Milliman

MILLIMAN RESEARCH REPORT

2024 Milliman Medical Index

May 2024

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2024 Milliman Medical Index

In 2024, the cost of healthcare for a hypothetical American family of four in a typical employer-sponsored health plan is $32,066, according to the Milliman Medical Index (MMI).[1]

$32,066
for a family of four

$7,151
for an average person

Healthcare costs for the average person increased 6.7% from 2023 to 2024. The MMI segments healthcare costs into five service categories: inpatient facility care, outpatient facility care, professional services, pharmacy, and other services. Pharmacy is the primary driver of the change in MMI healthcare costs, increasing 13% from 2023 to 2024 and contributing to nearly half of the total year-over year change in cost.

Since its inception, the MMI has always quantified the cost of healthcare for a defined family of four. For nearly two decades, the MMI family has remained constant, comprised of a male age 47, a female age 37, a child age 4, and a child under age 1. The MMI family was "mathematically average" when it was created in 2005, with healthcare costs four times that of an individual. However, this is no longer the case due to changes in the composition of families and distribution of healthcare costs. While we will continue to publish the Index based on the original MMI family for tracking consistency with prior versions of this report, we have introduced an interactive tool where users can model healthcare costs using their own definitions of a family.[2] We encourage users to explore different family models, and to observe how the costs of healthcare vary based on those assumptions.

The original MMI also excluded pharmacy rebates. In 2005, pharmacy costs and pharmacy rebates were much smaller, and thus ignoring rebates did not have a significant impact on the results. Today, pharmacy rebates are a significant component of the model for financing prescription drugs and health insurance premiums in the United States. We continue to present the MMI family of four cost gross of rebates to ensure the values remain comparable from year to year. However, all other values presented in this report are for an average person and net of pharmacy rebates, unless otherwise noted. All values listed in the interactive tool, including the family of four value, are also net of pharmacy rebates.

Each year, in addition to presenting the MMI value, we also discuss topics related to healthcare costs in the United States. This year, our report includes discussion of two timely topics:

- The MMI represents the employer and employee costs of a typical employer-sponsored preferred provider organization (PPO) plan. While this cost is substantial by itself, some families purchase healthcare services and products that are not commonly covered by employer-sponsored health plans. These costs are not included in the MMI, but represent a growing additional cost incurred by some families.
- Covered benefits evolve over time and are sometimes affected by government mandates or other actions. In fact, the government and employer-sponsored insurance are closely intertwined. Changes to public sector programs like Medicare and Medicaid, as well as changes in tax policy, the minimum wage, and other government actions can affect employer-sponsored health plans.

These topics are covered in greater detail below, followed by an in-depth discussion of this year's MMI.

1 The MMI family of four value ($32,066) represents healthcare costs for a specific family of four, gross of pharmacy rebates (the value is $30,486 net of rebates). The average person cost ($7,151) and all other costs in this paper are net of pharmacy rebates unless otherwise noted.

2 See www.milliman.com/mmi

Impact of benefits not commonly covered on the Milliman Medical Index

The concept of health insurance as an employee benefit traces back to the early 20th century, when some employers began offering medical services to employees as a form of employee welfare. However, it was not until World War II that employer-sponsored health insurance became widespread. During the war, the U.S. government imposed wage controls to combat inflation, restricting employers from offering higher wages to attract and retain workers. To remain competitive in their recruiting, many employers started providing healthcare benefits as an alternative form of compensation. This practice gained momentum after the war, especially with the passage of the Internal Revenue Code (IRC) in 1954, which provided tax advantages for employer-sponsored health insurance. Over time, employer-sponsored healthcare benefits evolved into a cornerstone of the American healthcare system, covering a significant portion of the population and playing a crucial role in shaping the dynamics of healthcare access and affordability. Today, almost half of all Americans receive health insurance coverage through their employer.[3]

Health benefit coverage provided by group health plans in the United States is subject to specific requirements mandated by federal laws, including the Affordable Care Act (ACA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These laws offer various protections and benefits to individuals covered by employer-sponsored health plans.[4] States also have the authority to enhance these protections at their discretion.[5] State mandates only apply to fully insured plans, not to self-funded plans, which are regulated by the federal Employee Retirement Income Security Act (ERISA).

