO GRANDFATHERED AND NON-GRANDFATHERED PLANS FOR APPLICABLE SERVICES.

When plan participants seek medical care, they may not be in control of whether the facility and healthcare providers delivering the service are in their networks. To address potential billing issues, plan sponsors covering out-of-network (OON) services establish plan and participant costs for OON medical care. Typically, the plan sponsor's Summary Plan Description (SPD) defines circumstances where a participant may be balance-billed by an OON provider or facility for any charges above the plan's allowable charge for a particular service received. Because there is no limit to the amount that OON providers or facilities can charge, balance billing can create significant financial burdens for participants, with medical balance bills averaging about \$1,500 and potentially reaching into the tens of thousands of dollars.¹

Although preferred provider organization (PPO) networks help reduce the frequency of balance billing, many participants still receive balance bills—even when they go through the proper steps to ensure they are seeking care from an in-network (INN) provider or facility. According to a March 2019 study of 620,000 hospital admissions, about one in seven patients using an INN hospital was nevertheless billed by an OON medical provider. Anesthesiology, emergency treatment, and lab services were among the most common causes of these unexpected bills.²

¹ Krütz, F. (August 8, 2019). What causes surprise medical bills? AARP. Retrieved April 11, 2021, from <https://www.aarp.org/money/credit-loans-debt/info-2019/what-is-balance-billing.html>.

² Ibid.

Seventeen states have already passed comprehensive legislation³ to prevent surprise medical bills in emergency and nonemergency situations. Fully insured plans are required to comply with these regulations. Self-insured plans governed by the Employee Retirement Income Security Act (ERISA) are not subject to state requirements. The No Surprises Act, one of the main components of the CAA, mandates a uniform level of protection that applies nationwide for the following medical services:

- All OON emergency facility and professional services, including post-stabilization care at OON facilities until a patient can be safely transferred to a different facility.
- Air ambulance transports, whether emergency or nonemergency in nature. Note that this provision does not apply to ground ambulance services.
- OON services delivered at or ordered from an INN facility, unless the provider follows the notice and consent provision described below.

For covered services in the above categories, a participant cannot pay more than the INN cost-sharing amount, and all amounts paid by a participant must count toward the participant's INN annual deductible and INN annual out-of-pocket maximum. A participant's cost-sharing amount must be calculated using the "recognized amount," defined in CAA legislation as:

- The amount specified by state law, if such a law exists
- The "qualifying payment amount," defined as:
 1. In calendar year 2022, the median INN rate for similar procedures performed in similar geographic areas as of January 31, 2019, increased using the Consumer Price Index for Urban Consumers.
 2. In all future years, the median INN rate for similar procedures performed in similar geographic areas in the previous year, trended using the Consumer Price Index for Urban Consumers.
- The amount specified in a state's specific All-Payer Model Agreement, if such an agreement exists.

Further, the notice and consent provision determines whether nonemergency services delivered by OON providers at INN facilities are protected from balance billing. Providers must obtain a patient's written consent for OON services, provide the patient with written notification of their OON provider status, and provide:

- A good faith estimate of charges
- A listing of INN providers within the facility who could also provide the service (supplied by the participating facility)
- Information about any prior authorization requirements or other care management protocols that need to be followed

The notice and consent provision does not apply in situations where no INN provider is available and for services where patients are typically unable to select their specific providers. This "no exception" group is defined as any service relating to emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic testing, and services provided by assistant surgeons, hospitalists, and intensivists.⁴

► IMPACT ON PLAN SPONSORS

Although the No Surprises Act protects participants, it does not provide the same level of protection to plan sponsors. This legislation can increase costs for self-funded plans by making plan sponsors responsible for amounts not covered by participant cost sharing. Prior to balance billing protections, plan sponsor liability was typically capped at the defined OON allowed amount minus participant cost sharing for OON benefits.

Plan sponsors do gain a path to reduce liability, either through direct negotiation with the provider or facility or through the Independent Dispute Resolution (IDR) process. Additionally, this legislation might reduce the frequency of appeals for plan sponsors.

NO SURPRISES ACT Independent Dispute Resolution

✓ TAKES EFFECT JANUARY 1, 2022.

✓ INTERPRETED TO APPLY TO BOTH GRANDFATHERED AND NON-GRANDFATHERED PLANS FOR APPLICABLE SERVICES.