The landscape of employee benefits is heavily influenced by market dynamics and employer practices aimed at attracting and retaining talent. Employers often tailor their benefit offerings based on industry standards and competitive benchmarks to remain appealing to prospective employees. However, certain benefits may not be commonly covered due to various factors, including cost considerations, regulatory constraints, and historical precedent.

One reason for the absence of certain benefits in employer-sponsored plans is the cost burden associated with their implementation. While many employers strive to provide competitive benefits packages, they must balance the desire to attract talent with the need to effectively manage costs. Benefits that entail significant financial commitments, such as coverage for fertility treatments, may be excluded from standard offerings due to their high cost.

Historical precedent and industry and market norms also play a role in shaping benefit offerings. If certain benefits have not been traditionally covered by employers in a particular sector or region, there may be little incentive for individual employers to deviate from established practices. One such example is coverage for obesity management, which has long been viewed as a cosmetic service and thus excluded from coverage as not medically necessary. This adherence to industry norms helps maintain consistency and stability within the benefits landscape but can also perpetuate the exclusion of certain less common or emerging benefits.

3 KFF (2022). Health Insurance Coverage of the Total Population. Retrieved May 12, 2024, from **https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D**.

4 The U.S. Department of Labor provides a compliance assistance guideline for those offering health benefit coverage: **https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf**.

5 National Conference of State Legislatures (January 25, 2024). Commercial Health Insurance Mandates: State and Federal Roles. Retrieved May 12, 2024, from **https://www.ncsl.org/health/commercial-health-insurance-mandates-state-and-federal-roles**.

Despite these factors, some noncovered benefits are gaining traction within certain markets and types of employers. Plans that choose to provide these benefits face additional upward cost pressure, though the precise impact is difficult to estimate. Because patients pay for these services out of pocket, there is limited data about their costs and utilization. Consequently, it is difficult to quantify the prevalence and costs of these benefits. The example benefits we discuss below are not included in the MMI, and this list is not comprehensive. Nonetheless, many of these benefits will be familiar to, and are valued by, consumers. When evaluating available data, it is essential to exercise caution, as the limited information may be from organizations that are advocating for access to these benefits.

PRESCRIPTION DRUGS

To bring new drugs to market, drug manufacturers must go through extensive research and development, including discovery, clinical research and trials, and product extensions. The "drug pipeline" refers to drugs that are undergoing this process and which have not yet been approved by the U.S. Food and Drug Administration (FDA). As drugs move through the pipeline, the FDA reviews and approves drugs to treat specific conditions or indications. The FDA also reviews drugs already on the market for new indications, resulting in existing drugs being approved for multiple indications.

Employer-sponsored health plans rely on formularies, which is a list of covered drugs, to determine which drugs are covered by the benefit and to manage costs. Formularies are dynamic in that pharmacy benefit managers (PBMs), who maintain them, must react to a variety of factors including brand patent expirations, new drugs, and new indications for existing drugs.

Healthcare providers may prescribe a drug for off-label use, which means the drug is prescribed for a non-approved indication. In some of these cases, the health plan may not cover the off-label use of this drug, which means an individual must purchase the drug outside of the health plan benefit.

One class of drugs growing in popularity is glucagon-like peptide-1 receptor agonists (GLP-1s), more commonly known by product names like Ozempic, Wegovy, and Mounjaro. Anticipated GLP-1 expenditures are the largest contributor to pharmacy trends in the 2024 MMI.

Drugs in this class are currently approved for chronic weight management, type 2 diabetes, and/or cardiovascular disease indications. They could be approved for additional indications in the future. Many employer-sponsored health plans do not provide coverage for all indications today, but this could change as the landscape evolves.

In the future, employer-sponsored health plan costs will be affected by new GLP-1 drugs in the pipeline, approved indications for new and existing drugs, and formulary decisions based on available drugs and approved indications.

Some individuals purchase GLP-1 drugs outside of their employer-sponsored health plan, sometimes with financial support from patient assistance programs or directly through programs created by drug manufacturers and other stakeholders. In these cases, the costs are not included in the MMI because the costs are not covered by the employer-sponsored health plan.

DENTAL AND VISION

Although dental insurance and vision coverage are often offered as part of an employee benefits package, these benefits are typically separate from major medical insurance benefits, and thus the costs for these benefits are not included in the MMI. Dental and vision care may also have minimal or limited coverage. For example, in some cases only certain services are covered, like preventive services or eye exams. Dental and vision benefits may have low annual limits and other benefit exclusions. Employees may need to either purchase separate insurance, like voluntary insurance benefits offered through their employer,[6] or pay out of pocket for these services.

LONG-TERM CARE

Long-term care services, such as nursing home care or in-home care for chronic conditions or disabilities, are offered by some employers,[7] but as a separate benefit not included in our MMI total. Some employers offer additional voluntary benefits or dependent care accounts that allow employees to set aside pretax dollars to pay for these services.

FERTILITY SERVICES

There has been a notable trend toward the inclusion of fertility benefits as part of employer-sponsored health plans. This shift reflects a growing recognition of the importance of reproductive health and family planning support. Fertility treatments, including in vitro fertilization (IVF) services, fertility medications, and assisted reproductive technologies can be costly and thus are often inaccessible for many individuals. Some states have laws mandating coverage of some infertility treatments for fully insured plans, but requirements vary widely from market to market.[8] There is a trend to expand coverage by employers, but many have lifetime benefit maximums and limits on the number of IVF procedures that are covered or they continue to provide no coverage for these services.[9]

DOULA COVERAGE

Doulas provide emotional, physical, and informational support to expectant parents before, during, and after childbirth, complementing the care provided by healthcare providers. Currently, most doula services are paid out of pocket by employees, although states are starting to encourage private plans to cover doula care.[10] Although doula support adds an additional cost, doula support is associated with improved delivery outcomes for pregnant people and babies.[11]

CAREGIVER BENEFITS

The inclusion of caregiver benefits in employer-sponsored health plans reflects a growing recognition of the vital role that caregivers play in supporting the health and well-being of their loved ones. Caregiver benefits typically encompass a range of support services and resources designed to assist individuals who provide care for family members or dependents with chronic illnesses, disabilities,

6 KFF (October 18, 2023). 2023 Employer Health Benefits Survey: Health Benefits Offer Rates. Retrieved May 12, 2024, from https://www.kff.org/report-section/ehbs-2023-section-2-health-benefits-offer-rates/.

7 Goth, G. (January 23, 2024). Is It Time To (Once Again) Consider Long-Term-Care Benefits? SHRM. Retrieved May 12, 2024, from https://www.shrm.org/topics-tools/news/benefits-compensation/long-term-care-insurance-benefits-growing-workplace-trend.

8 Resolve (September 2023). Insurance Coverage by State. Retrieved May 12, 2024, from https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/.

9 Luhby, T. (February 27, 2024). Fertility coverage is a popular employer benefit. Could Alabama's embryo ruling change that? CNN. Retrieved May 12, 2024, from https://www.cnn.com/2024/02/27/business/employer-fertility-benefits-alabama-embryo-ruling/index.html.

10 Chen, A. & Rohde, K. (March 14, 2023). Private Insurance Coverage of Doula Care: A Growing Movement to Expand Access. National Health Law Program. Retrieved May 12, 2024, from https://healthlaw.org/private-insurance-coverage-of-doula-care-a-growing-movement-to-expand-access-2/.

11 Sobczak, A. et al. (May 15, 2023). The Effect of Doulas on Maternal and Birth Outcomes: A Scoping Review. Cureus. Retrieved May 12, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10292163.

or aging-related needs. These benefits may include access to caregiver support groups, counseling services, respite care, and educational resources to help caregivers navigate the challenges associated with caregiving responsibilities. A recent survey showed that specialized caregiver services such as case management, backup care, or in-home modifications are only covered by 14% of employers (under a policy separate from major medical insurance).[12]

ADDITIONAL EXAMPLES

The list of healthcare services and products consumers pay for in addition to their health plan benefits is long, including:

- Alternative therapies or complementary therapies such as acupuncture, chiropractic care, massage therapy, and naturopathy
- Weight loss programs and related prescription drugs and surgical procedures
- Hearing aids
- Experimental treatments
- Cosmetic procedures

While these benefits may not be standard offerings in most employer-sponsored plans, there is growing recognition of their importance in supporting employee well-being and work-life balance. As societal attitudes and workforce demographics continue to evolve, employers may consider expanding their benefit offerings to address emerging needs and priorities. In the meantime, if employees want these services, they are likely incurring additional expenses outside the expenses quantified by the MMI.