When an OON provider or facility and a plan sponsor cannot agree on a payment amount for a claim subject to balance-billing protection within 30 days of an initial payment or notice of declination of payment, the parties can initiate the IDR process. IDR must be performed by an unbiased, third-party arbitrator, jointly selected by the parties from a set list of IDR service providers. If the parties cannot jointly agree on an IDR service provider, they will be assigned one.

During the IDR process, each party must submit a payment proposal, along with any information that may be relevant to the case, including the severity of the participant's illness, the skill level of the provider or facility, any attempts by the provider or

³ Hoadley, J., Lucia, K., & Fuchs, B. (December 17, 2020). Surprise Billing Protections: Help Finally Arrives for Millions of Americans. The Commonwealth Fund. Retrieved April 11, 2021, from <https://www.commonwealthfund.org/blog/2020/surprise-billing-protections-cusp-becoming-law>.

⁴ Adler, L., Fiedler, M., & Ginsburg, P.B. (February 4, 2021). Understanding the No Surprises Act. Bookings. Retrieved April 11, 2021, from <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/>.

facility to enter the plan sponsor's network, and the "qualifying payment amount" for similar services rendered in a similar geographic area.

The IDR service provider determines the amount to be paid on the claim by considering each proposal and supporting evidence, along with the "qualifying payment amount," which federal agencies will begin to regulate no later than July 1, 2021. The IDR service provider cannot consider billed charges, usual and customary charges, or Medicare, Medicaid, TRICARE, or the Children's Health Insurance Program (CHIP) allowed amounts. After the IDR service provider selects one of the two payment proposals, the losing party must pay the determined amount along with IDR fees within 30 days.

► IMPACT ON PLAN SPONSORS

The level of impact depends on whether the plan sponsor chooses to utilize the IDR process and the outcome of each IDR determination. If the IDR determines that the amount required to be paid on the disputed claim is less than the amount the plan sponsor would have paid using the OON allowed amount, then the plan sponsor could benefit. Additionally, any assistance needed by the plan sponsor to prepare for participation in the IDR process could come with a cost.

Plan sponsors participating in the IDR process must also pay an annual administrative fee to the U.S. Department of Health and Human Services (HHS). Although the fee is not part of the legislation, it is intended to pay for the costs of implementing the IDR program.

Until losing party and administrative fees are determined, it is difficult to assess a plan sponsor's financial impact when engaging in IDR.

NO SURPRISES ACT ID card requirements

✓ TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2022.

✓ INTERPRETED TO APPLY TO GRANDFATHERED AND NON-GRANDFATHERED PLANS.

Plan sponsors must include the INN and OON deductible and out-of-pocket maximum limitations on participant identification cards (ID cards). ID cards must also include a telephone number and internet website address for participant assistance information.

► IMPACT ON PLAN SPONSORS

Plan sponsors may need to pay to issue new ID cards if the required information is not already printed on them. Every time the deductible or out-of-pocket maximum changes, the plan sponsor must issue new ID cards.

NO SURPRISES ACT Advanced Explanation of Benefits

✓ TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2022.

✓ INTERPRETED TO APPLY TO BOTH GRANDFATHERED AND NON-GRANDFATHERED PLANS.

All providers and facilities must inquire whether a participant has health insurance no later than one business day after the medical appointment is made (if made at least three business days in advance) or no later than three business days after the medical appointment is made (if made at least 10 business days in advance).

If the participant is insured, the provider or facility then must provide a good faith cost estimate including billing and diagnostic codes to the plan sponsor. Once notified, the plan sponsor must provide the participant with an Advanced Explanation of Benefits (EOB) no later than one business day after receiving the notification (if the appointment was made at least three business days in advance) or no later than three business days after receiving the notification (if the appointment was made at least 10 business days in advance). The Advanced EOB must include the following:

- The network status of each provider and facility
- If the provider or facility is in-network, the contracted rate for the services scheduled to be received
- If the provider or facility is out-of-network, the good faith estimate supplied to the plan sponsor
- The expected participant cost-sharing amount
- The estimated amount the participant has accrued toward their annual deductible and annual out-of-pocket maximum
- Any medical management requirements for procedures, such as prior authorizations.
- A disclaimer that all information is estimated and is subject to change

Plan participants can also request an Advanced EOB for services they would like to schedule. After receipt, plan sponsors have three business days to fulfill the request.