Governmental impact on employer-sponsored health benefits

In evaluating the landscape of the employer-sponsored health plans, the role of the government should not be overlooked. As noted above, the employer-sponsored health plans were the private sector's response to government actions in the form of wage freezes. Today, public sector health benefit programs, including Medicaid and Medicare, provide health coverage to over a third of Americans[13] and account for about 45% of the total healthcare spend in the United States. These programs and related policy changes have a profound influence on the dynamics of employer-sponsored health plans.

Changes in the structure, funding, or policy of these programs can trigger ripple effects on insurers, policyholders, and healthcare providers alike. One example of this phenomenon occurs when public sector programs put pressure on provider reimbursement. Providers react to these cuts by seeking higher reimbursement from employer-sponsored health plans, which puts upward pressure on employer-sponsored health plan costs.

We highlight three examples of public sector program changes from recent years that affect the employer-sponsored health plans. It is unclear how these and other government actions will influence employer-sponsored health plans in the future.

12 Cohen, S., Culley, B., Gaspar, N., & Kurelich, C. (February 2023). Informal Caregiving: The Unseen Obligations and Opportunity. Milliman White Paper. Retrieved May 12, 2024, from https://www.milliman.com/-/media/milliman/pdfs/2023-articles/2-22-23_gutsi-ltc-white-paper.ashx.

13 U.S. Census Bureau (September 12, 2023). Health Insurance Coverage in the United States: 2022. Retrieved May 12, 2024, from https://www.census.gov/library/publications/2023/demo/p60-281.html#.

MEDICAID UNWINDING ACTIVITIES

State Medicaid programs played a key role in supporting continuous health coverage for low-income Americans during the COVID-19 public health emergency (PHE). The Families First Coronavirus Response Act[14] (FFCRA) required states to cease Medicaid program disenrollment activities during the PHE to be eligible for enhanced federal funding. This component of FFCRA, referred to as the Medicaid continuous enrollment requirement, resulted in Medicaid enrollment increasing by over 30% from January 2020 to March 2023, an increase of approximately 23 million Americans.[15] The Consolidated Appropriations Act, 2023, decoupled the continuous enrollment requirement from the PHE.[16] This enabled states to resume Medicaid redetermination activities and commenced the Medicaid unwinding period. As of January 2024, total Medicaid enrollment had decreased by around 10 million individuals since the end of the FFCRA enrollment requirements.[17]

It is anticipated that some individuals no longer covered by state Medicaid programs will become uninsured, while others may enroll in employer-sponsored health plans. This influx of new enrollment has the potential to materially influence the health insurance landscape, particularly in the ACA marketplace and fully insured employer-sponsored segments.

Employer-sponsored health plans, members, and healthcare providers will experience the impact of Medicaid unwinding throughout 2024. The average Medicaid recipient has a higher risk profile than those enrolled in employer-sponsored health plans. While the impact may not be known until sometime after 2024, the transfer of individuals previously covered by state Medicaid programs may serve to increase private sector costs. For healthcare providers, it is anticipated that increases in uncompensated care costs from newly uninsured members will be partially offset by the higher reimbursement received for members that transition from Medicaid to private coverage.

MEDICARE DRUG PRICE NEGOTIATIONS

On August 16, 2022, the Inflation Reduction Act of 2022 (IRA) was signed into law. The IRA includes **numerous drug pricing reform components** affecting Medicare Advantage and Medicare Part D, including authorizing the Secretary of the U.S. Department of Health and Human Services (HHS) to negotiate drug prices. The negotiation of drug prices for Medicare Part B and Medicare Part D—potentially as many as 80 drugs by 2030—could have a downstream effect on the employer-sponsored market.

It is widely accepted that commercial reimbursements are higher than Medicare (and Medicaid), with a recent Milliman study indicating that 2023 national commercial reimbursement rates are 188% of Medicare fee-for-service (FFS) rates.[18] Effectively, this indicates that, when the government sets reimbursement rates for public programs, the employer-sponsored market generally bears the brunt of higher costs for the same services. While there are some exceptions to this dynamic, the typical payer in the employer-sponsored market does not have the same negotiating leverage as the federal government.

While it is still too early to tell, it is possible that drug price negotiations on behalf of Medicare beneficiaries will result in price pressures for those same medications in the employer-sponsored market. This may exacerbate the employer-sponsored market prescription drug cost trend, which has already been one of the bigger drivers of cost increases in the past decade.

14 The full text of FFCRA is available at **https://www.congress.gov/bill/116th-congress/house-bill/6201/text**.

15 Medicaid. Medicaid and CHIP Enrollment Trend Snapshot. Retrieved May 12, 2024, from **https://www.medicaid.gov/medicaid/program-information/medicaid-chip-enrollment-data/medicaid-and-chip-enrollment-trend-snapshot/index.html**.

16 The full text of the Consolidated Appropriations Act, 2023 is available at **https://www.congress.gov/bill/117th-congress/house-bill/2617/text**.

17 Medicaid and CHIP Enrollment Trend Snapshot, op cit.

18 Anderson, C., Mills, C., et. al. (November 2023). Commercial reimbursement benchmarking. Milliman Research Report. Retrieved on May 13, 2024 from **https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking-payment-rates-medicare-fee-for-service**.

HEALTHCARE PRICE TRANSPARENCY

Multiple pieces of legislation enacted over the past five years have aimed at protecting patients from surprise medical bills and creating more transparency with respect to healthcare prices, allowing consumers to shop for healthcare services.

- The Hospital Price Transparency (HPT) rule went into effect on January 1, 2021, requiring hospitals to provide clear, accessible pricing information in both a machine-readable file (MRF) and a consumer-friendly format for shoppable services.
- The No Surprises Act (NSA) was signed into law as part of the Consolidated Appropriations Act of 2021 (CAA). It took effect on January 1, 2022, establishing protections against surprise medical bills.
- The Transparency in Coverage (TiC) rule, with enforcement starting on July 1, 2022, required group health plans and issuers to disclose pricing information for all covered items and services between the plan or issuer and in-network providers. The TiC rule also required an internet-based price comparison tool allowing an individual to receive an estimate of their cost-sharing responsibility for a specific item or service from a specific provider or providers—as of January 1, 2024, this affects all items and services.

The activity in Congress related to transparency of prescription drug prices continues. These efforts continue to have strong bipartisan support, raising the possibility that these rules will continue to be strengthened for the benefit of healthcare consumers.

The availability of this data could revolutionize the way stakeholders, including consumers and employer-sponsored plans, understand and interpret healthcare prices. There are already many payers and providers using this data to benchmark their prices and negotiate reimbursements. Employers are starting to evaluate how this data can be used to support benefit program design, selection of third-party administrators (TPAs), and member communication and navigation to high-value providers.

A deeper look into the MMI

HOW THE MMI IS CONSTRUCTED

The MMI represents the projected total cost of covered healthcare services for an average person as well as for a hypothetical family of four (two adults and two children) covered under an average employer-sponsored PPO health benefit program for a calendar year. The MMI reflects the following:

- Nationwide average provider fee levels negotiated by insurance companies and preferred provider networks
- Average PPO benefit levels offered under employer-sponsored health benefit programs
- Utilization levels representative of the average for people covered by large employer group health benefit plans in the United States

The MMI plan pays approximately 85.3% of the total cost of care in 2024, meeting the minimum requirement of 60% for a large employer's health plan under the ACA.

HOW THE MMI DIFFERS FROM OTHER INDICES

The MMI dollar amounts are the best estimates of annual healthcare grounded in actual health insurance claims incurred over multiple years. The most recent year of data reflects approximately 55 million lives. We have projected it forward from 2022 to 2023 and 2024 using estimated trend rates.

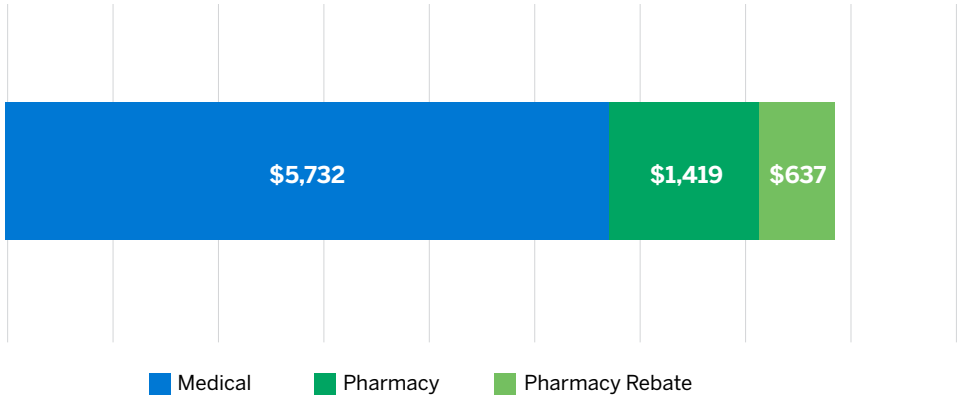
The MMI reflects the most recent data from Milliman's ongoing research on healthcare costs. The MMI is derived from our flagship health cost research tool, the **Milliman Health Cost Guidelines™** , as well as a variety of other Milliman and industry data sources, including **Milliman's Mid Market Survey**, **Milliman MedInsight® Emerging Experience research database**, and **Milliman Health Trend Guidelines™**.