► IMPACT ON PLAN SPONSORS

Plan sponsors need to implement a process to provide these documents, which will likely increase administrative costs. This new process will also require coordination between the plan sponsor's administrator, the plan's provider network(s), and the entire medical community providing participant care. However, this information might encourage participants to move their care INN, which could lower health plan costs.

NO SURPRISES ACT**Continuity of care**

- ✓ TAKES EFFECT ON JANUARY 1, 2022.
- ✓ INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.

If a participant is receiving continued care for an ongoing medical condition from a specific INN provider or facility, and that provider's network status changes from INN to OON, the participant can continue to receive care from the provider at the INN cost-sharing amount for 90 days. Note, however, that the legislation does not mandate the provider whose network status is changing to continue providing any transitional care.

Relevant ongoing medical conditions include, but are not limited to, terminal illness, postoperative care, and courses of treatment for pregnancies. The plan sponsor is responsible for notifying the participant of the change in network status and their right to continue care. This provision does not apply if the provider or facility contract is terminated with good cause, such as fraud or failing to meet quality standards.

► IMPACT ON PLAN SPONSORS

Depending on the extent of use, this provision could result in plan sponsors paying increased costs to providers or facilities that change network status. Additionally, plan sponsors are responsible for identifying and notifying affected participants when a provider or facility loses INN status.

NO SURPRISES ACT**Price comparison tool**

- ✓ TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2022.
- ✓ INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.

Plan sponsors must create and maintain a web-based price comparison tool for use by plan participants. The tool must include out-of-pocket cost comparisons for various services by an INN provider or facility for a specific geographic region and plan year. Plan sponsors must also make price comparison guidance available by phone.

► IMPACT ON PLAN SPONSORS

Plan sponsors will likely pay administrative costs to develop and maintain this tool. However, this information might help participants find the least costly provider, which could potentially reduce plan costs.

NO SURPRISES ACT**Provider directories**

- ✓ TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2022.
- ✓ INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.

Plan sponsors must establish a provider database on a public website that includes a list of all healthcare providers and facilities under contract. Plan sponsors must verify provider information in the database at least every 90 days and establish a process to remove providers when it cannot verify their information. Plan sponsors must update this database within two business days of receiving notification of any changes from a provider or facility. If a participant requests information about the network status of a provider or facility, plan sponsors must respond within one business day and retain evidence of the communication for two years.

If a plan sponsor provides inaccurate information to a participant about the network status of a provider or facility, and the participant receives services from that provider or facility, then the participant is only responsible for paying the INN cost-sharing amount. All cost sharing paid by the participant must count toward the participant's INN deductible and out-of-pocket maximum. If the provider bills the participant more than the INN rate, and the participant pays the bill, then the provider must reimburse the difference plus interest to the participant.

Plans sponsors must include the following information on the public website and on each Advanced EOB:

- All requirements and prohibitions related to balance billing
- The amount providers or facilities can charge according to state law (if applicable)
- Contact information for reporting malfeasance and non-compliance with these orders to state and federal agencies

► IMPACT ON PLAN SPONSORS

Provider directories are commonplace among medical insurance carriers and provider network suppliers. The diligence in maintaining them has not been uniform across the industry. This component of the legislation will require more rigor on the part of plan sponsors to ensure that the information is accurate and updated on a timely basis. This information may also help participants choose an INN provider, which could potentially reduce claims costs for plan sponsors. If there are errors on the database, or it is not well maintained, plan sponsors could pay more for claims from providers who are categorized incorrectly.

Gag clause removal

✓ INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.

Plan sponsors may not enter into an agreement with a healthcare provider, network, third-party administrator, or other service provider offering access to a network of providers that will restrict the plan sponsor from:

- Providing provider-specific cost or quality data to referring providers, plan sponsors, or participants
- Accessing electronically de-identified claims data that includes financial information, provider information, service codes, and any other data element included in a claim or encounter transaction for each participant

► IMPACT ON PLAN SPONSORS

Group health plans must submit an annual attestation to the Secretary of HHS stating that their plans comply with the requirements of this law.

Mental Health Parity and Addiction Equity Act requirements

✓ TAKES EFFECT FEBRUARY 10, 2021.

✓ APPLIES TO ALL PLAN SPONSORS SUBJECT TO MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) REQUIREMENTS.

The CAA of 2021 affects the MHPAEA of 2008 by shifting the focus to nonquantitative treatment limits (NQTLs). Plan sponsors that offer mental health or substance abuse disorder benefits face additional reporting and compliance requirements for NQTLs. Of particular urgency is a requirement that plan sponsors complete a formal compliance analysis and make the resulting documentation available, upon request, to applicable regulators.

The Secretary of HHS or the Department of Labor may request that plan sponsors present a comparative analysis of NQTLs between mental health and substance abuse benefits and medical or surgical benefits. This comparison must include:

- Specific coverage terms for NQTLs
- Factors used to determine whether a NQTL will apply to mental health or substance abuse disorder benefits and medical or surgical benefits and the evidentiary support for these factors

- An analysis demonstrating that the factors used to apply the NQTLs for mental health or substance abuse disorder benefits are comparable to and applied no more stringently than those used to apply NQTLs for medical or surgical benefits.

► IMPACT ON PLAN SPONSORS

While the CAA requires that documentation of NQTL compliance (including comparative analyses) to be completed by February 10, 2021, plan sponsors were not required to submit this information on that date. Instead, the information must be made available upon request, including for plans with suspected violations or complaints, or for other situations regulators find appropriate. Since the passing of the CAA, the Department of Labor issued FAQs regarding the requirements under the CAA as they pertain to the MHPAEA of 2008 and the comparative analyses. Within the FAQs, there is a list of nine elements the comparative analyses should contain to be considered minimally sufficient.⁵ These nine elements, along with the 2020 MHPAEA Self-Compliance Tool, should form the basis of the comparative analyses.

If regulators determine that the documentation or comparative analyses produced by the plan sponsor are insufficient, they can request additional information and analyses, which plan sponsors are then required to produce. If regulators determine that the plan sponsor is out of compliance, then corrective action plans to resolve any issues within 45 days may be required. If compliance is not achieved within 45 days, regulators will notify individuals covered by the plan that the insurance plan has been found to be not in compliance with MHPAEA.

Beginning on October 1, 2021, the CAA also requires the Secretary of HHS to submit an annual report to Congress, including the names of the plan sponsors that were found to be noncompliant. Being publicly identified as noncompliant in this report presents reputational risks for plan sponsors. Additionally, noncompliant plan sponsors may also be subject to penalties or fines, and the Internal Revenue Service (IRS) can assess fines from plan sponsors up to \$100 per day for each individual affected by a parity violation.⁶

⁵ U.S. Department of Labor (April 2, 2021). FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45. Retrieved April 11, 2021, from <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-45.pdf>.

⁶ Melek, S. & Davenport, S. (February 2021). How the Consolidated Appropriations Act of 2021 Affects MHPAEA. Retrieved April 11, 2021, from https://us.milliman.com/-/media/milliman/pdfs/2021-articles/2-25-21-the_impact_of_the_caa_on_mhpaea.ashx.

Pharmacy and drug cost reporting

✓ **TAKES EFFECT ON DECEMBER 27, 2021.**

✓ **INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.**

Starting December 27, 2021 and continuing June 1 of each subsequent year, each non-grandfathered plan sponsor must submit the following information to the Secretary of HHS, the Secretary of Labor, and Secretary of Treasury:

- Start and end dates of the plan year
- Total number of participants
- Each state where the plan or coverage is offered
- Top 50 brand prescription drugs by frequency and the total number of paid claims for each drug.
- Top 50 prescription drugs by annual total spend and the total amount spent on each drug.
- The 50 prescription drugs contributing to the biggest increase in plan costs compared to the prior plan year, and the total cost difference for each drug compared to the prior plan year.
- Total medical and prescription drug spend broken down into various categories, including hospital costs, professional costs for primary care and specialists, prescription drugs, and more.
- Average monthly premium paid, split between the employer and employee.
- Any premium or out-of-pocket cost impact due to rebates or other payments by drug manufacturers. This includes reporting on rebates or other remuneration paid by drug manufacturers to the plan sponsor by therapeutic class and for each of the top 25 drugs yielding the highest rebates or other remuneration.

► **IMPACT ON PLAN SPONSORS**

Plan sponsors will need to compile and submit this information annually. There will likely be a cost associated with compiling this report.

Transparency in coverage: Public disclosures

✓ **TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2022.**

✓ **INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.**

Plan sponsors must make the following information available on a public website through three machine-readable files:

- Negotiated rates for covered services with INN providers
- Historical OON allowed amounts and billed charges
- INN negotiated rates and historical prices for all covered prescription drugs

Plan sponsors will be required to update this information monthly. Plan sponsors can satisfy the requirement for this disclosure by signing a written agreement with a third-party administrator, specifying that they will complete the required disclosures for them. However, the plan sponsor is liable if this information is not made available correctly or updated monthly.