PHARMACY REBATES

Pharmacy rebates are channel incentives negotiated between payers (including PBMs) and drug manufacturers for preferred formulary placement and other benefit and plan design features that result in preference for particular pharmaceutical products. Rebate agreements are treated as proprietary information by the parties that negotiate them and thus it can be challenging to assemble a comprehensive picture of the volume and scope of rebates and other channel incentives. Health insurers report rebates and paid drug claims for fully insured business in statutory financial statements. However, the rebates for the self-insured employers are not publicly available. PBMs typically provide the rebate to the employers after paying for the claims with a lag of 90 to 180 days. Changes to the treatment of prescription drug rebates, including returning rebates to the consumer at the point of sale, have been, and continue to be, a hot topic of discussion among PBMs, pharmaceutical manufacturers, and regulators.

In most employer-sponsored PPO plans, rebates do not affect an employee's out-of-pocket costs but could reduce employee contributions. We project rebates in 2024 to be approximately 29% to 32% of allowed drug costs for an average person. Figure 1 illustrates the impact of rebates on the 2024 MMI value for the average person. If employers were not receiving the rebates, the MMI average person cost would have been $637 (or 8.9%) higher.

FIGURE 1: ILLUSTRATIVE IMPACT OF PHARMACY REBATE TO THE MMI AVERAGE PERSON



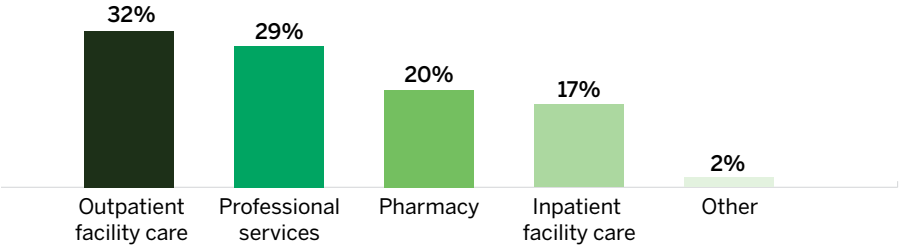
COMPONENTS OF COST

The MMI segments healthcare costs into five categories of services: inpatient facility care, outpatient facility care, professional services, pharmacy, and other services. Note that professional services includes costs for all professional fees, including those from physicians and other healthcare professionals, that are incurred when a patient uses a hospital, clinic, surgical center, stand-alone lab or imaging center, or a physician's office. Other services include home healthcare, ambulance services, durable medical equipment (DME), and prosthetics.

As shown in Figure 2, outpatient facility care and professional services for the MMI's average person are the two largest components of care, each accounting for approximately 30% of the total cost. Inpatient facility cost has slightly decreased its share to approximately 17% of the total cost, while the pharmacy cost after rebate is expected to increase to approximately 20% of the total cost. As a comparison, three years ago the MMI pharmacy cost was estimated at only 17% of the total cost after rebate.[19] Other services remain 2% of the total cost.

19 Houchens, P., Liner, D., Man, A. et al. (May 2021). 2021 Milliman Medical Index. Milliman Research Report. Retrieved May 12, 2024, from https://us.milliman.com/-/media/milliman/pdfs/2021-articles/2021-milliman-medical-index.ashx.

FIGURE 2: 2024 MMI COMPONENTS OF SPENDING FOR AN AVERAGE PERSON



EMPLOYEE SHARE OF COST

In the employer group insurance market, the total cost of healthcare is shared by employers and employees in the three categories.

- **Employer contribution.** Employers that sponsor health plans subsidize the cost of healthcare for their employees by allocating dollars to pay a large share of the cost. The portion paid by the employer can vary according to the benefit plan option the employee selects.
- **Employee contribution.** Employees who choose to participate in the employer's health benefit plan typically also pay a share of the premiums, usually through payroll deduction.
- **Employee out-of-pocket cost.** When employees receive care, they also often pay for a portion of these services via health plan deductibles and/or point-of-service copays or coinsurance. While these payments are capped by out-of-pocket maximums, the costs can still be substantial.