► **IMPACT ON PLAN SPONSORS**

Plan sponsors might have to pay additional administrative fees to make this information available and updated monthly.

Transparency in coverage: Participant disclosures

✓ **TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2023.**

✓ **INTERPRETED TO APPLY ONLY TO NON-GRANDFATHERED PLANS.**

Plan sponsors must make the following information available for 500 services specified by the Department of Labor:

- Cost-sharing information from a particular provider or providers
- Estimated cost-sharing liability
- Amounts participants have accumulated toward deductibles and out-of-pocket limits
- In-network negotiated rates for covered services
- Out-of-network allowed amounts
- A list of items and services subject to bundled payment arrangements
- A notice of prerequisites, such as prior authorization required, if applicable
- Disclosure notice, including balance billing provisions, variations in actual charges, and disclosure that the estimated cost sharing is not guaranteed

Plan sponsors must make this information available to participants through a self-service tool on a public web page, and in paper form if requested by a participant.

✓ **TAKES EFFECT ON THE FIRST PLAN YEAR ON OR AFTER JANUARY 1, 2024:**

Plan sponsors must make the information detailed above available for all services and items.

► **IMPACT ON PLAN SPONSORS**

This requirement is similar to the CAA price comparison tool provision, although it is more prescriptive and comprehensive. Plan sponsors could expand the price comparison tool to meet this requirement, although it is still likely to increase administrative costs.

Transparency in coverage: Hospital disclosures

✓ TOOK EFFECT ON JANUARY 1, 2021.

For all provided items and services, hospitals are required to make publicly available their gross charges, payer-specific negotiated charges, discounted cash prices, and de-identified minimum and maximum negotiated charges. Hospitals must make this information available through a single machine-readable file available online. They are required to update the file annually.

In addition, hospitals must make available online in a consumer-friendly format the payer-specific negotiated charges, discounted cash prices, and de-identified minimum and maximum negotiated charges for 300 “shoppable” services that the hospital provides. The law defines “shoppable” services as those that can be scheduled ahead of time and are routinely provided in a nonurgent setting.

► IMPACT ON PLAN SPONSORS

Plan sponsors will not need to take any action. Depending on the usability of the data provided, plans might benefit from these price disclosures. As of March 2021, according to a review of the data postings from 55 health systems (representing more than 600 hospitals across 42 states), 68% of health systems had posted a file containing the required pricing disclosures. The remaining 32% of the systems had not published data sets containing all required data elements.⁷

⁷ Barrington, A., Boschert, J., Gaal, M., & Lewis, D.C. Hospital Price Transparency: March 2021 Update. Milliman Brief. Retrieved April 11, 2021, from https://www.milliman.com/-/media/milliman/pdfs/2021-articles/4-5-21-hospital_price_transparency.ashx.

Conclusion

The No Surprises Act and transparency laws require plan sponsors to comply with some of the most burdensome tasks since the ACA. Compliance will require a significant amount of time and coordination among plan sponsors, medical insurance carriers, self-funded plan administrators, entities offering medical networks to self-funded plan sponsors, and many other stakeholders to manage and implement the various new processes and requirements.

While it seems evident that the No Surprises Act will lower out-of-pocket costs for participants, it is not clear at this time whether plan sponsors will experience lower overall costs as a result. Compliance typically comes with a cost (as outlined in a number of areas above) but it is not certain that these new requirements will produce offsetting claims cost reductions to produce lower total premiums.

Plan sponsors offering mental health or substance abuse disorder benefits, relying on the guidance issued in the FAQs, should already have their comparative analyses ready (or be in the process of analysis) in case they are requested by regulators. Most of the other provisions take effect on or after January 1, 2022. All plan sponsors need to start working on processes to meet the new informational requirements and specifications for plan ID cards and EOBs, as well as updating plan documents and communication materials. For all CAA healthcare provisions, the timeline for compliance is tight and plan sponsors are well-advised to move forward as quickly as possible.



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CONTACT

Sean Silva
sean.silva@milliman.com

Michael Halford
michael.halford@milliman.com

Kathryn Elizabeth Mohr
kathryn.mohr@milliman.com