Figure 3 shows the cost breakdown for the MMI average person in 2024. Of the $7,151 total cost for an average person, the employer pays about $4,117 (58% of the total) while the employee pays the remaining $3,033 (42% of the total), which is a combination of $1,891 in payroll deductions for the employee contribution and $1,142 in out-of-pocket costs paid when utilizing healthcare services. The employer's cost would be 9% higher if they were not receiving pharmacy rebates.

FIGURE 3: HEALTHCARE COST BY SOURCE OF PAYMENT FOR AN AVERAGE PERSON

	AVERAGE PERSON	% IN TOTAL
Employer Contribution	$4,117	58%
Employee Contribution	$1,891	26%
Employee Out-of-Pocket	$1,142	16%
Total	**$7,151**	**100%**

In addition to the variation of the total cost of care, the distribution of the cost among the five health service categories will be different for the MMI average person and other family compositions. For example, inpatient hospital costs vary by age. For very young people they are higher, due to complications associated with birth and infancy. A family that includes a child under age 1 may have a higher proportionate inpatient cost than an average person.

The contribution between employer and employee will vary by the size of the firm, industry, location of the employer and employees, the employee's demographics, claim histories, unionization, and the employer's financial health. Additionally, in general, employees with single coverage would pay 20% of their health insurance premiums.[20] But employees who elect family coverage would pay 32% of their premiums.[21] This indicates that the contribution to the total cost of care (e.g., allowed cost) by employers can be higher for employees with single coverage compared to those who with family coverage. The employer and employees could also benefit from potential tax benefits to fund the total cost of care, through lowering the employer's taxable income, providing health savings accounts (HSAs) or health reimbursement arrangements (HRAs), as well as receiving tax credits, if eligible.

VARIABILITY IN COSTS

Any family or individual could have significantly different costs. Variables that affect costs include:

Age and gender. There is wide variation in costs by age, with older people generally having higher average costs than younger people. Variation also exists by gender, driven primarily by maternity costs and differing healthcare needs by gender. Average utilization and costs of specific services will be different for other demographic groups.

Individual health status. Tremendous variation also results from health status differences. People with severe or chronic conditions are likely to have much higher average healthcare costs than people without these conditions.

Geographic area. Significant variation exists among healthcare costs by geographic area because of differences in population density, healthcare provider practice patterns, and average costs for the same services. For example, the relative cost of living affects healthcare costs, as labor costs (e.g., nurses and technicians) tend to be higher in areas where the cost of living is higher. Access to advanced technology also affects the utilization of services by geographic area.

Provider variation. The cost of healthcare depends on the specific providers used. Even in the same city, costs for the same service can vary dramatically from one provider to another. The cost variation results from differences in billed charge levels, discounted payment rates that payers have negotiated, and implementation of payment methodologies that may influence utilization rates, such as capitation or case rates.

Insurance coverage. The presence of insurance coverage and the amount of required out-of-pocket cost sharing also affects healthcare spending. With all other variables being equal, richer benefit plans usually have higher utilization rates and costs than leaner plans.

Provider network and choices. Although the MMI has been assuming a PPO health benefit program, health maintenance organization (HMO) plans and narrow network plans could be good choices for some employers that look for cost savings in the lower negotiated provider payment rates.

Pharmacy rebate agreements. Drug rebates are generally paid by pharmaceutical manufacturers to PBMs for preferred formulary placement. PBMs often share a portion of rebates with the health plan and employer clients, but there is wide variation in how much rebates are shared with employers and what employers do with those funds. It is possible that some small employers may have a difficult time negotiating a market average arrangement with their PBMs.

20 See https://www.bls.gov/news.release/ebs2.t03.htm

21 See https://www.bls.gov/news.release/ebs2.t04.htm

Acknowledgments

Many have contributed to this work. The authors thank Liam Kussman and Rachel Madden for their technical contributions, Jeremy Engdahl-Johnson and Rebecca Driskill for editorial contributions, and other Milliman professionals for their input and advice. Finally, the authors would like to recognize Doug Norris for his many years of service to Milliman and his contributions to the MMI.

Milliman

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